TH4- Telemedicine in PA/LTC: How to do it and do it Well

Thursday, March 22
8:00 AM- 11:30 AM

Session Description

Telemedicine is rapidly becoming a standard of care in modern medicine. By increasing access and responsiveness to care, telemedicine can improve clinical outcomes, reduce costs, and increase provider, patient, and family satisfaction. Despite these potential benefits, the technology and the requisite changes that it brings are relatively new in the PA/LTC setting. Many health care providers and leaders have expressed the need to build their knowledge and skills to reap the full potential value of this innovation. This half-day workshop will build attendee’s knowledge and skills in the standards for telemedicine care in PA/LTC through engaging lectures, roundtable interactive examples of telemedicine from PA/LTC settings, and facilitated discussions. Learners will leave with practical skills that are needed to “get started,” to advanced skills such as making the financial case for telemedicine in their PA/LTC system, to ensure that their program has the care processes and technology to accomplish their goals.

Learning Objectives

- Discuss the opportunities to use telemedicine to enhance PA/LTC.
- Identify technical and environmental considerations for high quality telemedicine in PA/LTC.
- Develop a strategy for establishing telemedicine services in their practice or medical group.

Presenter(s): Murthy Gokula, MD, CMD; Thomas Edmondson, MD, CMD; Steven Handler, MD, PhD; Suzanne Gillespie, MD, RD, CMD

Presenter(s) Disclosures: Murthy Gokula, MD, CMD: Has a financial disclosure; Curavi Health: Chief Medical and Innovation Officer, salary support; Thomas Edmondson, MD, CMD: Has a financial disclosure; Philips Healthcare: Full-time/Part-time Employee; Steven Handler, MD, PhD: Has a financial disclosure; Curavi Health: Chief Medical and Innovation Officer, salary support; All other speakers have reported they have no relevant financial relationships to disclose.
**Speaker Disclosures**

- Dr. Suzanne Gillespie: No financial disclosures.
- Dr. Murthy Gokula: Consultant, Curavi Health.
- Dr. Steve Handler: is the Chief Medical and Innovation Officer for Curavi Health.
- Dr. Thomas Edmondson: No financial disclosures. Previously employed by Philips Healthcare.
- Dr. Andrea Moser: No financial disclosures.
- Dr. Dallas Nelson: No financial disclosures.

**Learning Objectives**

By the end of the session, participants will be able to:

- Discuss the opportunities to use telemedicine to enhance post-acute and long-term care.
- Identify technical and environmental considerations for high quality telemedicine in post-acute and long-term care.
- Develop a strategy for establishing telemedicine services in their practice or medical group.

**Agenda (Thursday March 22nd 8am-1130am)**

- 0800-0845: Live Demo & Implementing Telemedicine
- 0845-1000: Making the Business Case for Telemedicine
- 1000-1015: Break
- 1015-1035: Project ECHO demo
- 1035-1120: Roundtable Discussions & Demonstrations
- 1120-1130: Discussion

**What is Telemedicine?**

Telemedicine is defined as the use of telecommunication and information technologies in order to provide clinical healthcare at a distance.

Types of telemedicine:

1. Interactive services (synchronous)
2. Store-and-forward (asynchronous)
3. Remote monitoring (self-monitoring)
4. mHealth (mobile devices)
Clinical vignette

When to Manage Changes of Condition with Telemedicine

Telemedicine Physician Pre-Flight Checklist

Telemedicine Live Demo
Telehealth Services

- Originating sites
- Distant site practitioners
- Telehealth services
- Billing and payment for professional services
- Billing and payment for originating site facility fee

https://tinyurl.com/TelehealthServices2017

Patient and Provider Location

Originating Site: Where the patient is located
Distant Site: Where the remote practitioner is located

Originating sites

- An originating site is the location of an eligible Medicare beneficiary at the time the service furnished via a telecommunications system occurs.
- Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in:
  - A county outside of a Metropolitan Statistical Area (MSA)
  - A rural Health Professional Shortage Area (HPSA) located in a rural census tract
- Determine if your NH is an authorized (rural non-MSA) originating site: http://tinyurl.com/HRSAcheck
  - Primary care
  - Behavioral/mental health
  - Dental medicine

Originating Sites Authorized by Law Are

- Offices of Physicians or Practitioners
- Hospitals
- Critical Access Hospitals (CAHs)
- Rural Health Clinics
- Federally Qualified Health Centers
- Hospital-based or CAH-based Renal Dialysis Centers
- Community Mental Health Centers (CMHCs)
- Skilled Nursing Facilities (SNFs)

Distant Site Practitioners

- Physicians
- Nurse practitioners (NPs)
- Physician assistants (PAs)
- Nurse-midwives
- Clinical nurse specialists (CNSs)
- Certified registered nurse anesthetists
- Clinical psychologists (CPs) & clinical social workers (CSWs)

Telehealth Services

- As a condition of payment, you must use an interactive audio and video telecommunications system that permits real-time communication between you, at the distant site, and the beneficiary, at the originating site.
- Asynchronous “store and forward” technology is permitted only in Federal telemedicine demonstration programs in Alaska or Hawaii.
Subsequent Nursing Facility Services

- For medical necessity, use the Subsequent Nursing Facility Care CPT E&M codes 99307-10 and include the “GT” modifier
- After January 1, 2017, you must use Place of Service (POS) 02: Telehealth
- Ensure that your H&P meets all requirements for that particular CPT E&M code and is documented in the NH medical record
- Limited to 1 visit per the same resident every 30 days

Consult Type, Time, Reimbursement, and RVUs: Subsequent Nursing Facility Care Codes*

<table>
<thead>
<tr>
<th>CPT &amp; M Codes</th>
<th>Face to Face Time</th>
<th>Pre and Post Time</th>
<th>Total Time</th>
<th>Non-Facility Price</th>
<th>Reimburse Per Min</th>
<th>Reimburse Per Hour</th>
<th>Work RVU</th>
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</table>

Advance Care Planning Services

- For advance care planning (ACP) services, use CPT E&M codes 99497 (first 30 min.) and 99498 (each addl. 30 min.) (starting Jan 2017)
- Include the “GT” modifier (via interactive audio and video telecommunications system) and POS 02 for Telehealth
- Ensure that your H&P meets all requirements for that particular CPT E&M code and is documented in the NH medical record
- There is no limits on the number of times ACP can be reported for a given beneficiary in a given time period

Psychiatric Diagnostic Evaluation Services

- For advance biopsychosocial assessment only, use CPT E&M code 90791, and for biopsychosocial assessment combined with medical assessment, use CPT E&M code 90792
- Include the “GT” modifier (via interactive audio and video telecommunications system) and POS 02 for Telehealth
- Ensure that your H&P meets all requirements for that particular CPT E&M code and is documented in the NH medical record
- There is no limits on the number of times ACP can be reported for a given beneficiary in a given time period

Consult Type, Time, Reimbursement, and RVUs: Psychiatric Diagnostic Evaluation Codes*

<table>
<thead>
<tr>
<th>CPT &amp; M Codes</th>
<th>Face to Face Time</th>
<th>Pre and Post Time</th>
<th>Total Time</th>
<th>Non-Facility Price</th>
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Originating Site Facility Fee

- Determine if your NH is an authorized (rural non-MSA) originating site: http://tinyurl.com/HRSAcheck
- HCPCS code Q3014, Telehealth originating site facility fee
- Can be billed for Short-term and LTC Medicare Beneficiaries
- The NH bills the MAC for the originating site facility fee, which is a separately billable Part B payment = revenue in addition to the daily RUGs rate for skilled residents
- Managed care companies can reimburse NHs for code Q3014 for all products if they elect to do so

NH Provider Perception of Telemedicine: Part 1

- The goal of this study was to survey NH physicians and nurse practitioners to quantify provider perceptions and desired functionality of telemedicine in NHs to reduce PAHs.
- Surveyed 435 physicians and nurse practitioners who attended the 2015 AMDA Annual Conference
- Highly positive and strongly-held beliefs of the value of telemedicine for managing PAHs in the NH setting
- Suggests that there is potentially unmet demand for telemedicine and that NHs may be receptive to appropriately designed solutions
- Need to focus on the sociotechnical aspects of implementation and continued use of telemedicine to ensure its continued use through a highly structured change mgmt. process

NH Provider Perception of Telemedicine: Part 2

- The goal of this study was to determine the perceived utility of providing specialty telemedicine in NHs.
- Surveyed 522 physicians and nurse practitioners who attended the 2016 AMDA Annual Conference
- Top 5 specialties that physicians and nurse practitioners would refer to: Dermatology > Geriatric psychiatry > Infectious disease > Neurology > Cardiology
- Top 5 Statements of agreement: 1) Fill an existing service gap; 2) Improve timeliness of resident care; 3) Increase access to appropriate care; 4) Decrease ED/hospitalization; and 5) Increase overall quality of care.

CMS Technical Specifications for Telemedicine (Appendix C)

- A standard system should include a mobile medical cart with the ability to hold a PC, supplies, diagnostic medical equipment, and a rechargeable battery.
- The system should include real-time interactive audio visual technology and not "store and forward" technology.
- All of the equipment should be connected using a What is HIPAA-compliant, secure wired or wireless system.
- A full-duplex speakerphone
- At least one high-performance=19x optical zoom, low light, pan/tilt/zoom camera
- A high-definition web cam
- An electronic stethoscope
- A digital Otoscope
- A PC-Based Resting 12-lead ECG/EKG System

Telemedicine Implementation: Medical Licensure/Credentialing

- Facility credentialing
- State licensure
- Interstate medical licensure compact
Telemedicine: Ethical Considerations

- Should we obtain consent for treatment vs. informed consent before conducting a telemedicine consultation?
- What are the environmental considerations for the use of telemedicine in the nursing home?
- What diagnoses or conditions should not be treated by telemedicine?
- Should we prescribe narcotics through telemedicine?
- Should studies of equivalency between face-to-face and telemedicine be done before we use this technology?

Interstate Medical Licensure Compact

- Basic requirements do not change for state licensure of a physician seeking only one license or who chooses to become licensed in additional states through the existing process.
- Once a physician receives a Compact-issued license from a state, the physician still must adhere to the existing renewal and CME requirements of that state.
- The Compact in no way overrides a state’s authority and control over the physician’s practice of medicine.
- State participation in the Compact is voluntary, and states are free to withdraw from the Compact at any time by repealing the enacted statute.
- The process of licensure proposed in the Compact would reduce costs by streamlining the process for licensees.

Section 2: Making the Case for Telemedicine (TM)

- What are the drivers to develop a TM program?
- What care processes does TM facilitate?
- What clinical value does TM add to the care of residents in SNFs and ALs?
- What is the added financial value of a TM program?
- How is the quality of your telemedicine program measured?
- Resources for program development

Drivers for Telemedicine

- Increasing utilization of SNFs
- Increasing acuity of patients in SNFs
- OIG Report, 2014
- Decreasing revenue margins
- VBP
- New Quality Measures
- Workforce issues & SNF capacity
- Hospital readmissions within 30 days
- 45% potentially avoidable per CMS
- "Head in the Bed"
- Value of ~ $550/day to the SNF
- Secure referrals
- Preferred SNF Networks
The SNF and REIMBURSEMENT

Value of Stay:
- Medicare coverage (Patient)
  - 1-20 days: Medicare 100%
  - 21-100 days: Medicare – coinsurance ($167.50 per day)
  - 100 days+: Medicare 0%

SNF Reimbursement (CMS)
- ALOS: 23 days
- Average value $15000 per patient
- Per Day Value est. $500-600

➤ Reducing readmissions ahead of discharge:
  ➤ increases revenue per day
  ➤ strengthens credibility with hospital for referral continuity

“If in doubt send it out”

REIMBURSEMENT and MARGINS

• 2012:
  - Average payment: $15,000
  - Medicare spending for SNFs: $28.7B

• SNF Margins (13.8% down to 12.5% in 2014)
  - For-profit: 16.1%
  - Not-for-profit: 5.4%
  - Hospital-based: -62.0%

➤ Average total NF margin: 1.8%
➤ Medicare covers losses on daily Medicaid rate

READMISSION RISK

Complications resulting from readmission

For Hospital
- 30 day readm penalties for 5 DRG @ 3%
- Reputation (hospital compare)

For SNF
- Cost of Open Bed Days
- Exclusion from preferred
- CMS VBP/policies & Report Card

For Patient
- "Hospital-phobia"
- Risk for multiple hospital-acquired conditions and illnesses

WHAT CARE PROCESSES DOES TM FACILITATE?

• Enabling Technologies:
  - Proactive/Population Health model
    ▪ Remote Patient Monitoring (aka, RPM or Telemonitoring)
      - Use of asynchronous technology: tablets, smartphones and Bluetooth-enabled devices to collect patient symptoms, vital signs and rectify, and provide patient education
      - Provides near real-time patient monitoring with identification of high-risk patients in need of further evaluation via trended data
      - Ability to monitor hundreds of patients per day
  - Escalation model
    ▪ Use of synchronous technology: Live 2-way video consultation (aka Video Visits)
      - Live, interactive assessment of patients remotely
      - Ability to assess and/or manage one patient at a time

➤ Use cases for both models:
  - Admissions, transitions of care, urgent care needs, and discharges

What clinical value does TM add to the care of residents in SNFs and ALs?

Escalation Model Proof Point

Randomized-controlled Trial
- 11 SNFs in Massachusetts, 10/2009 – 09/2011*
  - Intervention group = 6 homes; Control group = 5 homes
  - 2-way live audio-video consultation using a high-resolution camera to connect to an off-site provider (NP or Physician)∗
  - Urgent or emergent calls
  - Weeknights and weekend days (but not weekend nights)
  - Measured outcome: Hospitalization
  - Results

<table>
<thead>
<tr>
<th>Escalation Group</th>
<th>Control Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>After 20 weeks</td>
<td>Before 20 weeks</td>
</tr>
<tr>
<td>11% decrease</td>
<td>13% decrease</td>
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<td>P&lt; .05</td>
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SNF Program- Metrics/Outcomes

10 SNFs involved
- Program Metrics to date:
  - 758 patients monitored:
    - Diagnosis Profile
    - HF 75%
    - COPD 10%
    - HTN 5%
  - Average Days on Service: 20 Days

Outcomes
- Prior to Program: Readmission rate 24-30%
- Program Readmission Rate:
  - ~10% 30 day readmission rate for all cause
  - ~2% 30 day readmission rate for telehealth diagnosis

KPIs (Metrics)

<table>
<thead>
<tr>
<th>Financial</th>
<th>Operational</th>
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<tbody>
<tr>
<td>• 30 Day Readmission Penalties</td>
<td>• Number of consults per month</td>
</tr>
<tr>
<td>• Hospital Readmissions LOS</td>
<td>• Average daily census in the SNF</td>
</tr>
<tr>
<td>• Observation Status Days</td>
<td>• Workflow compliance</td>
</tr>
<tr>
<td>• Number of 911 calls per month</td>
<td>• Number of physician calls (off hours)</td>
</tr>
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</table>

Clinical Satisfaction

| • Consult call by reason and type (urgency) | • Facility Staff Satisfaction (pre / post) |
| • Available transfers to ED for evaluation | • Physician Satisfaction (post) |
| • Call response time | • Telehealth center staff satisfaction (post) |
| • # of patients requiring orders | • Patient / family (optional – post) |

Contributing Factors to Financial ROI: Proactive/Pop Health and Escalation Models

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Medicare Fee for Service</th>
<th>Medicaid Fee for Service</th>
<th>Managed Care Fee for Service</th>
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<tbody>
<tr>
<td>Hospital</td>
<td>- Selection of patients for RPM/Telemonitoring programs</td>
<td>- Hospital Readmission Risk Tool for SNF</td>
<td>- Telemedicine Staff Availability</td>
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<tr>
<td>Nursing Facility</td>
<td>- Average CMS readmission penalty per penalized hospital</td>
<td>- Average penalty 0.73 percent for ~80% of hospitals</td>
<td>- Average penalty 0.73 percent for ~80% of hospitals</td>
</tr>
<tr>
<td>Assisted Living</td>
<td>- Selection of patients for RPM/Telemonitoring programs</td>
<td>- RPM or Telemonitoring programs</td>
<td>- Video Monitoring Programs</td>
</tr>
<tr>
<td>Assisted Living</td>
<td>- Hospital Readmission Risk Tool for SNF</td>
<td>- Video Monitoring Programs</td>
<td>- Telehealth Services</td>
</tr>
<tr>
<td>Hospital</td>
<td>- Medicare</td>
<td>- Medicaid</td>
<td>- Telemedicine staff availability</td>
</tr>
</tbody>
</table>

Nursing Facility

| • Facility Staff Satisfaction (pre / post) | • Physician Satisfaction (post) |
| • Admission to hospital or skilled nursing facility | • Call response time |
| • Telehealth center staff satisfaction (post) | • # of patients requiring orders |
| • Patient / family (optional – post) | • Hospital / ACO (Stakeholders aligned financially) |

Assisted Living

| • Facility Staff Satisfaction (pre / post) | • Physician Satisfaction (post) |
| • Admission to hospital or skilled nursing facility | • Call response time |
| • Telehealth center staff satisfaction (post) | • # of patients requiring orders |
| • Patient / family (optional – post) | • Hospital / ACO (Stakeholders aligned financially) |

Assisted Living Value-Based Care or Risk-Sharing Model

| • Facility Staff Satisfaction (pre / post) | • Physician Satisfaction (post) |
| • Admission to hospital or skilled nursing facility | • Call response time |
| • Telehealth center staff satisfaction (post) | • # of patients requiring orders |
| • Patient / family (optional – post) | • Hospital / ACO (Stakeholders aligned financially) |

Hospital ACO (Stakeholders aligned financially)

| • Facility Staff Satisfaction (pre / post) | • Physician Satisfaction (post) |
| • Admission to hospital or skilled nursing facility | • Call response time |
| • Telehealth center staff satisfaction (post) | • # of patients requiring orders |
| • Patient / family (optional – post) | • Hospital / ACO (Stakeholders aligned financially) |

Vision of Technology-Enabled Monitoring and Continuum of Care

Uses of Telehealth & RPM

| • Patient Education & Self Management |
| - Provision of material on best practice supported by research, recommendations on self-care, principles on managing chronic conditions. |
| - Chronic Conditions Management in the Pre and Post Acute Periods, Stabilization of Patients After the Acute Phase, Remote Consultation, Treatment and Routine Check-Up |

Benefits of Telehealth & RPM

| • Better Health Outcomes & Management |
| - Lower Rates of Admissions & Readmission |
| - Patient Satisfaction, Quality of Life, Self Efficacy |
| - Physician Engagement Key to Success |
| - Caregivers Work Load 7 Efficiency |
| - Reduced Risk & Liability |
**HOW CAN HIT BE SUCCESSFUL?**

- Continuous patient monitoring.
- Data interpretation in a personalized context with specific healthcare objectives.
- Tailoring management as per indications.
- Efficient feedback process to the patients.
- Convenient cycle repetition when needed.

**STATES THAT MANDATE TELEHEALTH COVERAGE**

- California
- Colorado
- Georgia
- Hawaii
- Kentucky
- Louisiana
- Maine
- Maryland
- Michigan
- New Hampshire
- Oklahoma
- Oregon
- Texas
- Vermont
- Virginia

**WHATS HOT?**

- **CHRONIC CARE ACT**
  - Telehealth services are now included in the MEDICARE ADVANTAGE PLAN BID.
  - There is more flexibility for some ACOs' provision of telehealth services.
  - Dialysis check-ins can now be done from the comfort of home via telehealth.
  - Telehealth is now more available especially for stroke patients who may need minimal time to make a diagnosis and institute management.
  - The Physician Fee Schedule for 2018: reimbursement for RPM and CPT codes for telemedicine for the first time


**Where and How to start**

Do needs assessment and identify the solution for your needs

- What are the service needs?
- What opportunities exist for telehealth?
- Is there organizational readiness?

**Define Program Model**

- It should address the needs adequately

**Develop Business Case**

- Demonstrate the impact of offering telehealth

**Where and How to start**

Develop a Detailed Project Plan Incorporating Technology

**What is the plan for performance monitoring?**

- Define the process for monitoring and evaluation.
- Define processes for program improvement

**Project Implementation and Execution**

- Roll out the program
- Perform the work outlined in the program
- Continued surveillance and improvement

**BARRIERS TO TELMEDICINE**

- Reimbursement
- Licensure
- Credentialing
- Prescribing
- Consent
- Malpractice Liability
- Fraud and Abuse
- Privacy and Security
- Patient willingness
BUT STILL EARLY ADOPTERS WIN: LET'S DO IT

TOLEDO MODEL
• VISION
  - Combine evidence-based medicine and tele-health technology to manage health to improve patients’ lives and reduce healthcare costs.
• MISSION
  - Create and deliver simple and effective tools to manage multimorbidity and promote aging in place.
  - Leased different components to create a platform.
  - Created a PRISM approach to deliver care
  - PRISM is a true HOLISTIC biopsychosocial approach to health involving body, mind, and spirit by addressing the physical, mental and social wellbeing of the patient.

BUSINESS MODELS(NH)
• Pittsburgh Model
  - Provision of both hardware and software
  - Seamless transfer of data
  - QAPI
  - University level care
• New York Model
  - Physicians cover After Hours: value proposition of convenience, access and reduced hospitalization rates
  - Charges for the services at an hourly rate, rates vary different categories of care, and more services necessitate greater cost

BUSINESS MODELS(AL)
• European Model
  - Specialist services
  - Monitoring of chronic medical conditions
• Kentucky Model
  - Telemedicine room
  - Nurse does vitals
  - Improved Revenue 30%
  - [Visit](https://www.telehealthresourcecenter.org/reimbursement)
  - [Visit](https://www.telehealthresourcecenter.org/toolbox-module/medicares-telemedicinetelehealth-payment-policies)

BILLING CODES
• Medicare Telehealth Payment Eligibility Analyzer is available at:
  - There was addition of several services eligible for telehealth reimbursement
  - Star icon alongside the code
    - Indicates a telemedicine code
  - Important updates:
    - Advance care planning services
    - Chronic care management
    - Remote Patient Monitoring: End of 2018
    - Finalizing payment policies related to new POS code designed to report services furnished via telehealth

CAST PROPOSED BUSINESS MODELS
• HealthCare Model
  - Factors that will Drive Success
  - Implementation as a Major Driver of Success
  - Provider-Related Drivers
• Community Based Support Model
  - Factors that will Drive Success
  - Funding as a Major Driver of Success
  - Provider-Related Drivers.
• Real Estate-Based Models
  - Factors that will Drive Success
  - Provider-Related Drivers

HEALTH CARE MODEL
• Factors that will Drive Success
• Implementation as a Major Driver of Success
• Provider-Related Drivers

A proper utilization of telehealth services is a viable model for the delivery of care, providing a more efficient and accessible approach to healthcare. By leveraging these innovative technologies, healthcare providers can enhance patient outcomes while reducing costs and improving overall access to care.
BILLING REQUIREMENTS

- **Originating Site**
  - The facility fee is charged under HCPCS code Q3014

- **Distant Site**
  - Place of Service code 02
  - For compensation, they have to submit a CPT/HCPCS code for the covered telehealth service
  - Medicare: Append appropriate –GT or GQ as appropriate

CPT 2017 Updates

- **Appendix A**
- **Modifier 95**
  - Allows reporting of synchronous telemedicine services via real-time audio and video telecommunications systems

- **Addition of Appendix P**
  - Gives you the summary of CPT codes to report synchronous (real-time) telemedicine services
  - Modifier 95 must be appended

MODIFIERS

- Billing with modifiers only applies to services rendered from a distant site.
- Reimbursement claims should have accompanying CPT/HCPCS codes relevant to the professional service offered, and also one of several modifiers:
  - GT for interactive audio and video telecommunications system (live interactive) or
  - GQ for Store and forward applications.

MODIFIERS

- **Originating Site Fee**
  - Sites providing the e-health services are eligible for a facility fee, capped at $22.94 in 2014.
  - HCPCS code Q3014 is appropriate for sites facility fees claims.
  - A provider can only bill a recipient once a day for the fee.
MODIFIERS

- **Transmission Fee: Live Interactive**
  - Live interactive services are a source of costs. MediCal covers the cost for both original and distant sites.
  - It is determined as one unit of service being equal to one minute of transmission cost.
  - It is capped at 90 minutes per day, for the same recipient-provider pair.
  - It is code T1014 and is $0.24 per minute in 2014.

- **Clinical Fees: Live Interactive**
  - Service provision by health professionals is charged at the same rate as without telemedicine.

- **Reimbursement**
  - Financial information available at:
    - http://www.gptrac.org/cost-benefits/from-startup-to-sustainability/

Clinical Fees: Store and forward

- Dermatology and ophthalmology are the beneficiaries of these costs.

<table>
<thead>
<tr>
<th>Service</th>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office or other outpatient visit</td>
<td>99211 – 99213</td>
</tr>
<tr>
<td>Subsequent hospital care</td>
<td>99211 – 99213</td>
</tr>
<tr>
<td>Office consultation, new or established patient</td>
<td>99241 – 99248</td>
</tr>
<tr>
<td>Tele-medicine consultation</td>
<td>99251 – 99253</td>
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MODIFIER CONCERNS

- **Modifier 95**
  - Synchronous telemedicine service rendered via a real-time interactive Audio and Video Telecommunications System

- **Modifier GT**
  - Over interactive media for voice and video

- **Modifier GQ**
  - “through asynchronous electronic communication system” Certain distant sites in Alaska and Hawaii only

Payer Requirements


- The cost of furnishing some part B services by the physician are covered by Medicare.
- In federal telemedicine demonstration programs in Alaska or Hawaii, asynchronous store-and-forward technologies are used.
- The demonstration projects by the federal government whose funding was ongoing as at 12/31/2000 are exempt from rural HPSA and non MSA geographic requirements.
- Always make sure you understand and verify payer policies and requirements before you offer your services.
  - What’s the process to get approved?
  - Offered Telemedicine services List of services that may be offered via telemedicine
  - What are the requirements for billing?

MEDICARE

Telehealth Services (42 CFR 410.78) Funding for interactive media by Medicare Part B is on condition that:

1. The practitioner is licensed for the service under state laws.
2. Furnishing of the service is for beneficiary at a given originating site (includes office of practitioner, CAH, rural hospital, FQHC, SNF, community mental health center).
3. The originating site is not in the Metropolitan Statistical area and in an area with shortage of health professionals.
4. The practitioner is still in charge of patient examination.

- There is no remuneration for training from Medicare. A limited number of services are reimbursed.
- Interactive telecommunications system includes:
  - sound and video equipment
  - There is two-way communication
  - The interaction is real-time
  - Involve both the patient and distant site physician or practitioner
**MEDICARE**

- CMS’ 2015 physician payment fee schedule final rule expanded the telehealth list to include:
  - Psychoanalysis
  - Family psychotherapy
  - Prolonged evaluation and management services
- The ACA uses incentives to get the Medicare-participating hospitals and others to use clinically integrated care models.
- The Center for Medicare and Medicaid Innovation (CMMI) for testing innovative payment and service delivery models to reduce program was created by Congress to lower cost and improve quality
- Dec. 1, 2014 proposed rule issued by CMS:
  - Requires an ACO to demonstrate its utility and implementation of Telehealth.

**MEDICAID**

- Reimbursement differs from state to state and the federal government demands a demonstration of “efficiency, economy, and quality of care”
- Once qualified, states can:
  - Choose to cover telemedicine services
  - Select the extent of the coverage
  - Set payment criteria
  - Locations within state the services may be provided

**MEDICAID & PRIVATE INSURERS**

- Regulation of telehealth reimbursement by private insurers is also the mandate of the state, and is exercised in up to 45 states.
- Nineteen states have enacted parity laws; telehealth must be as in person
  - PARITY LAW STATES: Arizona, California, Colorado, Georgia, Hawaii, Kentucky, Louisiana, Maine, Maryland, Michigan, Mississippi, Missouri, New Hampshire, Oklahoma, Oregon, Texas, Vermont, and Virginia
- While some only have provisions for specific services, other insurers and Medicaid agencies cover all telehealth services where rationale for use is demonstrated to levels that are satisfactory to the agency.
- Additional coverage is in state waivers or for special programs such as:
  - Remote diagnostics
  - Remote monitoring for specific disease entities
  - Remote monitoring for particular populations
- Other states pay claims regardless of the modality of dispensation. E.g., telehealth or in person
- Managed care complicates the telehealth reimbursement policies since several state programs do not record specific utilization data.

**State Telehealth Laws & Medicaid Program Policies**

- 86% of states cover telemedicine services state-wide without distance restrictions or geographic designations
- States without coverage for telemedicine under Medicaid:
  1. Connecticut
  2. Rhode Island

**Private Payers – Parity Laws**

- As of January 2016, 29 states and DC have enacted “parity” laws, which compel insurance cover for telehealth in the same way as in-person services
  - 28 states and DC have enacted full parity laws, Arizona has enacted a partial parity law that limits coverage to a certain geographic area or pre-defined list of services
PRESCRIBING

- Physical examination of a patient is a precondition to prescription in some states.
- Since the telehealth communication is deemed as an inadequate medium for establishment of a doctor-patient relationship, this means prescription is impossible.
- However, some states allow for examination over these platforms.

CONSENT

- Informed consent of some sort is required in 29 either through statuses, medical codes or Medicaid policy (include KY, OH, TN, WI, CA, FL, PA)
- PA, OK, TX, WA require written acknowledgment from the patient

Medical Malpractice and Liability

- Reducing Risk and Liability
  - Typically separate consent
  - Lay out details of the telemedicine encounter
  - Specific risks
  - Information on the participating practitioners
  - State-specific informed consent requirements related to telemedicine may apply
- Ensure that physician has full insurance coverage
  - Does the policy specifically cover telemedicine negligence?
  - Does the policy extend coverage across state lines?

Fraud and Abuse – Anti-Kickback Statute

- Most common AKS issue is the provision of subsidized or free equipment to telemedicine physicians
- Ask: Can the originating site’s provision result in referrals?
- Safe Harbors that may be applicable:
  - Rental services for space or equipment
  - Personal services and management contracts
  - Bona fide employees
- Tip: Don’t let Medicare limited reimbursement fool you!
  - Telemedicine arrangements can still induce referrals beyond telemedicine services

Nurse Practitioner and Physician Assistant Prescribing - Ohio

- Nurse Practitioner and Physician Assistant can assist in prescription:
  - These parties have independent prescribing authority upon obtaining certificate to prescribe
- After certification, these parties are authorized to:
  - Conduct history-taking
  - Examine, including physical and mental
  - Diagnose
  - Prescribe
- Consult with the collaborating physician when necessary
- Document patient information.

Unique issues with Telemedicine:

- Appropriate standard of care
- FTC implications: The state licensing boards that impose different requirements for telehealth
- Anti-competitive practices and are liable for litigation under federal laws. See N.C. State Bd. of Dental Examiners v. FTC, 125 S. Ct. 1101 (2015)
- FY Admin Regs. 205, 3:170 (2011)

Medical Malpractice and Liability

- Unique issues with Telemedicine:
  - Appropriate standard of care
- Establishment of physician-patient relationship
- Can a relationship be formed with distant site physician? Yes. See White v. Harris, 36 A.3d 293 (Vt. 2011)
- Jurisdiction
- Choice of law

Ohio – OAC 4753.2-01

- Speech Language Pathology
  - A provider is required to inform the patient of specific telehealth limitations.


- The originating site provider must obtain and document verbal or written patient consent prior to service delivery.

CONSENT

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Medical Malpractice and Liability

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Fraud and Abuse – Anti-Kickback Statute

- OIG Advisory Opinion 11-12
  - Requestor provides neuroscience care through flagship hospital
  - Proposed Arrangement: Requester would provide services to certain community hospitals: (i) neuro emergency telemedicine technology; (ii) neuro emergency clinical consultations; (iii) acceptance of neuro emergency transfers; (iv) neuro emergency clinical protocols, training, and medical education
  - Goal: to reduce volume of transfers of stroke patients, reduce mortality and morbidity rates, and lower costs
  - OIG Conclusion: OIG would not impose administrative sanctions

Fraud and Abuse – Anti-Kickback Statute

- OIG Rationale:
  1. Since the objective of the program is to realize a reduction in transfers and the hospitals are not coerced into the program on the agreement that they refer patients, it is unlikely that the requestor will generate significant traffic from the program.
  2. The value and volume of previous business is not a condition for participation.
  3. The patients benefit more than the requestor or hospitals
  4. Each party bears its own cost of marketing and there are no joint marketing activities
  5. There is not impact to cost of federal care programs
- Other telemedicine advisory opinions: No. 99-14, 99-18

Privacy and Security

- HIPAA applies to telemedicine encounters and all necessary safeguards must be in place
- Challenges:
  - Secure wireless connection
  - Should web conferencing services (e.g. Skype, Face Time) have HIPAA-related obligations
  - Storage of electronic files, such as images or audio/video
  - States with more aggressive laws

CHRONIC CARE MANAGEMENT

- FOR ROI:
- Reimbursement Update for RRM & CCM
  - (CPT Codes 99091, 99490, 99487, 99489, and G0506)
  - Medicare will pay for CPT code 99091 and the 2018 unadjusted reimbursement rate will be $58.67/month.

CPT code 99091

- The unbundled CPT code 99091? What does that mean?
  - Is reimbursement for the time spent on information collection and interpretation to a minimum of 30 minutes.
- Key guidelines on the use of this code include:
  - Consent for the service must be included in the patient record by the provider
  - For new patients, this information should be collected at first visit
  - Providers can use 99091 no more than once in a 30-day period per patient.
  - The code includes:
    - Time spent accessing the data
    - Reviewing or interpreting the data
    - Any necessary modifications to the care plan that result, including communication with the patient and/or her caregiver and any associated documentation.
    - This code will not be subject to any of the restrictions on originating sites or technology that telehealth services are subject to by statute, allowing users of this technology more flexibility.

WHAT IS CCM?
Key Improvements for 2017

- Increased pay – It now ranges from $43 to $141 from previous $42
- Additional codes – There are now at least 3 codes
- Patients can now receive the simple or complex CCM. Complex CCM implies more clinical staff time and greater extents of care

SUMMARY OF CCM CHANGES 2017

NEW SERVICES :2018

- Counseling visit for lung cancer screening (HCPCS code G0296)
- Psychotherapy for crisis (CPT codes 90839 and 90840)
- Interactive complexity (CPT code 90785)
- Patient-focused and caregiver-focused health risk assessment (CPT codes 96160 and 96161)
- Chronic care management services including assessment and care planning (HCPCS code G0506)

Consultations

- MUST Demonstrate Medical Necessity
- Consult services furnished to patients in hospitals or SNFs
- Request for opinion or advice by an appropriate source, different from the attending physician
- Request should be documented by the consultant in the patient’s EMR and should also be reflected in the patient’s plan of care by the requesting physician or other qualified party.
- Written report of consultants findings and recommendations must be provided to the referring provider
- Consultant SHOULD NOT be the physician of record or the attending physician

BILLING REQUIREMENTS

- Language for Consult
  - Request examples: Opinion Advice Suggestion Direction Counsel

AT THE END

- Important to Know your payer policy
- Not Every one follows Medicare guidelines
- Remember that the Originating sites; Use HCPCS code Q3014
- Distant sites must use appropriate CPT/HCPCS code for the service and append the appropriate modifier
Break
10:00-10:15

Section 3. Project ECHO Demonstration

What is Project ECHO®?

- Project Extension of Community Health Outcomes
- Telehealth program created by Dr. Sanjeev Arora in 2002 at University of New Mexico
- Establishes hub-and-spoke knowledge-sharing networks between with academic health science centres and community care partners

![Project ECHO Model](image)

Current ECHOs in Ontario

Section 4. Roundtables

- Telemedicine 101
- To Telemedicine or Not to Telemedicine (when to/when not to use)
- Billing & Coding for Telemedicine
- Show & Tell (Synchronous)
- Show & Tell (Telemonitoring)
- Show & Tell (Asynchronous)
- Telemedicine Question and Answer
FUTURE TRENDS

1. Expansion of the opportunities for reimbursement and payment through the parity laws. States that have adopted these laws have doubled in the last four years.
2. Expansion to offer services globally. Currently, up to 200 US medical centres have global telemedicine operations.
3. Expand operations at state level by creating conducive legislation.
4. Creation of retail clinics or incorporation of telemedicine centres at the workplace as hinted at by CVS and Walgreens.
5. Increasing utilization of telehealth services in ACO to reduce costs and improve quality


Section 5. Discussion

• How can/should AMDA support members (and those they serve) in telemedicine now and in the future?

• What is/should the role of AMDA be in telemedicine?

Resources

• American Telemedicine Association
  • http://telemedicineresourcecenter.org/getProducts.cfm?searchmode=home&dir=251DAE&expCats=true#buyersguide

• Resource Center & Buyer’s Guide

• LeadingAge Center for Aging Services Technologies (CAST)
  • http://www.leadingage.org/center-aging-services-technologies