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# Audio-only Telemedicine Work Group Recommendations

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Blue Cross and Blue Shield of Vermont (BCBSVT) recognizes that audio-only telephone care bridges a critical gap during the COVID-19 pandemic. In the long term, however, BCBSVT has significant concerns about promoting audio-only care as a substitute for either audio-visual telemedicine or in-person care. Audio-only care can be a valuable addition to the suite of health care options available patients and providers, but it should not be an alternative for in-person care, particularly for individuals that live in rural or "inconvenient" locations and are already at risk for health care inequality.

## Widening health disparities

**Audio-only care should only supplement, not replace, high-quality in-person or audio-visual health care.** Numerous experts agree that audio-only care can have significant negative impacts on social determinants of health andsocio-economic disparities, and can lead to inequality in care for rural and economically disadvantaged populations.

- Harvard University's Dr. Ateev Mehrotra noted that socio-economic disadvantages and increased health disparities can be exacerbated by audio-only telemedicine.
- Blue Cross and Blue Shield of Vermont's Dr. Kate McIntosh spoke about concerns that audio-only medical care reinforces and perpetuates inequality in health care for poorer and more rural individuals and families.
- World-renowned health care scholar and physician Dr. Donald Berwick noted that the benefits to telemedicine are nuanced. Body language signals are difficult to be picked up telemetrically. The success of the appointment can depend on the patient being a good communicator.

Audio-only care may increase access to providers, and supplement audio-visual telemedicine or in-person care, but it cannot solve—and may ultimately contribute to—the health disparities of disadvantaged populations.

## Coding

**Audio-only care should only be coded using the telephone care CPT codes.** This will ensure that we do not deviate from accepted CPT language and definitions. CPT coding is not an area where Vermont should choose a unique policy path for many reasons. The only objective of non-standard coding appears to be higher payment levels for audio-only care. Deviation from national standards will prevent us from identifying fraud, waste, and abuse; and make tracking for quality purposes impossible. Compliance with unusual single-state CPT usage may be low for large national health care organizations and add cost and complexity to an overwhelmingly complicated system.

## Capitation versus global payments

**Appropriate fee-for-service payment levels are necessary.** There is little, if any disagreement, among stakeholders in the Vermont health care system that fee for service payment does not support high quality, cost effective care and that we must move to a better payment system. Thus, although BCBSVT supports capitation, capitating specific services does not serve the same goal as creating a global payment model where the best mode of treatment can be tailored to the patient's condition, need, and desire among a choice of many treatment options and modalities. BCBSVT has been striving toward a global payment model for years, and while we have had limited success in some areas, we are far from broad implementation of these payment structures. For example, telemedicine including audio-only care, is a better fit within a capitated or global payment when such payment applies to the full breadth of all primary care services. That is, when a primary care physician or practice is accountable for patient care, quality, and outcomes and the payment system reflects that accountability.

## Cost

**CPT codes for audio-only care should be set at 55% of the CPT for an in-person visit.** We must acknowledge the reduced cost that is required to provide audio-only service, as well as the inferior care provided by audio-only mediums. CPT code definitions takes into account both the work involved in the service provided, and the practice's overhead in supplying that service. Per the American Academy of Family Practice, primary care practice overhead is approximately 60% of receivables (Gordon, 2007). As a result, 40% of the payment of any code reflects the provider work. On par payments for audio-only care many encourage this modality in inappropriate circumstances and undermines our collective efforts to achieve affordability. Furthermore, BCBSVT members have complained that they are being charged the same as an office visit, when they feel the value is not equivalent.

## Quality measures

**Assessing the quality and value of audio-only health care is uncharted territory. Any recommendation must sunset to allow for reassessment.** We strongly caution that there are no accepted quality measures for audio-only care. As Reid Plimpton of the Northeast Telehealth Resource Center noted, audio-only care is not an evidence-based practice yet. The available data on quality measures looks almost exclusively at triage telephone calls. These calls focus on the screening process that assigns a degree of urgency to wounds or illnesses to decide the order of treatment. In other words, these studies focus on deciding whether or not a patient needs to come in to be seen, not on the provision of care over the telephone.

## Standards of care

**The standards of care cannot be lowered for audio-only care.** Instead, not all care can be provided through this modality and any recommendations should reflect the care that is disallowed by the State of Vermont. The quality of care needs to be equivalent across all modalities.

Outcome studies show that the quality of audio-visual and audio-only care is significantly inferior to an in-person visit for certain conditions. For example, Dr. Ateev Mehrotra noted the prescribing rate of antibiotics is significantly higher for ear infections when the doctor does not look in a child's ear. Given this and other evidence, it is essential that the standard of care be maintained through the curation of the proper channel for the assessment of any specific conditions. In this way, we can assure that all pertinent elements of the past medical history, physical exam, vital signs, assessment, and plan can be met at the same level as an in-office visit, as sufficient to meet the standard for care for that specific care episode.

Some have argued that there is a standard of care for audio-only care in that it is no different from the standard of care that is applicable to all medical services. However, this argument fails to acknowledge the lack of research pertaining to audio-only care necessary to meaningfully inform such standards. Blue Cross and Blue Shield of Vermont's telemedicine medical policy language reflects our concerns about vulnerable populations:

> *Audio-only telephone care may not be used in place of an in-person visit if the consequence of using telemedicine might reasonably result in **imminent harm** to the beneficiary. The care provided must be able to meet the standard of care as defined above.*
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> *Non-verbal children, developmentally delayed children and adults, incapacitated adults who cannot easily be evaluated over audio-only mediums, and children who are not old enough to interact with the provider over an audio-only connection present a special concern for quality and appropriateness of care. For these individuals especially, it is critical to understand the risks and concerns that third-party reporting may present in the clinical evaluation. Therefore, audio-only telephone care should only be utilized if the standard for care (as defined above) can be met for that care episode, taking into account the critical role that an in-person assessment, the physical examination, and vital signs may play in the care of these vulnerable individuals.*

**In summary, BCBSVT supports adding audio-only care to the options available for patients and providers, but significant protections and restrictions must be in place to ensure patient safety and recognize appropriate limitations of this type of health care.** The experts who presented to the Audio-Only Workgroup unanimously consider telephone care as part of a spectrum—used for triage, for routine follow up check ins, and for non-provider encounters. These experts did not support, nor is any other state considering, audio-only care as an ongoing primary treatment modality.