Gaps in the Coding Infrastructure Limit Innovation of Virtual Care Services

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Zach Gaumer
Amy Bassano
Dr. Jean Glossa

EXECUTIVE SUMMARY:

Despite the growing use of virtual care services and their ability to expand access for patients without a regular source of care, the existing medical coding infrastructure prevents payers, providers, and policymakers from tracking the use of E-visits and Virtual check-ins, especially when used by patients without an established relationship with a provider and when secure short messaging services (SMS) are used to deliver services. These and other forms of virtual care services were used during the COVID-19 public health emergency (PHE) in 2020 and 2021 to expand access to care, including to mental health care services, and have become integral pieces of payers' and providers' strategies for the future. However, currently, secure SMS services are embedded along with other modalities within definitions for E-visits and Virtual Check-ins. This means stakeholders are unable to decipher which modality is being used to deliver these two types of services and when new patients are using these services.

The infrastructure of Current Procedural Terminology (CPT®)[i] and Healthcare Common Procedure Coding System (HCPCS) has moved quickly in recent years to keep pace with new innovations, however, it is clear further expansion of the code sets is still necessary. Policymakers at Centers for Medicare & Medicaid Services (CMS) and Coding authorities responsible for maintaining the CPT and HCPCS code sets could address gaps in the coding infrastructure by:

- Creating a new set of time-based e-visit CPT and/or HCPCS codes specific to patients without an existing relationship with a provider, and

- Creating a new unique modifier code to report that care was rendered via secure SMS communication.

Continuing to update and modernize the medical coding infrastructure by incorporating new codes for these specific virtual care services and for new patients would have clear benefit to providers, payers, and patients. Providers require these new codes to accurately record their work, build new models of care, and assess the quality of care they are providing. Payers, including government payers, require these new codes to measure utilization, quality of care, and to appropriately pay providers for their services. Patients require continued and enhanced access to health care services through secure SMS and other innovative modalities. Policymakers can support these stakeholders by creating new codes and encouraging the use of guardrails to address concerns about misuse or fraud. While we recommend enhancements to the coding infrastructure, we also recommend the American Medical Association (AMA) and CMS continue to create new codes consistent with innovations in care delivery, such as the use of secure SMS, in a timely fashion.

INTRODUCTION:

Early in 2020, virtual care services became firmly embedded in the health care delivery system and innovations such as the use of secure SMS between patients and providers proliferated. Virtual care services were critical for filling gaps in access to care during 2020 and has changed how care is being provided to patients today.[ii,iii,iv]

In the health care context, the Health Insurance Portability and Accountability Act (HIPAA) permits providers or payers to implement electronic short messaging service (SMS) applications that possess the necessary controls and encryption to support HIPAA compliant exchange of sensitive protected health information (PHI).[v] What distinguishes secure SMS from common text messaging communication is the secure nature of the platform. By contrast, the use of common texting for health care delivery is largely not permitted under HIPAA, but during the PHE the U.S. Department of Health and Human Services (HHS) waived this restriction in order to expand access to health care services. Beyond the PHE, HIPAA dictates that unsecure channels of communication, such as common texting, are not permitted for health care delivery. However, HIPAA does permit providers or payers to implement and use SMS applications that possess the necessary controls and encryption to support HIPAA compliant exchange of PHI.[vi] Using secure SMS applications, medical professionals can communicate encrypted PHI from a desktop computer or mobile device within a private communications network or platform. These secure SMS applications have a familiar text-like interface and functionality, so none of the speed and convenience of common texting is lost.

Secure SMS is currently used to improve patient triaging, offer convenience, provide care management and coaching to patients, gather patient information, and expand access to care. Several different payers and providers offer patients standard telehealth visits (audio-only or audio/video) paired with the ability to text with a clinician from anywhere at any time.[vii] Many refer to these as virtual-first models of care.[viii,ix] During the COVID-19 pandemic several hospital systems and payers have implemented virtual-first models that include medical apps with secure text messaging to help patients remain in close contact with clinicians and assist providers with staffing concerns and navigate value-based care arrangements.[x,xi,xii,xiii,xiv] This model is also present within the Veterans Health Administration (VHA), which was an early adopter of secure SMS and in the development ofsecure messaging applications for health care services.[xv]

Despite the growing use of virtual care services and their ability to expand access for patients without a regular source of care, the existing medical coding infrastructure prevents payers, providers, regulators and policymakers from closely tracking the use of secure SMS services and making these services available to all patients, particularly those without an established relationship with a provider.[xvi] Absent codes that reflect current clinical practice, it is difficult to measure the frequency of use, quality of care, equity, and payment appropriateness. Further, these services are then unable to reach their full potential in expanding access to care.

During the PHE the two entities that establish and maintain the foundation of the coding system, the American Medical Association (AMA) CPT Editorial Panel and CMS, made enhancements to coding in order to keep pace with innovation and practice. The most noteworthy enhancements have involved creating modifiers for audio-only visits and creating virtual care

codes for non-physician providers. However, there are clear gaps in the complex coding infrastructure as it relates to secure SMS and caring for new patients via virtual care services.

## GROWTH IN THE USE OF VIRTUAL CARE SERVICES

Since 2020 the use of virtual care services has increased significantly. In early-mid 2020, amid the COVID-19 pandemic, the use of virtual care services increased to levels never before observed. Further, following this initial burst, the use of virtual care services receded but settled at levels that continue to far exceed pre-COVID-19 levels.

All-payer data demonstrate the rapid growth in the use of virtual care services. Data for commercially insured and Medicare Advantage patients collected by FairHealth[xvii] demonstrate that the share of medical claim lines containing a telehealth service increased from 0.2 percent in November 2019 to 6.0 percent in November 2020, declining slightly to 4.4 percent in November 2021. FairHealth data also indicate that the share of all telehealth claims attributed to mental health services increased from 24 percent in November 2019 to 48 percent in November 2020 to 62 percent in November 2021. [xviii] Similarly, private insurance claims data collected by The Chartis Group indicate that from February 2020 to April 2020 the share of primary care visits provided via telehealth nationally increased from 1 percent to 52 percent. However, since that peak in April 2020, the share of primary care visits involving telehealth declined to 11 percent by May 2021.[xix]

Medicare fee-for-service (FFS) claims data tell a similar story, with a sharp rise in virtual care service use in early 2020 and a gradual decline in use which settled at an overall higher level of use than pre-COVID-19. From October 2019 to April 2020, the share of Medicare FFS beneficiaries with a claim involving any type of virtual care service increased from less than 1 percent to 15 percent.[xx] Between June 2020 and April 2021, the share of Medicare beneficiaries with a claim involving any type of virtual care has fluctuated between 6 percent and 10 percent (Figure 1).

Figure 1:
Share of Medicare Fee-for-Service Beneficiaries with a physician claim for any type of virtual care service, 2019-2021
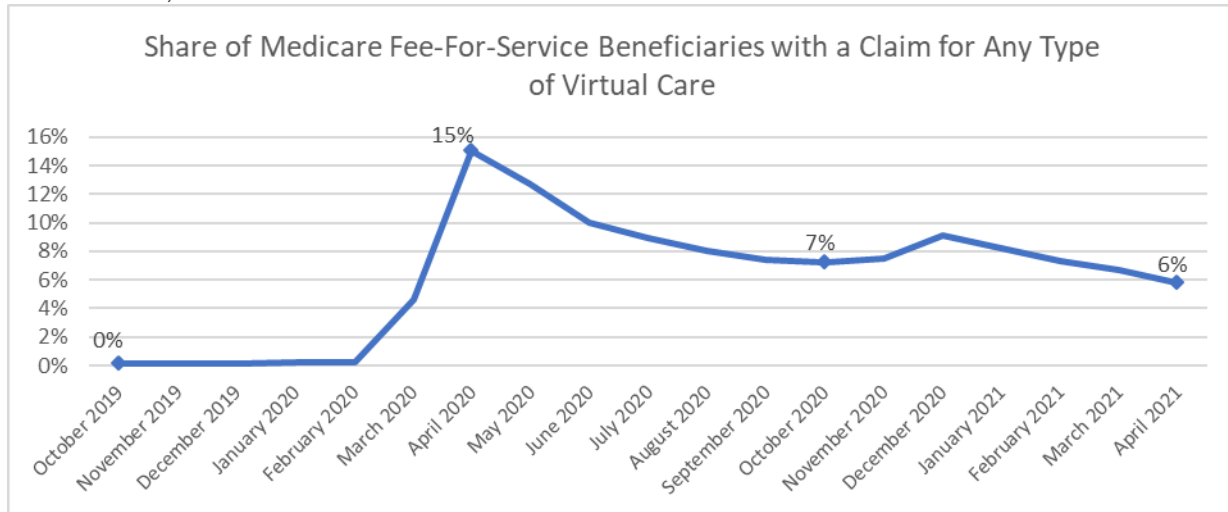
Source: HMA analysis of Medicare Fee-For-Service Physician Claims (100 percent claims file).

Note: While data from October 2019 to February 2019 suggest no Medicare beneficiaries used virtual care, the share of beneficiaries with a claim during this period has been rounded and is actually above 0 percent and less than 0.5 percent.

Medicare FFS claims data reveal continued use of various types of virtual care services as the COVID-19 pandemic has eased. Prior to the COVID-19 pandemic all forms of virtual care services were lightly used and were associated with just 82,000 claims in October 2019 (Table 1). During the peak use of virtual care services in the month of April 2020, telehealth and audio-only visits comprised the vast majority of service types used. Additionally, other types of virtual services were important to patient access during April 2020; the combined monthly use of these other services was more than 5 times the total across all virtual service types pre-pandemic. Even as use has dropped off, during September 2021, it appears that beneficiaries and providers are continuing to use virtual care services of all types at relatively higher levels than pre-pandemic.

Table 1: Number of virtual care Medicare fee-for-service physician claims, by type 2019-2021.

Types of Virtual Care Service	Pre-Pandemic (October 2019)	Peak Use during Pandemic (April 2020)	Most Recent Data (September 2021)
All Virtual Care Services	82,171	8,322,657	2,271,077
Audio-Visual visits	57,883	5,573,837	1,701,084
Audio-only visits	3,757	2,280,432	399,794
Remote Physiologic Monitoring	16,519	39,269	125,657
Virtual Check-ins	1,530	300,069	13,411
E-visits	-	95,035	10,256
E-consultations	471	17,520	6,250

Source: HMA analysis of Medicare Fee-For-Service Physician Claims (100 percent claims file).

The Coding Infrastructure for Professional and Virtual Care Services

National standardized code sets are used to report medical diagnoses, tests, services, and procedures on healthcare claims.[xxi] The foundation of the professional provider medical coding infrastructure is the AMA CPT system. Medicare, state Medicaid programs, and commercial payers often create their own codes to supplement the AMA's codes and fit their unique patient dynamics.

The CPT code set is maintained by the AMA and is used to report services furnished by physicians and other qualified health professionals or entities.[xxii] Most CPT codes (Category I codes) describe services and procedures that are in widespread use, meet specific criteria including Food and Drug Administration (FDA) approval, when applicable, and have clinical efficacy that is well-documented in the literature.[xxiii] Category II codes are used to track services for performance measurement and Category III codes are used to collect data on emerging technologies.

The AMA CPT Editorial Panel ("the Panel") administers and updates the CPT code set by adjudicating new code and code change applications. The Panel is comprised of 21 members and includes physicians from the national medical specialty societies and representatives from commercial payers and the American Hospital Association (AHA). In completing its work, the Panel involves officials from CMS and relies heavily on the CPT Advisory Committee, a body comprised of representatives from the 100+ national medical specialty societies represented in the AMA House of Delegates. The committee reviews new code and code change requests

and provides comments and options for modification to the Panel. The Panel will either: approve a new code or code revision, refer the request to a workgroup for further study, postpone the topic to a future meeting, or reject the request. Requests for code changes may be made by any relevant stakeholder, including providers, payers, patients, manufacturers, or others.

- New code requests are reviewed by the Panel three times a year (February, May, September), and up to 2 years in advance of publication in the print edition of CPT and on the Medicare Physician Fee Schedule (PFS). The 2-year timeframe accounts for the necessary steps for a different body (the AMA Relative Value Scale [RVS] Update Committee [RUC]) to develop valuation recommendations of the Category I codes. Coverage and reimbursement are not guaranteed for codes established by the CPT Editorial Panel. Category II and III codes are updated on a more rapid basis, as they contain some codes necessary to address imminent public health need as has been the case during PHE.

- Code Change Applications (CCAs) must state a specific reason why the code change is necessary and why existing codes are not adequate. The application also includes a summary Description of Procedure (DOP) and clinical vignette to succinctly explain in general (not proprietary) descriptive terms how the procedure or service is performed and the characteristics of the typical patient. This information informs the reviewer's understanding of the proposed, revised code descriptor. Modifier codes are created when an underlying code change is not necessary, but a mechanism is needed to identify when the service or procedure has been altered in some way or to track a specific detail or policy requirement.

As a temporary alternative to the AMA's process, the CMS HCPCS Workgroup enables the creation of HCPCS codes to report items and services not described in CPTs.[xxiv] The CMS Workgroup enables the creation of new codes on a quarterly or bi-annual basis. CMS interprets these codes as temporary; they are referred to as 'G-codes' and used by providers to bill Medicare for services. Commercial payers are permitted to request new codes through this CMS process and these are referred to as 'S-codes.'[xxv]

CODING OF VIRTUAL CARE SERVICES:
TYPES OF SERVICES AND PATHWAYS FOR CODING

Coding for virtual care services is standardized nationally but its adoption by payers varies because payers are not required to reimburse for all services. Virtual care services include several separately defined types of services, each with different permitted modalities and patient-provider relationship requirements. Interactive audio-video visits and audio-only visits could be viewed as generally equivalent to in-person office visits, while several other types of services are often described as Communication Technology-Based Services (CTBS). CTBSs include virtual check-ins, e-visits, remote physiologic monitoring, e-consultations, and other services. Secure SMS services are embedded with other modalities within definitions for services referred to commonly as E-visits and Virtual Check-ins. Among these various codes, specific codes do not exist that permit patients without an established relationship with a provider to receive an E-visit (Table 1).

Table 1: Types of virtual care services

Type of virtual care service	Description	Modality commonly permitted by payers	Patient-to-provider relationship commonly required by payers
Audio-video visits	Office visits provided via synchronous, real-time audio plus video communication	Audio-video	New and Established patients
Audio-only visits	Office visits conducted via two-way real-time audio-only communication	Audio-only	Established patients
Virtual check-ins	Brief communication technology-based service by a physician or other qualified health care professional, not originating from a related E/M service	Audio-video, audio-only, email, electronic health record patient portal, **secure SMS**	Established patients
E-visits	Asynchronous (not-real-time) patient-initiated communications requiring a clinician decision	Electronic health record patient portal, secure email, **secure SMS**, or other digital applications	Established patients
Remote Physiologic Monitoring	Use of digital technology to collect health data from patients in one location and electronically transmit that information securely to providers in a different location.[xxvi]	Electronic medical devices which transmit data	Established patients
E-consultation	An interprofessional telephone/internet consultation involving an assessment and management service in which a patients' treating physician requests the opinion of a consultant with special expertise.[xxvii]	Audio-only, audio-video, email, electronic health record patient portal	New and established patients

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The structure of coding for virtual care services varies by the type of service and follows one of two pathways. Under one pathway, services are coded using in-person CPT codes in tandem with either (or both) a place-of-service (POS) code or a modifier code to indicate that the service was conducted virtually. Under the second pathway, services are assigned a specific CPT (or HCPCS) code in which virtual care is specified in the code description.

Pathway 1: Telehealth visits are coded using in-person office visit CPT codes in tandem with a POS code and/or a modifier code. Payers define which services (or CPT codes) are permitted when delivered virtually and then define the POS or modifier codes that must be appended to the CPT codes. AMA also offers "Appendix P" within the CPT manual which lists services that are appropriate for telehealth and are options for payers to cover. The POS or modifier codes that payers require often influence payment levels, and they can vary by payer. In the context of virtual care there are two POS codes used widely (POS '02' for telehealth other than the patient's home and '10' for telehealth from the patient's home). Modifier codes related to telehealth include three different codes for synchronous services ('93', '95', and 'GT'), and how payers use of these codes can vary (Table 2). Modifier codes also include those for counseling and therapy provided using audio-only services ('FQ'), stroke care services provided using telehealth services ('G0'), and to report services delivered via asynchronous telecommunications systems ('GQ'). While most payers require providers to use POS and modifier codes to bill for telehealth visits, instructions for doing so can vary by payer. In addition, even within a given payer there can be variability in coding practices at different points in time. For example, the traditional Medicare program has required different modifier and POS coding practices for services temporarily covered as a part of the PHE and services covered on a more permanent basis.[xxviii] Most noticeably, for traditional Medicare, the 'GQ' modifier represents a collection of many different forms of communication, one of which is secure SMS.

Table 2: Virtual care modifier codes

Modifier code	Description
93	Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system
FQ	Audio-only services
GT	Interactive audio and video telecommunications systems
GQ	Asynchronous service (e.g., secure SMS, email, electronic health record patient portal)
G0	Stroke care services

Pathway 2: Specific virtual care CPT codes are defined for audio-only visits and all CTBSs. The definitions of these codes often specify characteristics such as the duration of the service, type of service, whether the patient is established or new to the provider, the goal of the service, which providers are permitted to bill the service, and in some instances the modality of the service.[xxix]

The coding mechanisms of pathway 1 and pathway 2 are limited in their ability to specify the modality of the service. Possible virtual care modalities include synchronous modalities such as audio-video or audio-only communication and asynchronous modalities such as email, online portal, remote physiologic monitoring, electronic health record exchange, and secure SMS. Under Pathway 1 service modality can be differentiated as either synchronous or asynchronous, but not at a more detailed level for the asynchronous services. Therefore, secure SMS is not distinguishable from services delivered via email or EHR portal. Under Pathway 2 service modality is limited to the detail specified in the CPT or HCPCS code description. These service-specific codes currently are not specific enough to enable providers to identify when each individual modality and type of patient (new or established) for each type of virtual care. Both pathways could be improved.

PRECEDENT FOR ADDING AND AMENDING VIRTUAL CARE SERVICES IN RESPONSE TO INNOVATION

In recent years new virtual care codes have been added by the AMA or CMS to reflect innovations in clinical practice. In 2008, the AMA added codes for audio-only services and further revised those codes in 2013. In 2019, the AMA added codes for e-consultations. In 2020, the AMA added codes for e-visits (online digital evaluation and management) for physicians (99421-99423) and non-physicians (98970-98972). In 2022, the AMA added modifier code '93' to enable providers to indicate when services are conducted via audio-only communication.[xxx]

CMS similarly added several virtual care codes or modified code descriptions within the Medicare program in recent years in response to innovation and access needs. Some of these changes have been permanent and others have been temporary in response to the COVID-19 PHE. In 2019, CMS created HCPCS codes for virtual check-ins, and began covering e-visits and e-consultations using the AMA's CPT codes.[xxxi] In response to the COVID-19 PHE, CMS waived the video requirement for telehealth services and established payment for audio-only phone visits using existing CPT codes.[xxxii] CMS created three new e-visit and virtual check-in codes to enable qualified non-physician clinicians to provide an online assessment to an established patient (G2061-G2063) and created a new virtual check-in HCPCS code to enable clinicians who cannot report an E/M service to provide these services (G2251). [xxxiii,xxxiv] Finally, in 2021 CMS created a new virtual check-in HCPCS code (G2252) to enable clinicians to conduct these visits for a longer duration (11–20 minutes). [xxxv]

GAPS IN THE CODING SYSTEM FOR VIRTUAL CARE SERVICE

Despite the proliferation of secure SMS services, the coding system lacks the granularity of service modality to discretely track the use of these communication technologies and services. Secure SMS is neitherspecifically recognized with a standalone code nor is it recognized as a modifier in either the current CPT or HCPCS codes or in the roster of virtual care modifier codes.

Secure SMS may be used for virtual check-ins and e-visits but the CPT and HCPCS codes do not distinguish this modality from other modes of virtual care communication. As e-visit codes are currently defined, providers record an e-visit conducted via secure text messaging identically to e-visits conducted via email and online portal communication. Similarly, as virtual check-ins are currently defined, providers record a virtual check-in conducted via secure SMS identically to virtual check-ins conducted via email, online portal, audio-only, and audio-video communication. As a result, neither payers nor researchers examining virtual claims/encounters are able to accurately study and evaluate the utilization and efficacy of various virtual care modalities.

In addition, the current set of virtual care modifier codes does not include modifiers that enable providers to distinguish care rendered via secure SMS from other forms of communication. As Table 2 above summarizes, unique modifier codes exist for audio-video and audio-only communication, but all forms of asynchronous communication (secure SMS, email, and online portal) are bundled into one modifier ('GQ'). It is reasonable to assume that these various forms of communication may have different costs and different levels of potential effectiveness in meeting patients' care needs.

ESTABLISHING A NEW PATIENT RELATIONSHIP VIA SECURE SMS

The existing coding infrastructure includes many codes designed around delivering in-person care to patients without an established relationship with a provider (i.e., new patients), but lacks codes for new patients in the context of virtual care. Specifically, no CPT and HCPCS codes exist for e-visits and virtual check-ins for new patients and this likely limits the ability of providers and payers to innovate using these services.

Enabling new patients to access e-visits and virtual check-ins is a benefit to patients and providers. For example, during the PHE, new patients have been able to access behavioral health and other services services through e-visits and virtual check-ins. Beyond the PHE, the use of e-visits and virtual check-ins for new patients will end.[xxxvi] Maintaining convenient access to care providers through e-visits and virtual check-ins remains essential, because it enables access to care without the burden of travel for patients. Further, triaging through secure SMS is likely to reduce the amount of time patients spend seeking providers best suited to treat their needs.

> During the COVID-19 PHE, the HHS Secretary enabled providers to serve new patients through Medicare telehealth visits as well as through e-visits and virtual check-ins by relaxing the requirement that virtual care claims demonstrate an established patient-provider relationship. Enabling patients to connect with providers absent an established relationship has been essential to expanding access during the PHE and has kept patients with more basic medical needs from seeking care in overburdened settings such as emergency departments.

From the provider's perspective, being able to communicate with and triage new patients via secure SMS will enable them to be more efficient with their limited time and better coordinate patient care. For example, secure SMS may enable providers to assist in avoiding unnecessary emergency department (ED) visits, by directing patients to physician offices or urgent care centers when appropriate.

An October 2021 report from the Office of the Inspector General (OIG) of HHS found that a large number of new patients used e-visits and virtual care visits during the PHE. Between March and December of 2020, 16 percent of Medicare beneficiaries received e-visits and virtual check-ins absent an established relationship with a clinician.[xxxvii] The OIG's analysis included beneficiaries enrolled in traditional fee-for-service Medicare and Medicare Advantage plans, and identified 26 million beneficiaries across both sides of the program who had a virtual care service. Therefore, roughly 4 million Medicare beneficiaries between March and December of 2020 had an e-visit or virtual check-in absent an established relationship with a clinician.

CMS and the Medicare Payment Advisory Commission (MedPAC) have noted their concern about permitting new patients to receive e-visits and virtual check-ins, citing concerns about misuse and fraud.[xxxviii] These are legitimate concerns that must be addressed in order to protect payers and taxpayers. However, **the AMA can create these codes based on a stakeholder application and then leave it to payers to build policy guardrails around these services to control for misuse or fraud.** As a payer, CMS's role differs from AMA. CMS has the ability to both implement new codes and insert guardrails to guide the use of the new codes. In the context of the AMA, we assert that it is preferable that the AMA create codes that reflect innovation occuring in the health care delivery environment so that payers have the option of covering these services and they are reflected in a standardized coding system. Further, as it

relates to fraud and misuse, we believe most payers maintain programs to monitor claims for fraud which would be applied to all covered virtual care services.

CONCLUSION

Innovation in virtual care services has occurred rapidly since the beginning of the COVID-19 pandemic, but coding systems have not adapted quickly enough to accurately capture the evolution of service modalities and patients accessing virtual care. There are gaps in the complex coding infrastructure as it relates to secure SMS and caring for new patients via virtual care services.

First, the infrastructure of CPT and HCPCS codes lacks a modifier code to differentiate secure SMS from other asynchronous modalities. This lack of granularity prevents policymakers and payers from establishing accurate payment rates for these services and measuring the quality of care delivered through them. Further, with this granularity of information, researchers may assess if new innovative virtual care services, like secure SMS, are capable of increasing access, reducing costs, and improving quality.

Second, the infrastructure of CPT and HCPCS codes lacks codes to define the provision of e-visits and virtual check-ins to new patients. Due to the absence of new patient codes, payers and providers have few options for extending care to new patients via these modalities and tracking their use and quality. Despite this gap, it may be advantageous to all patients, and particularly those who lack access to care, to be able to quickly access clinical guidance via secure SMS.

Coding authorities at the AMA and policymakers at CMS could rapidly address these two gaps by:

- Creating a new unique modifier code for services delivered via secure SMS; and
- Creating a new set of time-based e-visit CPT and/or HCPCS codes specific to patients without an existing relationship with a provider.

It is critical that in addition to providing a standardized method for billing and acting as a check on unproven innovative services, our coding systems quickly adapt to reflect innovations in virtual care services. Concerns expressed by policymakers about fraud risk are important considerations, and we support efforts to protect patients, payers, and taxpayers. However, it is also reasonable to assume that payers can implement policy guardrails to control or monitor for fraud, waste, and abuse, as they already do for other services. Guardrails could include pilot programs that test these services by geographic area or limiting use to only certain types of providers or specialties.

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xvii FairHealth, Monthly Telehealth Regional Tracker, downloaded 2/28/2022. https://www.fairhealth.org/states-by-the-numbers/telehealth

xviii FairHealth data also indicate that the share of all telehealth claims attributed to mental health services increased from 24 percent in November 2019 to 48 percent in November 2020 to 62 percent in November 2021.

xix The Chartis Group (Kythera Labs), Telehealth Adoption Tracker, downloaded 2/28/2022. https://reports.chartis.com/telehealth_trends_and_implications-2021/

xx The measure of virtual care services includes all telehealth services and Communication Technology-Based Services (CTBS) such as remote physiologic monitoring, e-visits, and virtual check-ins.

xxi The Department of Health and Human Services (HHS) adopted specific code sets for diagnoses and procedures used in all healthcare transactions following enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

xxii Current Procedural Terminology (CPT®), Fourth Edition, Introduction.

xxiii Criteria for CPT Category I and Category III codes. American Medical Association. Criteria for CPT® Category I and Category III codes | American Medical Association (ama-assn.org)

xxiv The Healthcare Common Procedure Coding System (HCPCS) was adopted by The Department of Health and Human Services (HHS) in calendar year (CY) 2000 as a national code set and is divided into two levels. Level I HCPCS codes consist of Current Procedural Terminology (CPT®)xxiv codes and is maintained by the American Medical Association (AMA). Level II HCPCS codes are administered by the Centers for Medicare and Medicaid Services (CMS) and describe items (products, supplies, durable medical equipment) and services not identified in the CPT code set. There are different processes and procedures to maintain Level I HCPCS (i.e., CPT) versus level II HCPCS.

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