American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

February 8, 2023

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Submission of Emergency Department Services to the List of Approved Medicare Telehealth Services

Dear Administrator Brooks-LaSure:

On behalf of our 40,000 members, the American College of Emergency Physicians (ACEP) wishes to formally request that the first three levels of the emergency department (ED) evaluation and management (E/M) codes as well as all the observation codes be added to the list of approved Medicare telehealth services. We would like this request to be considered for the calendar year (CY) 2024 rulemaking cycle that establishes physician fee schedule rates for CY 2024.

In all, ACEP strongly supports the delivery of telehealth services by board-certified emergency physicians and believes that adding these services to the list of approved Medicare telehealth services would add significant clinical value and has the potential to save lives and reduce costs, especially in rural areas. Please find a detailed description of our request as well as the required rationale and evidence below.

Formal Request

- **Name(s), address(es) and contact information of the requestor.**

  The American College of Emergency Physicians (ACEP) formally requests the addition of the ED and observation E/M codes to the list of approved Medicare telehealth services. ACEP is the national medical society representing emergency medicine. Through continuing education, research, public education and advocacy, ACEP advances emergency care on behalf of its 40,000 emergency physician members, and the more than 150 million Americans they treat on an annual basis.

  If you have any questions about the request, please contact Jeffrey Davis, ACEP's Director of Regulatory and External Affairs, at jdavis@acep.org or 202-370-9301. The address of ACEP's Washington DC office is:

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- **The HCPCS code(s) that describes the service(s) proposed for addition or deletion to the list of Medicare telehealth services.**

  The codes that ACEP wishes to add permanently to the Medicare Telehealth Services List include CPT Codes:

  The first three levels of ED E/M Codes
  - 99281 through 99283

  Inpatient/Observation Services
  - Initial Day: 99221 through 99223
  - Admitted/Discharged on Same Day: 99234-99236
  - Discharge Management Service: 99238 and 99239

- **A description of the type(s) of medical professional(s) providing the telehealth service at the distant site.**

  ACEP believes that these telehealth services should be provided by board-certified emergency physicians and all other clinicians who currently provide the same services to Medicare beneficiaries in-person, following all pertinent federal regulations and state scope-of-practice laws.

- **A detailed discussion of the reasons the proposed service should be added to the definition of Medicare telehealth.**

  During the COVID-19 public health emergency (PHE), CMS has taken numerous steps to expand the use of telehealth under Medicare, and many have argued that our nation will never go back to a "pre-COVID" world where telehealth services were rarely performed. However, it is first important to note that ACEP for years has strongly supported the delivery of telehealth services by board-certified emergency physicians. On December 31, 2019, prior to the HHS Secretary declaring a PHE due to COVID-19, ACEP formally requested that CMS consider adding emergency medicine codes to the Medicare Telehealth Services List in the CY 2021 proposed rule. In our request, ACEP stated that we believed that results from innovative emergency telehealth initiatives suggested that having the ability to provide ED E/M services remotely to Medicare beneficiaries will improve care and lower costs across the country, in both urban and rural areas. Different types of emergency care models have already been tested, from "direct-to-consumer" models to models that involve a hub that connects emergency physicians to EDs in remote locations or allows emergency physicians to provide consultations for specific clinical conditions. In general, studies have shown that physicians and patients are extremely satisfied with the care being provided through these models, and costs have decreased due to avoided ED visits and inpatient admissions.

  ACEP recognizes that the COVID-19 PHE has changed the landscape of telehealth since we made our formal request at the end of 2019. While CMS has made substantial changes to telehealth policies, there are a few that particularly impact emergency medicine. The most significant policy, which impacted all telehealth services, was CMS' use of its 1135 waiver authority to temporarily waive the originating site and geographic restrictions, allowing health care practitioners to provide telehealth services to patients regardless of where the clinicians or the patients are allocated—in both urban and rural areas. Further, CMS clarified that medical screening exams (MSEs), a requirement under Emergency Medical Treatment and Labor Act (EMTALA), could be performed via telehealth. Finally, CMS temporarily added all five ED E/M codes, some observation codes, and critical care codes to the list of approved Medicare telehealth services on a Category 3 basis through the end of CY 2023. Other observation codes have been added for 151 days past the end of the PHE (see the chart below).

Since the emergency medicine codes have been on the list of approved Medicare telehealth services since March 2020, emergency physicians have provided ED E/M telehealth services in the following three different clinical situations, all of which added clinical value to patients:

1. ***Preventing Medicare beneficiaries from making unnecessary visits to the ED.*** Medicare beneficiaries who had urgent medical needs, but were unsure if they were having a medical emergency, were able to contact their EDs and have a telehealth visit with an emergency physician to assess whether the patient could stay at home, go to an urgent care clinic, or visit the ED. While Medicare beneficiaries previously had the opportunity to go to the ED if needed, this type of telehealth visit has now provided Medicare beneficiaries with a safe way of getting their condition evaluated before making that decision. Emergency physicians are trained in rapid diagnosis and evaluation of patients with acute conditions, so they are most capable of providing these type of telehealth services. In many cases, we are able to provide treatment to patients with minor illnesses and injuries completely via telehealth.

2. ***Providing MSEs to patients who came to the ED.*** As alluded to above, CMS released guidance stating that physicians (or other qualified medical persons) can perform medical screening examinations (MSEs) via telehealth and, where appropriate, meet the MSE requirement without an in-person examination. Hospitals are temporarily allowed to set up alternative locations "on campus" for patients to receive an MSE other than in the ED. For example, patients presenting with possible symptoms of COVID-19 and meeting certain criteria (i.e., vital sign parameters) can be sent to a negative-pressure tent, where they are seen by an in-person nurse and a physician via telehealth (video and audio) who determines if the patient can be discharged from the tent or needs to be seen in the ED. After completing this process, a low percentage of patients need ED evaluation.

3. ***Ensuring appropriate follow-up care after ED discharges.*** Emergency physician groups have set up systems and protocols to follow up with patients once they are discharged from the ED, ensuring that patients are taking their medications appropriately or are seeing their primary care physician or specialist if needed. These follow-up services have helped enhance care coordination efforts and avoid trips back to the ED or inpatient admissions. In addition, for patients under investigation for COVID-19, the treating ED group has been able to follow up with the patient to make sure their COVID symptoms are not progressing. Some groups have sent patients home with portable pulse oximeters and followed up to check their general status and oxygen levels.

Further, emergency physicians have been able to use telehealth for observation services. Fundamentally, telehealth services are ideally suited for "cognitive" services, such as those defined in the American Medical Association (AMA) Current Procedural Terminology (CPT®) manual under "Evaluation and Management Services." This includes clinic visits, lower-level ED visits, and consultations. Observation services also fall into this small category of cognitive, or evaluation and management, services. The COVID-19 pandemic has allowed physicians to maximize staffing of ED observation units with dedicated "observationists" covering more than one observation unit via telehealth for "virtual rounds." EDs have implemented protocol driven ED observation units which been shown to lower the cost of care for payors, with fewer admissions, fewer readmissions, and improved patient satisfaction.[1] [2] Further, this model of care can reduce costs for hospitals, decrease observation length of stays, and improve inpatient bed utilization—which is extremely beneficial for rural hospitals.[3] Previous work has shown that these units can save the country $3.1 billion in annual health care costs.[4] Despite this potential, many hospitals

[1] Ross MA, Hockenberry JM, Mutter R, Wheatley M, Pitts S. Protocol-Driven Emergency Department Observation Units Offer Savings, Shorter Stays, And Reduced Admissions. Health Affairs. 2013 Dec; 32(12):2149-2156.

[2] Hockenberry JM, Mutter R, Barrett M, Parlato J, Ross MA Factors associated with prolonged observation services stays and the impact of long stays on patient cost. Health Services Research. 2014 Dec;49(3):893-909.

[3] Perry M, Franks N, Pitts SR, Moran TP, Osborne A, Peterson D, Ross MA, The impact of emergency department observation units on a health system, Am J of Emerg Med. 2021 Volume 48; 231-237. https://doi.org/10.1016/j.ajem.2021.04.079.

[4] Baugh CW, Venkatesh AK, Hilton JA, Samuel PA, Schuur JD, Bohan JS. Making greater use of dedicated hospital observation units for many short-stay patients could save $3.1 billion a year. *Health Aff (Millwood)*. Oct 2012;31(10):2314-23. doi:10.1377/hlthaff.2011.0926.

struggle to open and staff these units, particularly rural hospitals. Through these virtual rounds, providing both initial observation and subsequent observation services via telehealth has become part of the continuum of care delivered in many EDs across the country.

While all observation care can be delivered via telehealth, there are currently inconsistent telehealth coverage policies depending on what type of observation service is being delivered. There are four specific sets of observation codes, but they have different timelines for how long they are to remain on the Medicare Telehealth Services List.

CPT	Description	Status on the Medicare Telehealth Services List
99221-99293	Initial hospital care	Temporary Addition for the PHE; Expires with PHE plus 151 days
99231-99233	Subsequent hospital care	Permanently Added
99234-99236	Observ/hosp same date	Temporary Addition for the PHE; Expires with PHE plus 151 days
99238-99239	Hospital discharge day	Available Through December 31, 2023

Continuing to segment these observation services going forward would result in a fragmentation of practice patterns and clinical workflow. It would be extremely confusing, and possibly disruptive to patient care, to have different sets of policies for patients in an observation unit—and it would significantly increase the administrative burden on clinicians as they scramble to try to determine which patient has to wait for an in-person evaluation versus who can be seen right away by telehealth during virtual rounds. Therefore, all these observation codes should be permanently added to the Medicare Telehealth List.

We also believe that the advancement of telehealth in emergency medicine can help mitigate the ED "boarding" crisis our nation is facing. Boarding, a phenomenon in which patients are kept in the ED for days (or longer) due to the lack of available inpatient beds or space in other facilities where the patient could be transferred, has been an issue for years. However, boarding has become increasingly worse over the last year. The reason for this is multi-factorial, but mainly has to do with significant staffing shortages in hospitals and an influx of patients (both COVID- and non-COVID-related) who are extremely ill. There is ample research[5] that shows that ED boarding and overcrowding lead to increased cases of mortality related to downstream delays of treatment for both high and low acuity patients. Boarding can also lead to ambulance diversion, increased adverse events, preventable medical errors, lower patient satisfaction, violent episodes in the ED, and higher overall health care costs. In November 2022, ACEP and 34 organizations sent a letter[6] to President Biden urging the Administration to convene a summit of stakeholders from across the health care system to identify immediate and long-term solutions to this urgent problem. We believe that the expanded use of telehealth could alleviate some of the underlying issues contributing to boarding, particularly staffing shortages, and could possibly help avoid in-person ED visits.

- **An explanation as to why the requested service cannot be billed under the current scope of telehealth services, for example, the reason why the HCPCS codes currently on the list of Medicare telehealth services would not be appropriate for billing the service requested.**

[5] Morley, C, Unwin, M, Peterson, G, Stankovich, J, Kinsmin, L, Emergency department crowding: A systematic review of causes, consequences and solutions. 2018. August 30. https://doi.org/10.1371/journal.pone.0203316.

[6] The letter is available at: https://www.acep.org/globalassets/new-pdfs/advocacy/emergency-department-boarding-crisis-sign-on-letter-11.07.22.pdf.

ACEP has previously requested that these services be added to the list of approved telehealth services. In CMS' response to our request in the Calendar Year (CY) 2017 Physician Fee Schedule (PFS) Final Rule, highlighted below, CMS discussed the unique nature of these services and why they are distinct from services currently on the list of approved telehealth services:

"The current request to add the emergency department E/M services stated that the codes are similar to outpatient visit codes (CPT codes 99201–99215) that have been on the telehealth list since CY 2002. As we noted in the CY 2005 PFS final rule, while the acuity of some patients in the emergency department might be the same as in a physician's office; we believe that, in general, more acutely ill patients are more likely to be seen in the emergency department, and that difference is part of the reason there are separate codes describing evaluation and management visits in the Emergency Department setting. The practice of emergency medicine often requires frequent and fast-paced patient reassessments, rapid physician interventions, and sometimes the continuous physician interaction with ancillary staff and consultants. This work is distinctly different from the pace, intensity, and acuity associated with visits that occur in the office or outpatient setting. Therefore, we did not propose to add these services to the list of approved telehealth services on a category one basis.

The requester did not provide any studies supporting the clinical benefit of managing emergency department patients with telehealth which is necessary for us to consider these codes on a category two basis. Therefore, we did not propose to add these services to the list of approved telehealth services on a category two basis. Many requesters of additions to the telehealth list urged us to consider the potential value of telehealth for providing beneficiaries access to needed expertise. We note that if clinical guidance or advice is needed in the emergency department setting, a consultation may be requested from an appropriate source, including consultations that are currently included on the list of telehealth services."[7]

Given this response, we asked CMS to consider adding these codes under a category 2 basis in our 2019 request mentioned above. We did not receive a formal response from CMS on the 2019 request for CY 2021, and therefore are making a new request for CY 2024, since the ED E/M codes are currently set to be removed from the telehealth list at the end of 2023.

Although, ACEP is now making this request, we do note that ACEP and 45 other organizations sent a letter[8] to CMS on January 26, 2023, requesting that the agency issue an interim final rule (IFR) as soon as possible to align the date that certain telehealth policies will expire with the new timeline established by the *Consolidated Appropriations Act, 2023* (Pub. L,117-328, December 29, 2022). This will ensure CMS' policy is aligned with Congress' intent under the Act of ensuring continued flexibility and payment for vital telehealth services.

In the Calendar Year (CY) 2023 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) Final Rule,[9] CMS finalized policies temporarily extending payment for certain telehealth services. First, the rule allowed certain telehealth services, which would otherwise not be available via telehealth after the expiration of the COVID-19 public health emergency (PHE), to remain on the Medicare Telehealth Services List for 151 days after the expiration of the PHE. The rationale behind this policy was to align the availability of these services with the flexibilities that were extended under the *Consolidated Appropriations Act, 2022* (Pub. L. 117–103, March 15, 2022). That law had extended a number of flexibilities that have been in place during the PHE for COVID–19 for 151 days after the end of the PHE. Second, the CY 2023 PFS and QPP Final Rule continued CMS' policy to keep other codes on the list of telehealth services on a Category 3 basis through the end of CY 2023.

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[7] Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Bid Pricing Data Release; Medicare Advantage and Part D Medical Loss Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model; Medicare Shared Savings Program Requirements Final Rule, 81 Fed. Reg. 80196 (November 15, 2016).
[8] The letter is available at: https://www.acep.org/globalassets/new-pdfs/advocacy/1.26-telehealth-coalition-letter.pdf.
[9] 87 FR. 69404 (November 18, 2022).

The *Consolidated Appropriations Act, 2023* extended the telehealth flexibilities that were previously extended 151 days after the expiration of the PHE until the end of CY 2024. ***Using the precedent of the policy finalized in the CY 2023 PFS and QPP Final Rule, CMS should keep all available codes (including Category 3 codes and all other codes currently set to expire 151 days after the expiration of the PHE) on the Medicare Telehealth Services List until the end of CY 2024.*** That way, CMS could continue its policy objective of aligning the availability of the flexibilities granted by Congress with the availability of codes that are on the Medicare Telehealth Services List.

We also urge CMS to issue an IFR rather than wait until the CY 2024 PFS and QPP rulemaking cycle to extend the availability of these codes on the Medicare Telehealth Services List until the end of CY 2024. As stated previously, the current policy, as established in the CY 2023 PFS and QPP Final Rule, is for certain codes to be removed from the list 151 days after the expiration of the PHE. The PHE will end on May 11, 2023, and 151 days after that date is October 9, 2023. If CMS were to wait until the CY 2024 PFS rulemaking cycle to modify the current policy, there would be a gap between that date of October 9, 2023, and the effective date of the CY 2024 PFS and QPP Final Rule, January 1, 2024 (60 days after the publication of the Final Rule, on or around November 1, 2023). During this gap period, certain codes would be, at least temporarily, removed from the Medicare Telehealth Services List—creating an unintended barrier to vital health care services, as well as potential confusion among providers and beneficiaries. Many Medicare beneficiaries who have been dependent on receiving care virtually would have trouble finding suitable alternatives to meet their needs. Thus, to ensure continuity of care, CMS must issue an IFR in the next several months.

- **Evidence that supports adding the service(s) to the list on either a category 1 or category 2 basis.**

  As stated above, we request that CMS consider these services under a category 2 basis. The category 2 standard requires that "the use of a telecommunications system to deliver the service produces demonstrated clinical benefit to the patient."[10]

  ACEP believes that results from current innovative emergency telehealth initiatives suggest that having the ability to provide emergency and observation services remotely to Medicare beneficiaries will improve care and lower costs across the country, in both urban and rural areas. In general, studies have shown that physicians and patients are extremely satisfied with the care being provided through these models, and costs have decreased due to avoided ED visits and inpatient admissions. Some successful programs of note and studies demonstrating the merits of enhanced telehealth use within emergency medicine include:

  - A tertiary care suburban teaching hospital and level I trauma center in Chicago, Illinois, implemented an emergency department-based, electronic intensive care unit (eICU) monitoring system for ICU boarders including a 24-hour support center, staffed with critical care nurses and physicians who have access to the electronic medical record, laboratory results, and radiology images. The staff used two-way video monitoring and smart alarms to monitor and treat patients in real time. Thirty-six percent of eICU patients were ultimately transitioned to a less intensive level of care in lieu of ICU admission while still in the emergency department, compared with zero patients in the emergency department care group. Among all ICU boarders transferred to the ICU, in-hospital mortality was lower in the electronic ICU care cohort when compared with the emergency department care cohort, suggesting that in critically ill patients awaiting transfer from the emergency department to the medical ICU, electronic ICU care was associated with decreased mortality and lower ICU resource utilization.[11]

  - In a study of 118,990 adult patients from 56 ICUs in 32 hospitals from 19 US health care systems to measure the effects of nonrandomized ICU telemedicine interventions on crude and adjusted mortality

[10] CMS Medicare Telehealth webpage: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Criteria.
[11] Kadar RB, Amici DR, Hesse K, Bonder A, Ries M. Impact of telemonitoring of critically ill emergency department patients awaiting ICU Transfer*. *Critical Care Medicine*. 2019;47(9):1201-1207. doi:10.1097/ccm.0000000000003847

and length of stay (LOS), mortality in the ICU telemedicine intervention group was significantly better than that of control subjects. Moreover, adjusted hospital LOS was reduced, on average, by 0.5, 1.0, and 3.6 days, and adjusted ICU LOS was reduced by 1.1, 2.5, and 4 days among those who stayed in the ICU for 7, 14, and 30 days, respectively. [12]

- In a study of 6,290 adults admitted to any of 7 ICUs (3 medical, 3 surgical, and 1 mixed cardiovascular) on 2 campuses of an 834-bed academic medical center in which the hospital mortality rate and hospital stay length was measured before and during the implementation of an adult tele-ICU unit, researchers found a reduction in mortality rate (11.8 percent compared to 13.6 percent) and shorter hospital length of stay (9.8 vs 13.3 days) for patients who utilized the tele-ICU unit versus patients who did not receive tele-ICU care.[13]

- The New England Healthcare Institute (NEHI) and the Massachusetts Technology Collaborative (MTC), working in collaboration with PricewaterhouseCoopers (PwC), conducted a demonstration study analyzing two clinical metrics, ICU mortality and ICU length of stay. According to these metrics, tele-ICUs would prove they had significant value if they could demonstrate a 10 percent decrease in severity adjusted ICU mortality rates coupled with an average decrease of 12 hours for an ICU length of stay. Following the study of patients at the University of Massachusetts Memorial Medical Center, NEHI, MTC, and PwC determined that if tele-ICU systems were broadly and effectively implemented in Massachusetts, more than 350 additional lives could be saved each year, the hospitals would benefit financially, and the potential savings for payers would exceed $122 million annually.[14]

- In an observational before-after telemedicine ICU intervention study in seven adult ICUs in two hospitals measuring ICU and ICU mortality, ICU mortality improvements were driven by nighttime ICU admissions as compared to daytime ICU admissions, whereas hospital mortality improvements were seen in both subgroups but more prominently in nighttime ICU admissions as compared to daytime ICU admissions, thus suggesting that telemedicine ICU intervention can effectively supplement low intensity bedside staffing hours (nighttime). Telemedicine ICU intervention was associated with improvements in care standardization and decreases in ICU and hospital mortality and length of stay.[15]

- Intermountain Healthcare in Murray, Utah, created the TeleHealth Critical Care Program for critically ill patients, offering an extra layer of support to front-line clinicians, keeping critically ill patients close to home, and supporting patient transfers when warranted by employing a team of critical care physicians and advance practice providers (APPs), nurses, and pharmacists to provide help 24 hours a day, 365 days a year, to approximately 260 ICU rooms at more than 35 hospitals throughout the Intermountain West. Since the inception of the program, Intermountain Healthcare community hospital ICUs with less than 10 beds have seen statistically significant (P=0.02) reductions in average ICU mortality rates, from 3.00 percent to 1.98 percent, as well as enhanced patient and clinician satisfaction and overall lower cost of providing high-cost critical care patient management.[16]

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[12] Lilly CM, McLaughlin JM, Zhao H, Baker SP, Cody S, Irwin RS. A Multicenter Study of ICU Telemedicine Reengineering of Adult Critical Care. *Chest*. 2014;145(3):500-507. doi:10.1378/chest.13-1973

[13] Lilly CM. Hospital mortality, length of stay, and preventable complications among critically ill patients before and after Tele-ICU reengineering of Critical Care Processes. *JAMA*. 2011;305(21):2175. doi:10.1001/jama.2011.697

[14] Fifer S, Everett W, Adams M, Vincequere J. Critical Care, Critical Choices: The Case for Tele-ICUs in Intensive Care. Network for Excellence in Health Innovation. https://www.nehi-us.org/publications/19-critical-care-critical-choices-the-case-for-tele-icus-in-intensive-care/view. Published December 1, 2010. Accessed 2023.

[15] Becker CD, Fusaro MV, Al Aseri Z, Millerman K, Scurlock C. Effects of telemedicine ICU intervention on care standardization and patient outcomes: An observational study. *Critical Care Explorations*. 2020;2(7). doi:10.1097/cce.0000000000000165

[16] Telehealth critical care program takes stress off local providers while ensuring better care for patients, closer to home. Intermountain Healthcare. https://intermountainhealthcare.org/ckr-ext/Dcmnt?ncid=529940912. Published June 14, 2021. Accessed January 30, 2023.

- A recent study of 20,861 ED observation patients evaluated the impact virtual care with usual care.[17] Virtual emergency observation unit care was shown to be non-inferior to in-person observation unit care. However, the benefit of virtual observation care relative to traditional hospital inpatient care was much better; with shorter hospital stays (19.1 hours vs 37.9 hours), lower costs ($1,890 vs $2,814), lower inpatient admission rates (17.5 percent vs 26.0 percent), and lower adverse event rates (0.7 percent vs 1.7 percent). In an analysis of the two study hospitals, the annualized impact of virtual observation care, compared with traditional care, was that: a) patients were 32.7% less likely to be admitted to the hospital as an inpatient; b) 134,834 hours of patient observation care was safely avoided; and c) $6,626,928 of health care costs were saved. Based on the U.S. Bureau of Labor Statistics data (registered nurse average hourly wages of $39.78 / hour), this equates to $5,363,697 in nursing wages saved or made available for other patients.[18] Virtual observation care was shown to be superior to traditional inpatient observation care, offering a model of care that can preserve limited hospital resources, at a time that health systems are struggling to maintain financial viability while facing critical nurse staffing challenges.

- An innovative program using observation codes is a virtual observation unit, leveraging the tools of telehealth, community paramedicine/Mobile Integrated Health, and hospital-at-home infrastructure to enable patients to receive their observation care at home. For such a program, appropriate emergency department patients are enrolled and go home with a tech bag including remote monitoring equipment, a tablet (iPad), and a mobile Wi-Fi hotspot. Once these patients arrive home, they receive audio or video check-ins by the remote virtual observation unit nurses, paramedic visits up to twice a day for vital sign collection, potential intravenous medication administration and/or point-of-care labs, and a facilitated video visit with an emergency medicine physician. Preliminary results of a propensity matching analysis with on-site emergency department observation patients demonstrated that, during the first year of this program, virtual observation patients experienced lower median emergency department length of stay (11.9 vs 30 hours) and lower inpatient admission rates (9.7% vs 24.7%). The 72-hour return rate was higher for virtual observation patients (15.3% vs 2.5%). Among those with return visits, the rate of inpatient admission was higher among virtual observation patients (72% vs 11%). There were no significant patient safety events recorded.

- The University of Mississippi Medical Center (UMMC) in Jackson, Mississippi provides emergency medicine specialist expertise to advance practitioners in approximately 20 to 30 rural EDs throughout the state of Mississippi through their TelEmergency program. Many of these EDs may have closed without the UMMC program providing emergency physician back-up and support to the mid-level providers on-site. Since the program's inception, over 500,000 patients have had access to board certified emergency medicine specialists without ever leaving their small community. UMMC was recognized by the Health Resources and Services Administration in 2017 as a Center of Excellence in Telehealth for its work and accomplishments in telehealth.

- A study comparing hospitals who have employed the UMMC telehealth ED network and similar rural hospitals from Arkansas, Georgia, Mississippi, and South Carolina that did not use TelEmergency found that, controlling for ownership type, critical access hospital status, year, and size, the TelEmergency program was associated with an estimated 31.4% lower total annual ED costs compared with similar matched hospitals that did not provide TelEmergency.[19] These findings suggest that access to quality ED care in rural communities can occur at lower costs.

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[17] Abiri A, Keadey M, Hughes G, Pitts SR, Moran TP, Ross M. The impact of virtual care in an Emergency Department Observation Unit. Ann Emerg Med. 2022. Pub pending: 1-12.

[18] The data from the U.S. Bureau of Labor Statistics are available at: https://www.bls.gov/oes/current/oes291141.htm.

[19] Williams D, Simpson AN, King K, et al. Do hospitals providing tele health in emergency departments have Lower Emergency Department costs? *Telemedicine and e-Health*. 2021;27(9):1011-1020. doi:10.1089/tmj.2020.0349

- Avel eCare based in Sioux Falls, SD provides telehealth services through a program called Avel eCare Emergency to approximately 440 unique health care facilities in 25 states; 200 of which are rural hospitals. The model centers around a telehealth hub which is staffed 24 hours a day by an interdisciplinary team of physicians, nurses, pharmacists, and social workers. During an eCare shift, clinicians only see patients via telehealth and are attuned to the specific needs of the rural facilities. Started in 2009, eCare has provided instant access to board-certified emergency physicians and critical care nurses who operate as a part of the rural emergency team. The eCare emergency team can expedite care, bring in specialists, assist with patient codes, call in support staff, and arrange transfers or whatever else is needed during a critical emergency case. Results to date include:
  - $49,841 in average annual savings to hospitals, because of better staffing options[20]
  - Potential to result in net savings of $3,823 per avoided emergency transfer[21]
  - $117,406 decrease in total ED costs[22]
  - $30 million saved in avoided transfers.

In summary, these emergency telehealth initiatives have proven to be successful and add clinical benefit to patients. We appreciate the opportunity to submit these codes for consideration. If you have any questions, please contact Jeffrey Davis, ACEP's Director of Regulatory and External Affairs, at jdavis@acep.org.

Sincerely,

Christopher S. Kang, MD, FACEP
ACEP President

[20] MacKinney AC, Ward MM, Ullrich F, Ayyagari P, Bell AL, Mueller KJ. The Business Case for Tele-emergency. Telemed J E Health. 2015 Dec;21(12):1005-11. http://www.ncbi.nlm.nih.gov/pubmed/26226603.

[21] Natafgi N, Shane D, Ullrich F, MacKinney C, Bell A, Ward M. (2017). Using Tele-Emergency to Avoid Patient Transfers in Rural Emergency Departments: An Assessment of Costs and Benefits. Journal of Telemedicine and Telecare. March 7, 2017. doi: https://doi.org/10.1177/1357633X176965854.

[22] Ward M, Merchant AS, Carter KD, Zhu X, Ullrich F, Wittrock A, Bell A. (2018) "Use of Telemedicine For ED Physician Coverage In Critical Access Hospitals Increased After CMS Policy Clarification." Health Affairs (Millwood). 2018, 12, 37. doi: 10.1377/hlthaff.2018.051032.