

Telehealth Expansion and Communication Based Tech Services

David A. McKenzie, CAE
ACEP Reimbursement Director

Definitions

- **Telehealth (or Telemonitoring)** is “the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance.” Telehealth is a broad term and can refer to clinical and non-clinical services involving medical education, administration, and research. Telehealth includes technologies such as telephones, facsimile machines, electronic mail systems, and remote patient monitoring devices which are used to collect and transmit data for monitoring and interpretation. For example, physicians use email to communicate with patients, order drug prescriptions and provide other health services.
- **Telemedicine** is more narrowly defined. Per CMS, “Telemedicine seeks to improve a patient’s health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment.” This is referred to as an “Interactive” system.
- Some technologies used in the broader category of Telehealth do not meet the definition of Telemedicine. These are referred to as “Asynchronous, or store and forward, applications”, and include the use of a camera (e.g., audio clips, video clips, still images) to record (store) an image that is transmitted (forwarded) to another site for review at a later time. Per CMS guidelines, asynchronous technology is permitted only in federal Telehealth demonstrations programs conducted in Alaska or Hawaii.
- **Teleconsultations** is another broad term that includes using telecommunications between a patient and a health professional for use in rendering a diagnosis and treatment plan. Generally, in order to bill Medicare, the service provided should meet the definition of Telemedicine.

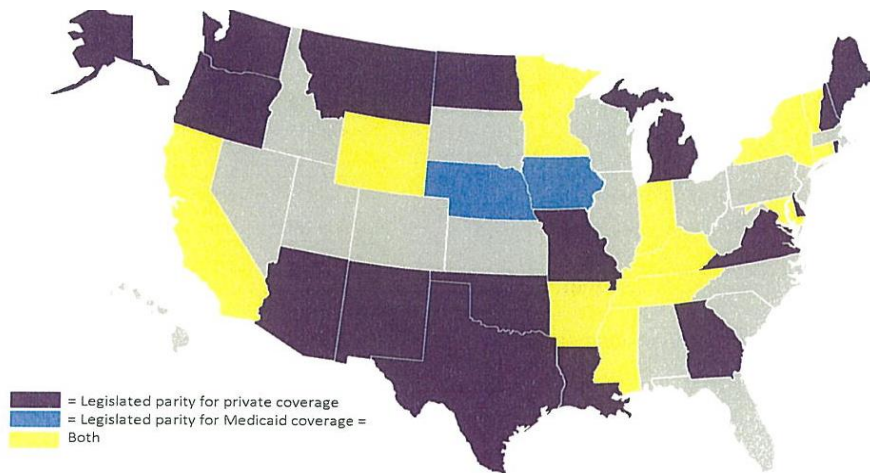
Originating vs. Distant Site

- CMS requires the reported telemedicine services include both an originating site and a distant site.
 - The originating site is the location of the patient at the time the service is being furnished.
 - The distant site is the site where the physician or other licensed practitioner delivering the service is located.
- A telehealth facility fee is paid to the originating site. Claims for the facility fee should be submitted using HCPCS code Q3014: "Telehealth originating site facility fee." 2019 payment of \$26.15 for originating site.
- Originating sites include: the office of a physician or practitioner, Hospitals, Critical Access Hospitals (CAH), Rural Health Clinics (RHC), Federally Qualified Health Centers (FQHC), Hospital-based or CAH-based Renal Dialysis Centers (including satellites), Skilled Nursing Facilities (SNF), and Community Mental Health Centers.

Reimbursement Landscape

- All 50 States have passed legislation permitting the practice of Telemedicine.
- Each State's requirements differ related to Provider-patient relationship and mandating payer reimbursement for Telemedicine encounter.
- Reimbursement by Private Payer varies by State and Health Plan depending on State Parity Law legislation enforcing payment on par with in person encounter. ***34 States have mandated payer coverage and 29 States currently have Parity Law.*** Others may only recognize in rural areas.
- Medicaid – Varies by State. All 50 States and Wash. DC provide some level of Medicaid Reimbursement.
- Currently, most telemedicine initiatives by health systems have been entered into for benefits other than reimbursement.

Telemedicine Parity by State



Private Payers

- Commercial payers have been most aggressive in reimbursing for telemedicine (TM) in recent years.
- Many have their own telehealth programs.
- The top five payers – Aetna, Cigna, Blue Cross Blue Shield, Humana and United Healthcare all offer some form of coverage for telemedicine, even when not required by parity laws.
- Reimbursement rates depend on state policy and negotiated rates with providers.
- No guarantees, consult payer policies and your contracts!

Potential Benefits of TM in the ED

1. Improved Quality of Care- improved speed of access has the potential to eliminate transfer for higher acuity patients and prevent progression of adverse outcomes
2. Lower Cost of Care- lower cost alternative the ED, Reduce number of transfers
3. Improved Access to Care- rural and mobility impaired patients who can't get to your ED, but don't meet EMS criteria
4. Expanded Hospital ED Model- greater reach and opportunity for referral to your facility
5. APM Participation- AUCM and AACM models
6. Improved patient Satisfaction- faster triage, easy follow up care

Recent Congressional Action Its Gaining Traction!

The CONNECT for Care Act

- Introduced by Sens. Schatz (D-HI), Wicker(R-MS), Cochran (R-MS), Cardin (D-MD), Thune (R-SD), and Warner (D-VA) and Reps. Black (R-TN), Welch (D-VT), and Harper (R-MS) respectively last session. The AMA endorsed.
 - **New** bill would authorize HHS Secretary to waive telehealth restrictions for individual services if CMS Actuary certifies service will maintain quality, and save or not increase costs. The **AMA** endorsed.
- **The Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017**
 - Reintroduced by Sens. Ron Wyden (D-OR), Mark Warner (D-VA) and Johnny Isakson (R-GA)

HR 6101, to improve the Medicare ACO program and other purposes

- Will be reintroduced by Reps. Welch and Black -provides greater flexibility to ACOs to utilize telehealth and remote patient monitoring
- **S. 787, the Telehealth Innovation and Improvement Act**
 - Reintroduced this month by Sens. Cory Gardner (R-CO) and Gary Peters (D-MI) Encourages Center for Medicare and Medicaid Innovation (CMI) telehealth demos
 - Calls on the CMI to evaluate telehealth models "for cost, effectiveness, and improvement in quality of care without increasing the cost of delivery," and to reimburse them under Medicare if they meet those criteria.

Congress Action cont.

- **National Defense Authorization Act for Fiscal Year 2017**

- S. 2943, the National Defense Authorization Act for Fiscal Year passed and signed into law last year.

- Requires the Secretary of Defense to incorporate telehealth services, including mobile health applications, across the military health system. Requires TRICARE to cover telehealth services to the same extent as in-person services, and at a rate that incentivizes the provision of telehealth.

- Sec. 705(d) Change of location of care under TRICARE provision dropped.

- **The VETS Act**

- S. 2170 and H.R. 2516, the VETS Act of 2015, introduced by Sen. Jon Ernst (R-IA) and Rep. Charles Rangel (D-NY), would have allowed VA providers, including contractors, to practice telemedicine across state borders without regard to licensure or where the patient or provider is located.
 - New draft under revision would address VA employees, not contractors, and would allow VA telemedicine services to be provided to patients physically located outside of VA facilities
Reintroduction expected.

Examples of ED Telemedicine Care Models

1. ED Provider to Patient
2. ED Provider to Consultant
3. ED Provider Remote Triage
4. ED Provider Follow-up Post ED Visit
5. ED Provider to Extended Care Facility
6. ED Provider to EMS

ED Provider to Patient

- Potential Applications:
 - Remote app or website patient direct login
 - Pre contracted prison, clinic, employer, insurer, school TM program
 - Minor Care area of ED staffed by TM provider
- Minor conditions with triage protocols.
- ED Provider can be in ED or remote center.
- Reimbursement either cash, Fee for Service commercial payer, or precontracted arrangement – eligible for Office E/M codes with modifier.
- Most states have parity law forcing Commercial Payers to reimburse for TM encounter.

ED Provider for Remote Triage

- TM Station in Triage area of ED with remote ED Provider.
- Patients triaged to proper care area and diagnostic studies initiated.
- Requires onsite Nurse / Assistant.
- Onsite Provider resumes care once TM Triage complete.

ED Provider for Follow-up Post ED Visit

- Upon discharge, patient can be assisted with downloading app or instructions on website access.
- ED Provider provides follow-up on condition within set period per protocols.
- Promotes patient satisfaction, potential early intervention of adverse outcome, and reduced cost of follow-up visit.
- ACEP Acute Unscheduled care Model (AUCM)

ED Provider to Extended Care Facility (EFC)

- Pre contracted arrangement with ECF (Assisted Living, Nursing Home) allows early TM triage by ED Provider and potential unnecessary transfer and admission.
- Multiple studies have shown both transfer and admission rates decreased an average of 10%.
- Provides ED Provider with awareness of condition and advanced preparation for necessary transfers.
- Reimbursement through contracted agreement or commercial payer.
- ACEP Acute Alternative Care Model (AACCP)

Proposed Medicare Policy Waivers (ED physicians will be able to bill for these services)

Telehealth	Emergency physicians will be allowed to provide telehealth services into the beneficiary's home or residence and to bill one of the in-home visits under the same waiver that was put in place in the CJR and other APMs.
Post discharge Home Visit	Licensed clinical staff may provide home visits under the general supervision of an emergency physician to eligible Medicare beneficiaries. The providers may bill these services utilizing the same G-codes utilized in other APMs.
Transitional Care Management	Authorize emergency physicians to bill for a transitional care management code. This could be done utilizing the current CPT codes (99494 and 99496) or the ED specific Acute Care Transition codes submitted to the CPT Editorial panel in 2016. (Appendix B)

ED Provider to EMS

- Enables Prehospital audio-visual transfer of assessment, vitals, diagnostic studies (EKG, etc.), and triage and management discussion with EMS.
- Allows for patient triage and initiation of defined care plan pre- hospital.
- Able to prevent unnecessary ED visits or arrange alternative transport for many minor conditions.

“Triage” at MedStar Hospital in Washington, DC

- Reduced ED wait times by 26%
- Average wait for a physician encounter via telehealth is 90 seconds
- Saves time and money in the hospital, but not separately billed
- Increased volume due to video care coordination



CMS Activity- Telemedicine

CMS reminds stakeholders that requests to add services to the list of Medicare telehealth services must be received no later than December 31 of each calendar year to be considered for the next rulemaking cycle. The following requests were received in CY 2016 for inclusion in 2018 organized by the two categories for telehealth services created by Medicare

- (1) Services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services.
- (2) Services that are not similar to the current list of telehealth services, (This includes an assessment of whether the service is accurately described by the corresponding code when furnished via telehealth and whether the use of a telecommunications system to furnish the service produces demonstrated clinical benefit to the patient.)

Medicare Telehealth Services 2019

- Telehealth consultations, emergency department or initial inpatient
HCPCS codes G0425–G0427 (2.81 – 5.67 RVUs)
- Telehealth Consultation, Critical Care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth (effective for services furnished on and after January 1, 2017)
HCPCS code G0508 (5.90 RVUs)
- (Telehealth Consultation, Critical Care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth (effective for services furnished on and after January 1, 2017)
HCPCS code G0509 (5.57 RVUs)

From the 2019 Medicare Final Rule

- **Medicare Telehealth Services**
- For CY 2019, CMS is finalizing our proposals to add the following codes to the list of telehealth services:
 - HCPCS codes G0513 and G0514 (Prolonged preventive service(s))
 - Virtual check ins with photos shared by patients
- CMS is also finalizing policies to implement the requirements of the Bipartisan Budget Act of 2018 for telehealth services related to beneficiaries with end-stage renal disease (ESRD) receiving home dialysis and beneficiaries with acute stroke effective January 1, 2019.
- Medicare pays for 1/3 of opioid related hospital stays and has seen the largest increase in these stays over the past two decades

Impact of Changes Related to Telehealth

As discussed in section II.D. of this final rule, we are adding two new codes, HCPCS codes G0513 and G0514, to the list of Medicare telehealth services. Although we expect these changes to have the potential to increase access to care in rural areas, based on recent telehealth utilization of services already on the list, including services similar to the proposed additions, we estimate there will only be a negligible impact on PFS expenditures from these additions.

For example, for services already on the list, they are furnished via telehealth, on average, less than 0.1 percent of the time they are reported overall. This addition was responsive to longstanding stakeholder interest in expanding Medicare payment for telehealth services. The restrictions placed on Medicare telehealth by the statute limit the magnitude of utilization; however, we believe there is value in allowing physicians and patients the greatest flexibility when appropriate.

Final Rule 2019 Opioid Related TM (Page 156)

Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder and Other Substance Use Disorders

- Through an interim final rule with comment period, CMS is implementing a provision from the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act that removes the originating site geographic requirements and adds the home of an individual as a permissible originating site for telehealth services furnished for purposes of treatment of a substance use disorder or a co-occurring mental health disorder for services furnished on or after July 1, 2019.
- Additionally, the SUPPORT for Patients and Communities Act establishes a new Medicare benefit category for opioid use disorder treatment services furnished by opioid treatment programs (OTP) under Medicare Part B, beginning on or after January 1, 2020. We note that there is a 60-day period to comment on the provisions of the interim final rule discussed earlier, during which we are requesting information regarding services furnished by OTPs, payments for these services, and additional conditions for Medicare participation for OTPs that stakeholders believe may be useful for CMS to consider for future rulemaking to implement this new Medicare benefit category.
- Still limits the scope of telehealth serves to those on the Medicare telehealth list.
- Possible bundled episode of care for management and treatment of substance use disorders (SUD)

CPT Telemedicine

- Modifier 95 (Synchronous telemedicine services rendered via real time interactive audio and video telecommunications system)
- CPT requires proof of payer policy that covers a telemedicine service by code for it to be included in Appendix P.
- Possible addition of current G codes?
 - G0425 Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communication with the patient via telehealth; and
 - G0426 Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communication with the patient via telehealth

CPT Application to Make G codes into CPT Codes

- Was not accepted by CPT
- 994X1 Telehealth consultation, critical care, physicians typically spend 60 minutes communicating with the patient via telehealth (initial)
- 994X2 Telehealth consultation, critical care, physicians typically spend 50 minutes communicating with the patient via telehealth (subsequent)
- 994X3 Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth

CPT Telehealth Modifier 95

- 95 (Synchronous telemedicine services rendered via real time interactive audio and video telecommunications system)
- The modifier descriptor specifies that the service must be synchronous, meaning in real time, for correct application
- The totality of the information exchanged must be commensurate with the key components or other requirements to have reported the service or procedure as if the distant provider were physically present with the patient

Telehealth Modifiers, cont.

- The CPT Editorial Panel considered, but apparently chose not to include, a second new modifier for asynchronous (not real time interaction) services, perhaps because of a lack of specificity for the services with which the modifier would be used
- CMS has previously had a HCPCS modifier, GT (Via interactive audio and video telecommunication systems) available for use, but -95 was a new modifier for CPT in 2017

Appendix P Detail

- Appendix P, which currently lists 77 codes that may be used for reporting synchronous telemedicine services when using interactive telecommunications equipment that includes, at a minimum, audio and video.
- Appendix P will now be marked with a star symbol (★)

★ 99406 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes


What is in Appendix P?

- No ED E/M, Critical Care or Observation codes were included!
- The codes selected for inclusion were based on a search of payer policy requiring the use of the HCPCS Level II synchronous modifier with CPT codes
- The ED codes did not come up anywhere in those payer policies so were not included in Appendix P
- Perhaps they can be added in future years with evidence that ED services are widely recommended for performance via synchronous real time communication
- There is opportunity for Freestanding EDs or Urgent Care Centers that use office visit codes 99201-99215!

What is in Appendix P?

- Psychiatric, psychotherapy, psychoanalysis, pharmacy management, ESRD
- Ophthalmological remote imaging for detection of retinal disease, cardiovascular monitoring and telemetry
- Genetic or neurobehavioral assessments, medical nutrition
- Office, subsequent hospital, outpatient consult, inpatient consult, subsequent nursing facility, prolonged services (Urgent Care?)
- Behavioral change interventions and transitional care management codes

Telemedicine Place of Service Code 02



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

MLN Matter#: Number: M38718 Related Change Request (CR) #: CR-9726

Related CR Release Date: August 11, 2016 Effective Date: January 1, 2017. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the effective date for nonmedical data code sets, of which the POS code set is one, is the date set in effect the date the transaction is initiated. It is not date of service.

Related CR Transmittal #: R3886CP Implementation Date: January 1, 2017

New Place of Service (POS) Code for Telehealth and Distant Site Payment Policy

Provider Types Affected

This MLN Matters® Article is intended for physicians, other practitioners, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

Provider Action Needed

CR 9726 updates the Place of Service (POS) code set by creating a new code (POS 02) for Telehealth services, effective January 1, 2017. You should ensure that your billing staff are aware of this new POS code.

Background

As an entity covered under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Medicare must comply with standards, and their implementation guides, adopted by regulation under this statute. The currently adopted professional implementation guide for the ASC X12N 837 standard requires that each electronic claim transaction include a Place of Service (POS) code from the POS code set that the Centers for Medicare & Medicaid Services (CMS) maintain. The POS code set provides setting information necessary to appropriately pay Medicare and Medicaid claims.

Change Request # 9726
Effective date 1.3.2017

Non medical code uses transaction
date note date of service

New Place of Service for telehealth-
POS 02

Practitioner furnishing telehealth
services from a distant site

Modifier GT eliminated except for CAH
Method II claims as of Jan 2018

GQ still required as applicable

Interprofessional Telephone/Internet/Electronic Health Record Consultation Revised for 2019

- The codes are for use by the Consultant not the treating provider

▲99446	<i>Interprofessional telephone/Internet/electronic medical record assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified healthcare professional; 5-10 minutes of medical consultative discussion and review</i>
▲99447	<i>11-20 minutes of medical consultative discussion and review</i>
▲99448	<i>21-30 minutes of medical consultative discussion and review</i>
▲99449	<i>31 minutes or more of medical consultative discussion and review</i>
●994X6	<i>Interprofessional telephone/Internet/electronic medical record assessment and management service provided by a consultative physician including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time</i>

Summary -Telemedicine Reimbursement is Still Widely State Specific

Each State's Medicare, Medicaid, and Payer reimbursement rules vary, so check your state for proper claims submission and proper use of HCPCS vs CPT Codes and Modifiers.

Consult Appendix P of the CPT Manual for the latest TM Codes and Modifiers.

More info



- ACEP Emergency Telemedicine Section <https://www.acep.org/how-we-serve/sections/telemedicine/#sm.00007qfoax1bwndjuwiyoa6p5rro5>
- CMS.gov/Medicare/Medicare-General –Information/Telehealth.aspx
 - Chapter 15 of the Medicare Benefit Policy Manual (Publication 100-02)
 - Chapter 12 of the Medicare Claims Processing Manual (Publication 100-04)
- Medicare Telehealth Payment Eligibility Analyzer
 - <https://datawarehouse.hrsa.gov/tools/analyzers/geo/Telehealth.aspx>