

**AMERICAN COLLEGE OF RHEUMATOLOGY  
POSITION STATEMENT**

**SUBJECT:** Telemedicine

**PRESENTED BY:** Committee on Rheumatologic Care

**FOR DISTRIBUTION TO:** Members of the American College of Rheumatology  
Members of Congress  
Carriers/Private Insurers  
State Insurance Commissioners

**Positions:**

1. The American College of Rheumatology (ACR) supports the role of telemedicine as a tool with the potential to increase access and improve care for patients with rheumatic diseases, but it should NOT replace essential face-to-face assessments conducted at medically appropriate intervals.
2. The ACR supports continued parity of reimbursement for in-office visits, audio-visual visits and audio-only visits, both by CMS and by commercial payers, after the declared COVID-19 public health emergency (PHE) has ended, if telemedicine services abide by the following principles:
  - a. The provider-patient relationship should include both in-person and telemedicine services in accordance with the American Medical Association (AMA) Code of Medical Ethics, specifically Ethical Practice in Telemedicine [1]
  - b. Patients should have a choice of provider for telemedicine services, as is required for all medical services.
  - c. The standards and scope of care provided remotely via telemedicine services should be consistent with related in-person services. The limitations of the relevant technologies should be recognized, and appropriate steps taken to mitigate these limitations.
  - d. The provision of telemedicine services must be properly documented.
3. The ACR recommends that telemedicine platforms provide an efficient mechanism to obtain informed consent for delivery of telemedicine services, including information for patients or their surrogates about the distinctive features of telemedicine, the credentials of the health care professionals involved, and the limitations of the technologies.

4. The ACR supports appropriate protocols to protect the security and integrity of patient information, while balancing the need for access to telehealth services.
5. The ACR opposes geographical restrictions on telemedicine practice and supports the ongoing ability of patients to access telemedicine services from their home after the PHE has ended.
6. The ACR supports proposals that would facilitate interstate practice of telemedicine.
7. The ACR believes that any fees charged by hospitals for telemedicine support should be based on a transparent and fair formula (such as percentage of revenue).
8. The ACR opposes payer policies that mandate the use of specified telemedicine platforms or use telemedicine as a means of constructing restrictive networks or diverting patients to their “preferred” providers.
9. The ACR supports and encourages outcomes-based research regarding telemedicine use in the practice of rheumatology.

### **Background: Barriers and Opportunities for Telemedicine**

Telemedicine is the provision of health care services and education over a distance through the use of telecommunications technology. The COVID-19 pandemic has presented both challenges and opportunities to rheumatologists and rheumatology health professionals who have rapidly adopted telemedicine in routine practice. Prior efforts on the part of rheumatology providers to expand use of telemedicine had been hampered by a multitude of factors [2], including federal and state regulations, reimbursement issues, and practical issues pertaining to the provision of care. Telemedicine’s potential benefits in improving patients’ access to care both during and after the COVID-19 pandemic necessitate careful evaluation and investment for its success.

On a federal level, major obstacles have included HIPAA regulations, originating patient site requirements, and poor reimbursement. Specifically, HIPAA-obliged information technology (IT) encryption costs could not be recouped due to low reimbursement rates, patients faced the inconvenience of having to travel to outlying health care facilities to establish the audio-visual connection (as opposed to their homes), patients had to live in designated rural areas, and only follow-up visits were covered.

On a state level, both the requirements for licensing, credentialing, and malpractice coverage of telemedicine providers as well as the differences in these requirements between states have imposed further financial and administrative costs on rheumatology providers. States generally require that providers be licensed in the state where the patient receives telemedicine services, restricting providers' ability to provide patient care. In addition, informed consent laws, which also vary between states, may require written documentation of patient consent for telemedicine care to be entered into the patient's medical record.

From a reimbursement perspective, inconsistencies in private payers' coverage of telemedicine services, as well as poor coverage by some state Medicaid programs, have been a deterrent to implementation of telemedicine. CMS policy also restricted reimbursement for certain audio-only as well as audio-visual encounters to less than that of face-to-face visits. Despite ongoing interest on the parts of both providers and patients in telemedicine as a means of improving patient access to rheumatology care, these cumbersome financial and administrative concerns have hindered adoption of telemedicine even in geographic areas of great need [3; 4].

Using telemedicine also poses some practical difficulties for rheumatology providers due to the lack of a direct musculoskeletal exam as well as inability to remotely monitor changes in the musculoskeletal exam over time. Some disease activity measures, especially those dependent on physical exam findings such as swollen joint counts, cannot be easily measured by patients remotely without a surrogate examiner. Prior studies on use of telemedicine in rheumatology suggest a role for its use in monitoring established patients with rheumatoid arthritis [5], but evidence is limited in patients with other rheumatic diseases. Thus, the ACR endorses the use of telemedicine but recognizes shortcomings of virtual visits and recommends that telemedicine be used in conjunction with periodic in-person visits.

During the COVID-19 pandemic, many federal, state and reimbursement barriers were waived to enable rheumatology practices to provide telemedicine services (including audio-only and audio-visual visits) as part of ongoing efforts to prevent exposure to and spread of SARS-CoV-2 among providers, office staff, and vulnerable patients. Going forward, the benefits of telemedicine for patients in terms of preserving access and continuity of care are undeniable. In the short-term, favorable changes in reimbursement rates and regulatory barriers for telemedicine visits have increased patient access to rheumatology care and provided support for rheumatology practices to continue to care for patients. As providers plan for rheumatology care post-COVID, taking into consideration rheumatology workforce shortages and geographically distant patients, it is apparent that telemedicine could help rheumatology providers improve care models for their patients if the long-term economic and regulatory landscape remains favorable.

## **Access for Patients**

Several aspects of the patient's telemedicine experience must be considered in preparation for a successful encounter. These include effective informed consent, which is not required by CMS but is required by many state regulatory bodies. The ACR recommends that telemedicine platforms provide an efficient mechanism to obtain written informed consent, but in situations where this is not feasible, documentation of verbal consent should be sufficient even in the post-COVID-19 era. The informed consent should be tailored to the telemedicine process and include information for patients or their surrogates about the distinctive features of telemedicine, the credentials of the health care professionals involved, and the limitations of the technologies. Additionally, patient education regarding accessing the electronic platform is critical, ideally in advance of the encounter. Many telemedicine platforms have seen a rapid uptake in utilization that has outpaced availability of customer support. The ACR urges telemedicine platforms to optimize their patient (and provider) support, including clear and concise instructions on using their platforms, troubleshooting guidance, and easy access to patient and provider customer support.

During the COVID-19 crisis, relaxation of regulations regarding the HIPAA compliance of telemedicine platforms has been critical to providers' ability to maintain access for as many patients as possible, since many patients are unable to successfully access conventional telemedicine platforms for a variety of technical reasons. The ACR supports appropriate protocols to protect the security and integrity of patient information, while balancing the need for access to telehealth services. The ACR urges regulators to re-examine HIPAA guidelines concerning the use of platforms authorized during the PHE (i.e. FaceTime, Zoom, Skype etc.) in an effort to improve patient access.

Additional section 1135 waivers by CMS due to the COVID-19 pandemic include allowing patients to access telemedicine from their homes and removing restrictions requiring the patient to be in a designated rural area to qualify for telemedicine coverage. The ACR strongly believes the relaxation of these restrictions should be made permanent. There should be no geographical limitation on telemedicine utilization between a provider and patient with an established relationship.

### **Economic Impact for Practices**

The rapid adoption of telemedicine has helped to combat the financial strain associated with a reduction of in-person visits for many practices. Under recent CMS policy changes put in effect for the duration of the COVID-19 public health emergency (PHE), clinicians can be reimbursed for telemedicine services at the same rate as in-person visits. While this change was initially applicable only to synchronous video visits, these policy changes were expanded to

cover audio-only visits, as well as to tele-health services provided by occupational and physical therapists, as of March 1, 2020 [6].

Some rheumatology patients are unable to access audio-visual technology in order to use telemedicine services, or may be unable to set up audio-visual services due to limitations in wireless internet access, constraining them to rely on audio-only communication with their providers. The changes announced by CMS have allowed practices to continue to provide and be reimbursed for high-level care to Medicare beneficiaries throughout the pandemic. For all practices, especially those that serve older and/or underserved populations, these changes have been critical to keeping their doors open in order to care for patients and to employ the staff essential to continuing the work that has not stopped during the pandemic, including ensuring patients continue to have access to their necessary medications.

In order to preserve the economic viability of rheumatology practices and to provide the best care for patients with rheumatic diseases, the ACR supports continued parity of reimbursement for audio-visual visits and audio-only visits, both by CMS and by commercial payers, after the declared PHE has ended.

## **Regulatory Implications**

As commercial payers have followed CMS in expanding telemedicine services, discrepancies in coding guidance from payer to payer, as well as changes over time by some payers, have created unmanageable burdens on rheumatology providers' billing teams. The ACR urges all payers to adopt uniform coding standards that mirror CMS coding guidance.

Additionally, many rheumatologists and rheumatology health professionals provide care to patients residing across state lines. The adoption of telemedicine during the COVID-19 pandemic has revealed a patchwork of state regulations regarding interstate practice of telemedicine. Some states have fully removed restrictions on interstate practice, others require simple emergency licensure, and still others require full state licensure. The ACR supports proposals that would streamline interstate practice of telemedicine. This could include transitioning the definition of site of care from the location of the patient to the location of the provider, and/or uniform adoption of the Federation of State Medical Board's Interstate Medical Licensure Compact. Additionally, the streamlining of interstate practice of telemedicine will only be meaningful if malpractice carriers uniformly cover telemedicine across state lines. Malpractice carrier policies vary, and the ACR urges malpractice carriers to cover all interstate telemedicine services by providers who have coverage in their state of practice and who are duly licensed to practice in the patient's state of residence.

## **Preservation and Future of Telemedicine**

While the COVID-19 pandemic has impelled rheumatology providers to adopt telemedicine on an accelerated timeline, long-term opportunities to improve patient care remain. Due to the rheumatology workforce shortage [Battafarano 2018], patients with rheumatic disease by necessity may live a large distance from their provider. Rheumatologists and rheumatology health professionals may be able to continue using telemedicine, especially for their geographically distant patients, to provide follow-up at appropriate intervals (as opposed to the reduced intervals often dictated by geography). Such opportunities to improve patient care will be predicated upon ongoing payment parity for both audio-visual and audio-only encounters.

The ACR welcomes the input of payers who seek to partner with rheumatologists and rheumatology health professionals in order to optimize their members' use of telemedicine services. Effective use of telemedicine could facilitate uptake of value-based care models by allowing for intensive monitoring of patients at high risk of complications, if payers provide reasonable reimbursement. It would be inappropriate, however, to require use of a "preferred" telemedicine platform, or to divert patients from their usual provider to a remote provider preferred by a payer solely for financial purposes. Under no circumstance should payers use telemedicine to interfere with an established provider-patient relationship; rather, it should serve to augment such a relationship and improve the health and care of the patient.

Finally, despite promising preliminary evidence regarding efficacy and cost-effectiveness of telemedicine in rheumatology practice, areas of uncertainty persist regarding the use of telemedicine in rheumatology. These include best practices in assessing patients' musculoskeletal problems without a direct musculoskeletal exam, tracking disease activity over time, and the need for periodic in-person visits. The ACR encourages the rheumatology community to study telemedicine rigorously with respect to outcomes of remote care, best use of less frequent in-person visits, and validation of remote disease activity monitoring. Looking forward, the ACR supports the role of telemedicine as a tool with the potential to increase access and improve care for patients with rheumatic disease.

## **References**

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