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Perspective

COVID-19 and Telemedicine: Old Barriers Come Down and New Ones Come Up

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Perspective

In the space of a few weeks the COVID-19 pandemic has changed the way medicine is practiced in the United States. In order to control the spread of COVID-19, the Centers for Disease Control and Prevention (CDC) and department of health (DOH) of various states recommended isolation of sick persons, quarantine for those who may have been exposed to the virus and social distancing. Social distancing also referred to as physical distancing meant keeping space between people outside of their homes. A distance of at least 6 feet (2 meters) was recommended and people were asked not to gather in large groups, avoid crowded places and mass gatherings. All non-essential staff were advised to stay home and work remotely if the facility to do so was available to them. Hospitals across the country were forced to make some drastic changes in order to prepare for the expected surge of COVID-19 patients. In New York City, hospitals canceled all elective surgeries, closed in-patient epilepsy and stroke units and canceled all outpatient clinics. Patients were discharged from the hospitals. Beds especially ICU beds and other resources such as ventilators were reserved for COVID-19 patients. Physicians working in these hospitals were advised to adopt telemedicine in order to primarily maintain continuity of care for their existing patients. Barriers which over years had started to shackle the physician-patient relationship and physician autonomy in the practice of medicine came tumbling down.

The Health Insurance Portability and Accountability Act (HIPAA), a US law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers was relaxed to state that covered health care providers will not be subject to penalties for violations of the HIPAA Privacy, Security, and Breach Notification Rules that occur in the good faith provision of telehealth during the COVID-19 nationwide public health emergency [1]. While physicians were encouraged to practice telehealth through their existing electronic health record (EHR) software, other modalities for pursuing telehealth were approved. Telehealth could be pursued via Zoom, WhatsApp or Face Time. For physicians and patients who are unable to use any of the above modalities, a telephone encounter could be carried out. The above measures are a welcome relief to both physicians and patients as it helps maintain continuity of essential medical care during the COVID-19 pandemic. But just as the old barriers seem to come down, new ones started to come up. The HHS Office of Civil Rights (OCR) recommended the following: "OCR expects health care providers will ordinarily conduct telehealth in private settings, such as a doctor in a clinic or office connecting to a patient who is at home or at another clinic. Providers should always use private locations and patients should not receive telehealth services in public or semi-public settings, absent patient consent or exigent circumstances. If telehealth cannot be provided in a private setting, covered health care providers should continue to implement reasonable HIPAA safeguards to limit incidental uses or disclosures of protected health information (PHI). Such reasonable precautions could include using lowered voices, not using speakerphone, or recommending that the patient move to a reasonable distance from others when discussing PHI."

Overnight it seems new documentation guidelines came out with respect to televisits [2]. We were told that physician documentation should include time start/end, participants on call and physical location of the patient at the time of the televisit. There had to be documentation of verbal consent that the patient understood that this is a billable visit. Patient could not have a phone visit within 7 days following last evaluation and could not be scheduled for an in-patient visit within 24 hours after a telephone visit else the physician could not bill for the televisit. We were informed of new billing codes and Medicare and Commercial Insurance rates for different time duration visits (5-10 minutes, 11-20 minutes, >21 minutes). A flurry of e-mails from the compliance specialists, medical billing specialists and office managers followed informing us of what we could or could not do. It has been said that the COVID-19 pandemic is going to change the world as we knew it. When it comes to the practice of medicine the rules are expected to change too. While some old barriers have thankfully fallen, unfortunately new barriers have come up. It seems removing the shackles is easier said than done.

References

1. Summary of the HIPAA Security Rule.
2. FAQs on Telehealth and HIPAA during the COVID-19 nationwide public health emergency. p. 1-6.