

Telehealth: The New Normal

Learning Objective: At the conclusion of this continuing medical education activity, the participant will be able to describe the current state of telehealth legislation and restrictions, identify an appropriate selection of a videoconferencing platform for HIPAA compliance, apply data from telehealth research for urological conditions to their own practice and properly code telehealth visits for accurate reimbursement.

This AUA Update aligns with the American Board of Urology Module on Core/General Urology. Additional information on this topic can be found in the AUA Core Curriculum section on Business/Communications.

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INTRODUCTION

The use of telehealth in the assessment and treatment of patients with urological conditions increased dramatically during the COVID-19 public health emergency.^{1,2} Although telehealth has been used in urology for many years prior to the pandemic, the requirement of safe social distancing while still providing patient care motivated patients and providers to rapidly adopt virtual methods of healthcare delivery.³ Telehealth is typically defined as the use of any remote technology to provide healthcare and related services at a distance, while telemedicine more specifically refers to a remote clinical visit between a patient and a provider.⁴ However, the terms are frequently used interchangeably to reference the “exchange of medical information from one site to another through electronic communication to improve a patient’s health.”⁵ For the purposes of this Update, we will focus on video visits as the primary method of urological telehealth delivery. **We explicitly define a video visit as a virtual medical encounter between a provider and patient with live simultaneous audio and video communication.** We will also discuss telephone visits, as not all patients and providers can access videoconferencing software required for video visits.

In this Update, we aim to first review logistical components of telehealth, including federal and state laws, office readiness, and videoconferencing platforms. Next, we assess the evidence behind using telehealth for specific urological conditions. Finally, we will focus on business considerations of costs, coding, and reimbursement for telehealth services.

LEGISLATIVE CONSIDERATIONS

Prior to the COVID-19 public health emergency, patient restrictions on video visit eligibility were a major hurdle for widespread use. Namely, Medicare beneficiaries had to reside in a Healthcare Professional Shortage area and conduct the visit from an approved medical facility (ie patients were not allowed to conduct visits from their homes). However, this so-called “originating site requirement” was waived in March 2020 via the 1135 Waiver in response to the COVID-19 pandemic.⁶ **As a result, all Medicare Part B beneficiaries were eligible to perform video visits from their home.** Many private payers and state Medicaid programs followed suit and removed many pre-pandemic restrictions on telehealth use. The Center for Connected Health Policy (<https://www.cchpca.org>) is an excellent resource for state specific restrictions on video visit and telephone visit use, including any waivers during the ongoing COVID-19 public health emergency.⁷

After the COVID-19 public health emergency, the 1135 Waiver will expire and the pre-pandemic restrictions for Medicare beneficiaries on video visits will resume. However, there is strong bipartisan support for modernization of telehealth use. For example, the Telehealth Modernization Act of 2020 was introduced on the floor of the 116th Congress, but was not voted on prior to that Congress’s concluding session.⁸ We

remain optimistic that the 117th Congress will pass legislation that will permanently allow all Medicare beneficiaries to remain eligible for video visits from home.

One component of telehealth delivery that remains inconsistent is that of crossing state borders, eg, when a patient resides in Alaska and the urologist is in Washington State. Prior to the pandemic, the Washington urologist would need to also have a full medical license in Alaska to legally perform and bill for the video visit. During the COVID-19 public health emergency response, many state medical boards relaxed this state licensure requirement for telehealth; however, this was not universal across all states.⁹ **Following the pandemic, it is likely that most states will again require state licensure of the provider in the state where the patient resides to legally perform telehealth visits.** In order to streamline the state licensure process, the Interstate Medical Licensure Compact (<https://www.imlcc.org/>) had formed prior to the pandemic. Currently 28 states participate in the Compact. Board certified physicians in those states can first apply to the Compact for a \$700 fee. Once approved by the Compact, the physician can easily select other states belonging to the Compact in which they would like to obtain a medical license; the physician then is required to pay the licensure fee for each state (ranging from \$75-\$790 per state) in addition to the original \$700 Compact application fee.¹⁰

OFFICE READINESS

In order to safely and securely provide video visits, urologists and patients need the devices, software, and Internet connectivity required to participate in video visits. Devices that are capable of performing a video visit include desktops/laptops with webcams, tablet computers, and almost all smartphones. Providers should ensure that their video visit location is in a secure area where private visits can take place. Next, providers must have an appropriate videoconferencing platform to conduct the video visit. **These platforms should be secure, and the urology practice must enter into a HIPAA Business Associate Agreement with the platform company to ensure ongoing HIPAA compliance.** Some EMRs actually have embedded proprietary video visit software, whereas other EMRs allow for integration of commonly used stand-alone software platforms which can streamline the check-in and visit initiation process. Not all platforms can be integrated with all EMRs, so this is something that should be clarified prior to selecting a videoconferencing platform. Table 1 lists commonly used videoconferencing platforms for video visits. These platforms provide the ability to share screens, invite family members to the visit, and also for language interpreters to join. An additional component is whether the platform requires patients to download software or a smartphone application prior to the visit. Although this is often a onetime download prior to the first visit, it can prove to be a source of frustration for less technologically savvy patients, and could result in the video visit failing and being converted to a telephone visit.

Another component of successful video visits is having office staff who are comfortable and capable of assisting patients with video visits. A good strategy is to have a medical assistant open

ABBREVIATIONS: CPT=Current Procedural Terminology, EMR=electronic medical record, HIPAA=Health Insurance Portability and Accountability Act of 1996, PSA=prostate specific antigen, UTI=urinary tract infection, VA=Veterans Affairs

the video visit link 5–10 minutes before the appointment time to ensure the patient has successfully logged in. If issues arise, the medical assistant can contact the patient via telephone to help troubleshoot the log-in phase. Once the patient is successfully logged in for the video visit, the medical assistant can confirm the patient's identity and current medications, and obtain self-reported height and weight. The provider is then notified and joins the meeting to conduct the video visit. If the patient is unable to successfully log in for the video visit, the provider can call the patient on the telephone. Following the visit, it is important that follow-up plans be coordinated by the clinic team for imaging studies, lab requisitions, prescriptions, and follow-up visits.¹¹ These tasks that could be completed when a patient checked out of the clinic following an in-person visit often require a phone call or secure electronic message following a telehealth visit. These workflows following telehealth visits require some adjustment for providers, staff, and patients. Furthermore, it is important that new staff members and providers conduct mock video visits in the onboarding process to ensure they know how to troubleshoot common problems encountered during video visits and adapt to that particular clinic's workflow for coordinating follow-up.

Finally, not all patients will have the ability to perform video visits. It is important for providers to be aware that varying geographic and socioeconomic factors may prohibit patients from having devices, broadband access, or familiarity with technology, which are all required to conduct a successful video visit.^{12,13} Family members can sometimes provide devices or assist with the log-in process for video visits, but ultimately some patients may only be able to partake in telephone or in-person visits.

EVALUATION OF UROLOGICAL CONDITIONS

Many urological conditions can be successfully evaluated through video visits.¹⁴ Reports from the VA hospitals demonstrated that video visits can be safely incorporated into both the initial evaluation and subsequent follow-up care for common urological conditions such as lower urinary tract symptoms, elevated PSA, hematuria, and sexual dysfunction (erectile dysfunction, infertility, premature ejaculation, etc).^{15,16} Nourian et al reported that 36% of conditions were managed completely through video visits.¹⁶ These video visits also provided significant travel cost savings while maintaining high patient satisfaction.¹⁵ Additionally, in a urology advanced practice provider telemedicine program for incarcerated patients in Iowa, Sherwood et al reported that 90% of patients with general urological issues had accurate diagnoses made via telemedicine when they later presented for in-person evaluation.¹⁷ The authors also estimated that 50% of patients could have been completely managed via telemedicine visits. An important caveat to these reports from the VA system and Iowa prison system is that patients were located at a local VA clinic and prison clinic, respectively, when the video visit took place. Thus, local medical providers (nurses or physicians) at the clinic could assist with physical exam, as needed. In evaluating patients conducting visits from their home, Andino et al reported on 600 video visits and 600 in-person visits for established patients at an academic tertiary referral center across a wide spectrum of urological diagnoses.¹⁸ The authors found that the need for in-person revisits for urgent urological concerns within 30 days of the index visit

was <1% from both in-person and video visits. These studies demonstrate that urological care can be effectively delivered through video visits.

The evaluation and surveillance of patients with nephrolithiasis is particularly well suited for telehealth, given that treatment decisions weigh heavily on imaging and patient symptoms. In a study of over 1000 patients presenting to the emergency department or outpatient clinics with suspected renal colic and no infectious signs or symptoms, Ong et al found that a system of computerized tomography 3 weeks later and a urology telephone visit to review scan results prevented over 700 unnecessary in-person urology visits.¹⁹ In a separate study, Hughes et al found that a nursing-led telephone based imaging follow-up clinic for 290 patients with known nephrolithiasis resulted in >80% of patients not requiring in-person visits, while only 2% of patients had imaging findings and symptoms requiring urgent urological intervention.²⁰ This led to dramatic healthcare system cost reductions for nephrolithiasis surveillance. Thus, telehealth use in the care of patients with nephrolithiasis could replace many in-person urologist visits.

Recent work that was done during the COVID-19 public health emergency also supports the successful use of both telephone and video visits in the initial evaluation and return visits for patients presenting with sexual dysfunction (Peyronie's disease, erectile dysfunction, infertility).^{21–23} Patients reported a relatively high level of satisfaction with telephone visits;²¹ however, the optimal use and effectiveness in patients presenting with sexual dysfunction remain to be determined.

Telephone visits have been shown to be beneficial in the initial evaluation of patients with hematuria. For 150 patients referred for hematuria to the Atlanta VA Hospital, Safir et al found that an initial telephone consult allowed for successful history gathering and results review.²⁴ Patients were then scheduled for cystoscopy and appropriate follow-up imaging to complete the hematuria evaluation. **A post-visit survey revealed that 98% of patients preferred the initial telephone evaluation over an in-person visit. Additionally there was significant cost-savings to the healthcare system and patients for telehealth evaluation.**²⁵ Particularly given the new AUA guidelines for microscopic hematuria with differing imaging studies recommended based on patient risk categories, initial video visit or telephone evaluation can ensure appropriate imaging is obtained prior to in-person examination and cystoscopy.²⁶

Telephone visits have also been found to be successful in monitoring established patients. In a study of over 600 patients whose planned in-person follow-up visits for benign urological conditions (81% benign prostatic hyperplasia, 11% nephrolithiasis) were converted to telephone during COVID-19, only 12.5% required an in-person visit within 2 weeks following the phone call for further evaluation.²⁷ The remaining 87.5% of patients were scheduled for routine follow-up. Similarly, in 1679 telephone visits done during COVID-19, Turcotte et al found that urologists classified over two-thirds of visits as having been completely managed over the phone.²⁸ The success of telephone visits for established patients does pre-date the COVID-19 pandemic: in a study of over 400 patients with follow-up telephone visits after an in-person evaluation, Miah et al reported that 68% of patients required no additional follow-up visits after the telephone visits.²⁹

The treatment of urinary tract infections is a specific area that utilized telehealth with significant effectiveness prior to the

pandemic. However, it is important to note that these studies focused on uncomplicated UTIs in women, a condition more commonly managed by primary care providers than urologists in the United States. Vinson and Quesenberry reported on over 4000 women who were initiated on antibiotics for presumed uncomplicated UTI after discussion with a centralized nursing call center that had a standardized protocol for screening UTI symptoms.³⁰ They found that 18% of women had subsequent medical encounters for UTI-related symptoms in the 6 weeks after the telephone nursing visit. No patients developed sepsis, and only 0.5% went on to develop pyelonephritis.³⁰ Similarly, Schauburger et al studied 273 women with nursing-based telephone triage and treatment of uncomplicated UTI and found that 17% had subsequent medical encounters for persistent UTI-related symptoms, and 2% developed pyelonephritis.³¹ Blozik et al also found that after telephone triage and antibiotic treatment initiation for uncomplicated UTI in 526 women, only 12% later presented for persistent symptoms.³² One main component of these studies is that most women were started on antibiotics without a preceding urinalysis or urine culture. Although this is common for uncomplicated UTI, these are not the typical patients urologists are evaluating for possible complicated or recurrent UTIs. Thus, telehealth visits for urologists would likely need to be combined with urine tests either before or after the telehealth visit.

Urologists have also implemented telehealth across a broad spectrum of urological conditions for postoperative visits. Telehealth visits following pediatric urological operations,^{33,34} radical prostatectomy,³⁵ and female stress urinary incontinence surgery^{36,37} have all been specifically evaluated. **These studies reported that telehealth visits significantly reduced patient travel burdens, maintained high patient satisfaction, and that patients requiring urgent in-person evaluation were very rare.**

Although not all domains of urology have published reports to specifically support the use of telehealth in providing patient care, it can likely be incorporated into the evaluation of many disease processes. Some urological conditions could potentially be managed without any in-person visits. Table 2 demonstrates examples of how video visits may be utilized in the initial evaluation and follow-up of patients with common urological problems.

BUSINESS CONSIDERATIONS

There are a number of financial and business considerations regarding the use of telehealth in a urology practice. These include balancing the costs of providing telehealth with the successful coding and reimbursement of telehealth visits. Video visits require the practice to invest in hardware required for video visits (eg webcams, additional computer stations, microphones, and headsets). More substantial are the ongoing costs of increasing the Internet bandwidth to the office and videoconferencing software subscription fees. As discussed previously, if providers wish to provide out-of-state telehealth visits after the pandemic, the cost of maintaining out-of-state medical licenses will also contribute to total expenses.

Once telehealth visits are completed, coding the visits correctly is critical for accurate billing and appropriate reimbursement. **Table 3 lists the CPT codes and modifiers for video visits, virtual check-in visits, and telephone visits.** Video visits are coded with the same CPT codes as in-person visits. Prior to the COVID-19 public health emergency, the Place of Service

was set to 02 to denote a telemedicine visit for Medicare claims. However, from March 1, 2020 through the duration of the COVID-19 public health emergency, the Place of Service should be the same as in-person visits, but modifier 95 should be used for a video visit.³⁸ For most private payers, both before and during the COVID-19 public health emergency, modifier 95 or GT is used. Prior to 2021, video visits were almost exclusively coded based on time, given the physical exam components required for higher level coding. This often resulted in video visits having lower levels of billing compared to in-person visits,³⁹ and such reimbursement disparity was considered a major barrier to widespread use in urology.⁴⁰ However, the 2021 modifications of the evaluation and management guidelines state that the physical exam is not a component of selecting a billing level and that it does not need to be documented unless clinically relevant.⁴¹

The Medicare program also created codes for “virtual check-ins” that can be either video or telephone. These visits are intended to be brief interactions with patients to determine if an in-person assessment is required. These codes cannot be billed within 7 days of a prior visit (video or in-person) or if they lead to an in-person evaluation in the next 24 hours.⁶ During the COVID-19 public health emergency, however, Medicare does reimburse for telephone visits (CPT 99441-3). **However, once the public health emergency is over, these telephone codes will no longer be accepted; virtual check-in codes will be the only method to code and be reimbursed for visits conducted via telephone for Medicare beneficiaries.**⁴²

Currently, reimbursement for video visits from Medicare is the same as for in-person visits of the same level. Table 3 contains the work relative value unit for each of the CPT codes. All 50 state Medicaid programs now reimburse for video visits at some level.⁴³ Many states also have private payer laws that ensure parity in terms of services covered by video visits and in-person care (ie, coverage parity), but fewer than 10 states have laws that require identical reimbursement between in-person and video visits for the same level of care (ie, payment parity).⁴³ Given that reimbursement was cited as a major barrier to urological telehealth use prior to the COVID-19 pandemic,⁴⁰ the continued widespread use of telehealth after the public health emergency will likely require increased payment parity.

CONCLUSION

The COVID-19 pandemic and the need to continue providing medical care caused an immense and rapid rise in telehealth utilization. Urologists and patients experienced both the advantages and growing pains of this rapid uptake of telehealth. Once changes to telehealth policy enacted during the COVID-19 public health emergency are made permanent, telehealth will be entrenched as an integral part of how urologists provide safe and effective care to patients. Careful attention to documentation and coding is critical to ensuring the financial viability of video visits to urologists. We remain optimistic that telehealth will also provide a means to improve access to urological care for previously underserved patient populations.

DID YOU KNOW?

- The COVID-19 Public Health Emergency resulted in many restrictions in telehealth being lifted and subsequent widespread use in urology.
- Compared with in-person visits, both telephone visits and video visits have been shown to reduce patient travel and cost burdens while providing safe medical care across a wide spectrum of urological conditions.
- For Medicare and most private payers, video visits are billed using the same CPT codes as in-person visits with the addition of modifier GT or 95 (private payers), or changing the Place of Service to 02 (Medicare). However, during the COVID-19 public health emergency, Medicare video visits should be billed with modifier 95 and the same Place of Service as an in-person visit.

Table 1. Common videoconferencing platforms for video visits

Platform	HIPAA Business Associate Agreement Available	Patient Software/Application Download Required	EMR Integration Available*
Doximity	Yes	No	No
Updox	Yes	No	Yes
Doxy.me	Yes	No	No
Zoom for Healthcare	Yes	Yes	Yes
Google Meet	Yes	No	No
Microsoft Teams/ Skype for Business	Yes	Yes	Yes
VSee	Yes	Yes	No

*Depending on EMR system used.

Table 2. Common urological diagnoses and examples of how telehealth can be incorporated into initial and follow-up care

Diagnosis	Initial Visit	Follow-up
Elevated PSA	Video visit to confirm history, assess other etiologies, order additional diagnostic tests if indicated	In-person visit for prostate exam, review additional test results, and possible biopsy
Prostate cancer	Video visit to discuss diagnosis and treatment options	In-person for preoperative exam* or surveillance biopsy. Telehealth to review post-treatment PSA
Renal mass/kidney cancer	Video visit to discuss treatment options, obtain additional imaging or laboratory studies	In-person for preoperative exam,* review additional studies. Telehealth for review of surveillance imaging
Hematuria	Video visit to discuss evaluation and imaging modality based on risk category	In-person visit for cystoscopy and review imaging
Bladder cancer	Video visit to discuss treatment options	In-person for preoperative exam* or surveillance cystoscopy. Telehealth for review of surveillance imaging
Voiding dysfunction/ lower urinary tract symptoms	Video visits to classify symptoms, order urine tests if indicated. Medication initiation	In-person visit for prostate exam, uroflow or post-void residual assessment if indicated. Telehealth to monitor response to medications
Stone disease	Video visit to discuss surgery vs medical management (in the non-emergency setting)	In-person for preoperative exam* or post-procedural stent removal. Telehealth for surveillance imaging and laboratory studies
Sexual dysfunction (infertility, erectile dysfunction etc)	Video visit to gather history, contributing factors. Order additional diagnostic tests	In-person for physical exam if indicated. Telehealth to review test results
Urinary tract infections	Video visit to clarify time course, severity, and frequency of infections. Order additional lab and urine tests	In-person visit for physical exam if indicated. Telehealth to monitor response to treatment and review test results.

*Depending on patient characteristics and physician preferences, preoperative physical examination could be deferred to the day of planned surgical procedures.

Table 3. Outpatient telehealth CPT billing codes based on Centers for Medicare and Medicaid Services final rule 2021

CPT		Description	Modifier	Work Relative Value Unit: 2021
		<i>Video visits</i>		
99202-5		New patient visit* 2: 15-29 min 3: 30-44 min 4: 45-59 min 5: 60-74 min	Medicare: During COVID-19: Modifier 95 Prior to COVID-19: Place of Service 02 Non-Medicare: Modifier 95 or GT	2: 0.93 3: 1.60 4: 2.60 5: 3.50
99211-5		Established patient visit* 1: <10 min 2: 10-19 min 3: 20-29 min 4: 30-39 min 5: 40-54 min	Medicare: During COVID-19: Modifier 95 Prior to COVID-19: Place of Service 02 Non-Medicare: Modifier 95 or GT	1: 0.18 2: 0.70 3: 1.30 4: 1.92 5: 2.80
		<i>Virtual check-in (video visit or telephone)</i>		
G2012/ G2251		Established patient, brief virtual check-in, 5-10 min	None	0.25
G2252		Established patient, brief virtual check-in, 11-20 min	None	0.50
		<i>Telephone (only reimbursed by Medicare during COVID-19 public health emergency)</i>		
99441-3		Telephone visit (new or established) 1: 5-10 min 2: 11-20 min 3: 21-30 min	None	1: 0.70 2: 1.30 3: 1.92

*Time-based coding includes total time on the day of service, including pre-visit review of records, video visit time and post-visit care coordination. Depending on the complexity of medical decision making, higher level coding may be appropriate even if the time thresholds are not met.

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Study Questions Volume 40 Lesson 21

1. Following the COVID-19 Public Health Emergency, an audio-only 20 minute telephone call for an established Medicare Beneficiary who has not been seen in the prior 7 days and does not require in-person evaluation in the next 24 hours should be submitted with the CPT code
 - a. 99213 with Place of Service 02
 - b. 99213 with Modifier 95
 - c. G2252
 - d. 99442
2. The most important aspect in selecting a videoconferencing platform to use for video visits is one in which
 - a. the platform provider can enter a HIPAA Business Associate Agreement with the medical practice
 - b. the platform can integrate directly into the electronic medical record
 - c. patients do not need to download a program to have the video visit
 - d. interpreter services are integrated into the platform
3. The initial evaluation of hematuria through telehealth has been shown to
 - a. be preferred by patients over an initial in-person evaluation
 - b. increase the overall costs of the evaluation
 - c. create dissatisfaction among patients
 - d. result in significant delays of care
4. During the COVID-19 public health emergency, Medicare beneficiaries can participate in video visits
 - a. only if they reside in a Healthcare Professional Shortage designated area
 - b. only for care related to COVID-19 exposures or symptoms
 - c. from a local physician's office or healthcare clinic
 - d. from any location, including their home
5. Compared to in-person visits, video visits in postoperative care following radical prostatectomy have been shown to
 - a. increase the number of patients needing urgent in-person evaluation
 - b. correlate with very high rates of patients being lost to follow-up
 - c. increase out-of-pocket costs for patients
 - d. decrease travel burden for patients