Physician Specialties Best Positioned to Take Advantage of Telemedicine During (and After) the COVID Crisis

- Due to the postponement of non-emergent services, many physician specialties have faced significant reductions in revenues and volumes
- One strategy to mitigate the impact of these reductions is to take advantage of temporary government and commercial payor policies, including increased coverage of telemedicine
- However, as Marwood explores below, certain provider types, such as behavioral health and primary-care-focused specialties, are better positioned and able to transition in-person visits to telemedicine than others

Background: Expanded Telehealth Coverage

Both Medicare and commercial payors have expanded telehealth coverage and reimbursement during the COVID-19 Public Health Emergency (PHE). Medicare, in particular, has lagged behind other payors in telehealth usage; but we believe that many telehealth flexibilities provided during the PHE will likely be higher priority legislative items post-crisis, and thus will become permanent regulatory fixtures moving forward.

Providers are now able to take advantage of new temporary Medicare regulations, including:

- Medicare will make payment for Medicare telehealth services furnished to beneficiaries in any healthcare facility and in their home
- Providers can render these services to both new and established patients
- In many cases, these visits are considered the same as in-person visits and are paid at the same rate as regular in-person visits
- Providers can now deliver telehealth services for Medicare beneficiaries across state lines
- CMS added more than 80 new codes to the telehealth list in March and then an additional 40+ codes in April
- CMS increased reimbursement for audio-only telehealth codes
- Medicare rules around HIPAA video conferencing platforms have also temporarily eased during the crisis; providers are able to use non-HIPAA compliant platforms such as Skype and Facetime to conduct visits for the duration of the crisis
- Three main types of telehealth services can be provided to Medicare beneficiaries under the new regulations: Medicare telehealth visits, virtual check-ins, and e-visits. Medicare telehealth visits are considered the same as in-person visits and can be completed by new patients, who do not have an established relationship with a provider. These visits must include an interactive audio and video system that permits real-time communication. Virtual check-ins can also be provided to both new and established patients. These check-ins can occur through a number of modalities, including over telephone or via the sending of images. Finally, e-visits can occur via non-face-to-face patient-initiated communications over a week-long period

Additionally, the DEA has temporarily eased restrictions on the ability of providers to prescribe controlled substances through telehealth; this change will likely eventually revert to pre-COVID restrictions but the PHE relaxation could expedite long-awaited DEA guidance.

In many cases, commercial payors had more robust coverage than Medicare, though many have waived member cost-sharing in order to encourage utilization, expanded the list of codes that are covered, and eased restrictions around which telehealth platforms providers are able to use.

Specialty Specific Considerations

Not all providers benefit equally from the temporary telehealth regulations; when considering which provider specialties will likely benefit the most from increased coverage and reimbursement, it is important to consider several factors:

1) **Code and service mix:** Providers whose code mix is heavily weighted towards office visits, home visits, observation, psychiatric or substance abuse counseling, and ESRD are best positioned to be able to take advantage of new coverage and reimbursement regulations. This is because these codes make up the vast majority of services that providers may bill via telemedicine.

2) **Provider type**: Until April 30th, 2020, providers with the ability to furnish and receive Medicare reimbursement for covered telehealth services (subject to state law) included physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals. These providers were designated "distant site practitioners." Notably, physical therapists (PTs), occupational therapists (OTs), and speech-language pathologists (SLPs) were not included in the list of distant site practitioners, which meant that they could only bill a small portion of covered telehealth codes with limited reimbursement.

   CMS released guidance on April 30th, 2020 that waives the distant site practitioner requirements and appears to allow PTs, OTs, and SLPs to bill Medicare for furnishing telemedicine services. However, due to initial restrictions and continuing lack of clarity around billing regulation language, PTs, SLPs, and OTPs are likely disadvantaged relative to other providers who were more immediately able to take advantage of expanded coverage and reimbursement.

3) **Practical considerations**: Even if a given CPT code may now be billed via telemedicine, that does not necessarily mean a telehealth visit is a medically appropriate substitution for an in-person visit. Additionally, because physicians must typically receive patient consent to be eligible for reimbursement, patient choice as well as comfort with and access to technology is an important factor, though necessary use during the PHE could increase patient comfort. There are also differences in each practice's ability to quickly ramp up telemedicine services, as some physician groups may have more experience with telemedicine than others.

   - According to a study published by the AMA, radiologists (39.5%), psychiatrists (27.8%), and cardiologists (24.1%) were the physician specialties most likely to use telemedicine to interact with patients, while allergists/immunologists (6.1%), gastroenterologists (7.9%), and ob-gyns (9.3%) were least likely

Based on Marwood's analysis of Medicare fee-for-service claims data from 2017, behavioral health and primary-care-focused specialties are likely to benefit the most from temporary telemedicine regulations, while specialties with a higher portion of payments attributed to surgical procedures, or other services not able to be done through telemedicine, will benefit least.

- Marwood looked at 2017 Medicare fee-for-service claims data and attributed the total allowed charges (or payments) by specialty for CPT codes now able to be billed using telehealth

Figure 1: Many specialties with a high level of Private Equity investment have under 45% of allowed charges attributed to CPT codes able to billed through telemedicine

Specialty	% Of Allowed Charges Attributed to CPT Codes Able to be Reimbursed Through Telemedicine During the PHE	Specialty	% Of Allowed Charges Attributed to CPT Codes Able to be Reimbursed Through Telemedicine During the PHE
Licensed Clinical Social Worker	100%	Urology	45%
Registered Dietitian/Nutrition Professional	100%	Gastroenterology	45%
Psychologist	100%	Sports Medicine**	44%
Hospitalist	99%	Obstetrics/Gynecology	42%
Clinical Psychologist	99%	Pain Management	41%
Hospice and Palliative Care	98%	Ophthalmology*	40%
Geriatric Psychiatry	96%	Otolaryngology	40%
Psychiatry	96%	Interventional Pain Management	39%
Clinical Nurse Specialist	94%	Interventional Cardiology	39%
Addiction Medicine	94%	Podiatry	39%
Infectious Disease	94%	Gynecological/Oncology	39%
Geriatric Medicine	93%	Allergy/Immunology	38%
Emergency Medicine	93%	Cardiac Electrophysiology	32%
Internal Medicine	89%	General Surgery	31%
Endocrinology	89%	Hand Surgery	31%
Nurse Practitioner	88%	Orthopedic Surgery	27%
Family Practice	86%	Maxillofacial Surgery	27%
Critical Care (Intensivists)	86%	Surgical Oncology	27%
Nephrology	85%	Colorectal Surgery (formerly Proctology)	25%
Occupational Therapist in Private Practice	83%	Dermatology	24%
Pulmonary Disease	82%	Peripheral Vascular Disease	21%
Hematology	77%	Neurosurgery	19%
Physical Medicine and Rehabilitation**	76%	Plastic and Reconstructive Surgery	18%
Pediatric Medicine	76%	Radiation Oncology	17%
General Practice	75%	Oral Surgery (dentists only)	17%
Optometry*	74%	Thoracic Surgery	16%
Advanced Heart Failure & Transplant Cardiology	74%	Cardiac Surgery	14%
Neuropsychiatry	71%	Vascular Surgery	13%
Physician Assistant	70%	Nuclear Medicine	11%
Physical Medicine and Rehabilitation	69%	Anesthesiology	11%
Rheumatology	69%	Audiologist (Billing Independently)	4%
Medical Oncology	68%	Interventional Radiology	3%
Hematology/Oncology	68%	Pathology	0%
Neurology	65%	Diagnostic Radiology	0%
Osteopathic Manipulative Medicine	61%	Radiation Therapy Centers	0%
Certified Nurse Midwife	57%	Certified Registered Nurse Anesthetist (CRNA)	0%
Preventive Medicine	57%	Independent Clinical Laboratory	0%
Speech Language Pathologist**	56%	Independent Diagnostic Testing Facility (IDTF)	0%
Single or Multispecialty Clinic or Group Practice	53%	Anesthesiologist Assistant	0%
Sleep Medicine	52%	Portable X-ray Supplier (billing independently)	0%
Cardiology	48%	Chiropractic	0%

Indicates specialty with high level of Private Equity Investment

**Initially eye exam codes were not included in the telehealth code list, but were added 4/30*

***Medicare guidance released on 4/30 appears to allow PTs/OTs/SLPs to bill Medicare for telemedicine services, though the language is unclear, and providers will likely seek additional guidance from CMS*

Note: Marwood excluded specialties with under $3 million in total allowable charges from this analysis

Sources: Marwood Group Research, CMS Utilization Data, AMA

Closing Remarks

Expanded coverage and reimbursement of telemedicine presents the opportunity for many specialties to mitigate decreases in volume caused by COVID-related postponement of office visits, as well as the potential for an additional revenue stream post-COVID. However, ongoing changes in payor requirements for coding, billing, and the required clinical documentation may present challenges for clinicians and office staff, leading to risk of repayment or recoupment in the event of payor scrutiny in the future. Marwood explores, in detail, how providers can mitigate these risks in a forthcoming white paper to be released next week.

About the Author

Kate Gibson is a **Senior Vice President** at Marwood Group Advisory and has been with the firm since 2013. Ms. Gibson is responsible for leading Advisory projects across healthcare sectors. Prior to joining the Marwood Group, Ms. Gibson worked at Truven Health Analytics where she designed models to analyze both qualitative and quantitative data for healthcare businesses, as well as conducted targeted interviews with healthcare stakeholder for clients. Ms. Gibson received her BA degree with honors from the University of St. Andrews.

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