Emerging Trends in Reimbursement

RHC Update Seminar

Hour 5

1:00 to 1:30 PM

chartspan®

HBS

Healthcare Business Specialists

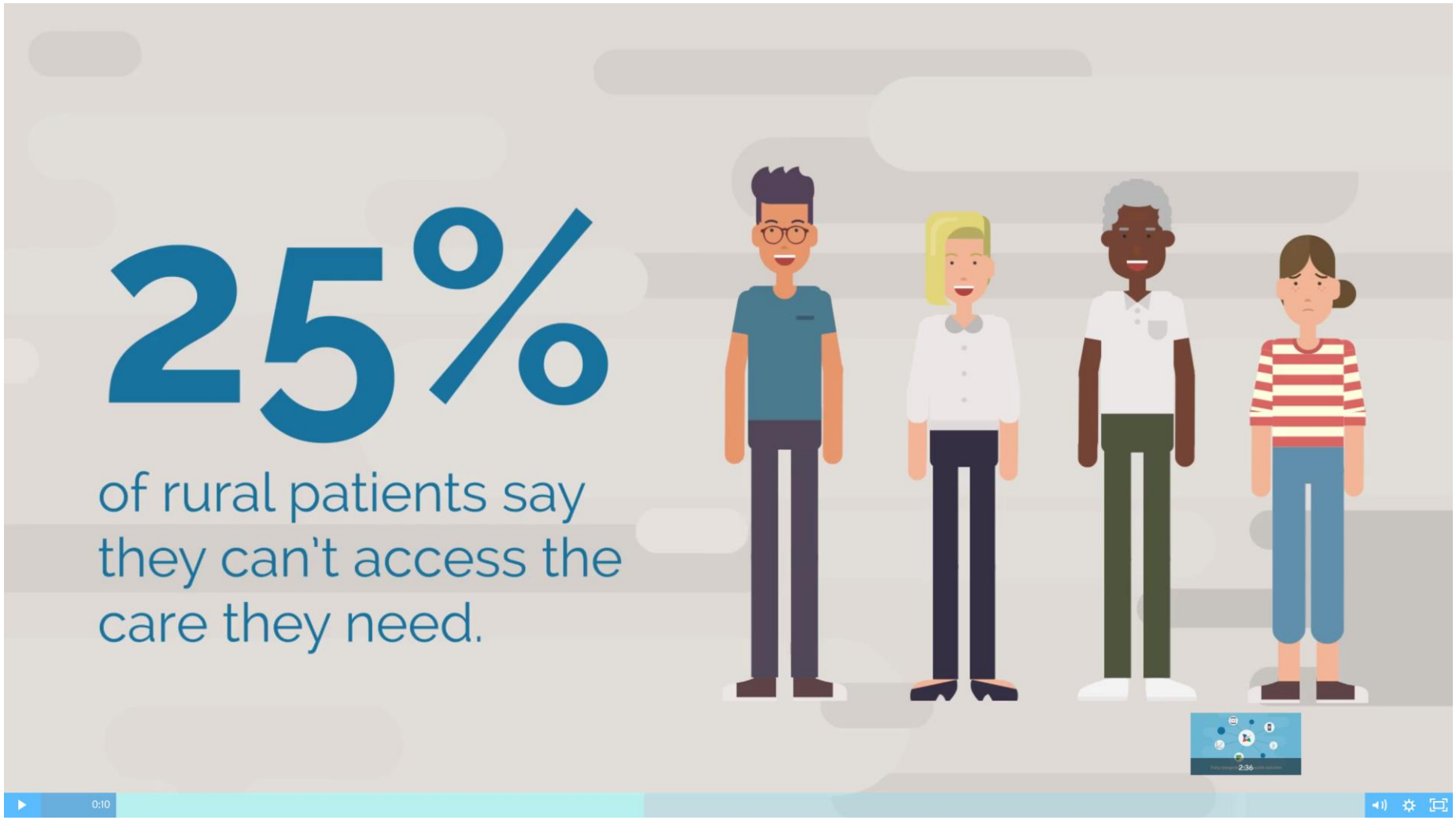
Reconnect 4 Health

Telehealth is Changing the way healthcare is delivered

Technology has changed how we:

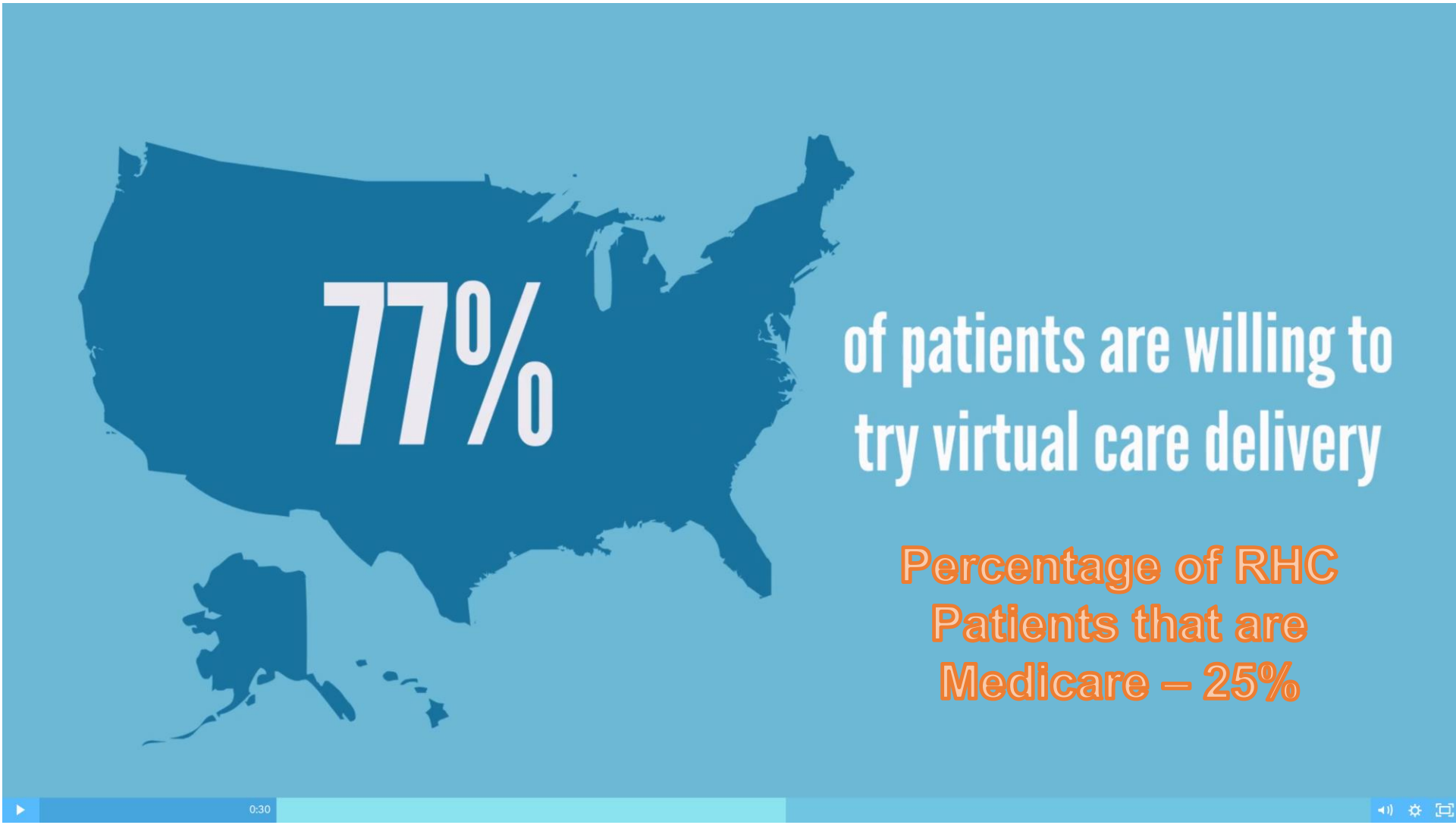
- **Communicate**
- **Watch TV**
- **Bank**
- **Educate**
- **Date**
- **Work**

The Need for Telehealth is Here



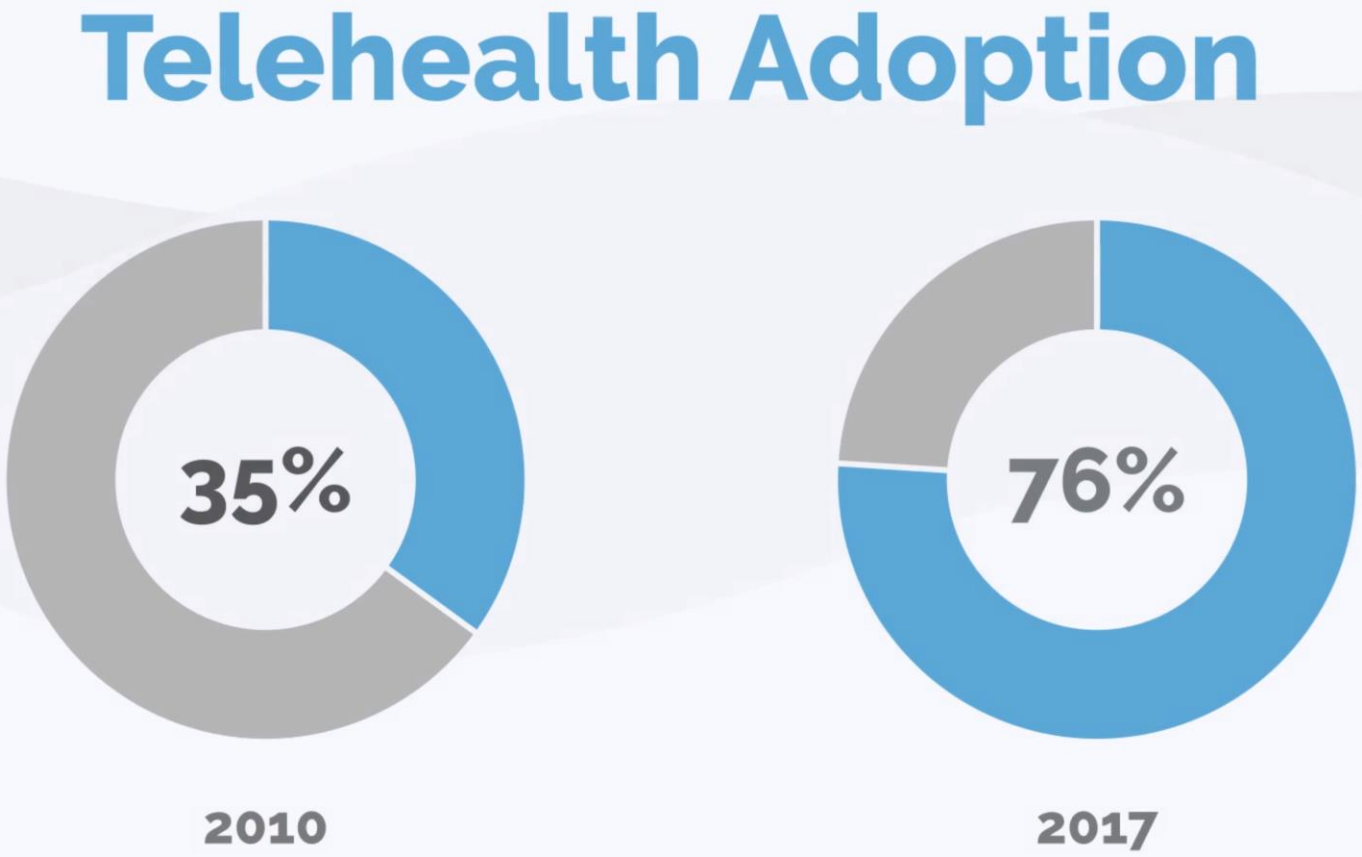
https://www.azaleahealth.com/solutions/telehealth/

Patient Demand for Telehealth is Here



https://www.azaleahealth.com/solutions/telehealth/

Telehealth is Here



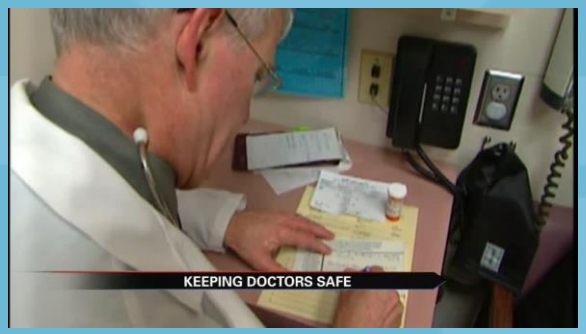
https://www.azaleahealth.com/solutions/telehealth/

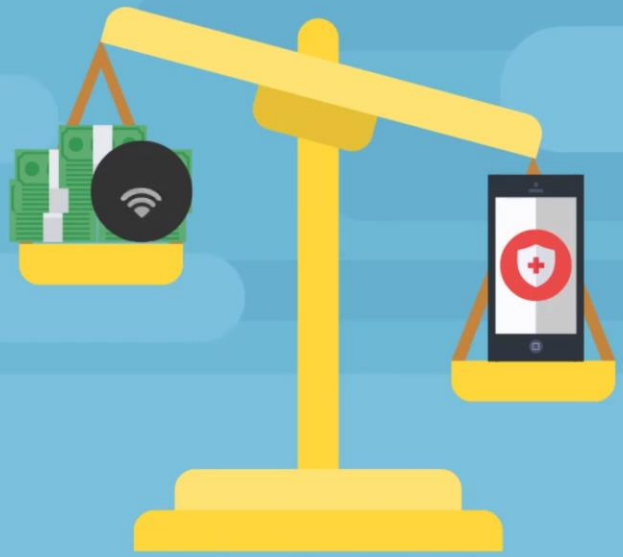
By 2021, 88 percent of health systems plan to have consumer telehealth programs in place; 64 percent already offer such services. The number of health systems with no plan to offer consumer telehealth has fallen in half in just three years.

With this growth in consumer telehealth, provider organizations are becoming more evolved in their approach to how they integrate telehealth and reimbursement. What once was an aspirational, exploratory pursuit is now more focused and driven by patient demand for convenience and access to care.

https://s3.amazonaws.com/communications.teladoc.com/knowledge-center/survey/Teladoc_Health_Consumer_Telehealth_Survey_Report_2019.pdf

Advantages of Telehealth





- Improved efficiency and access to care
- Improved care coordination
- Reduced hospital readmissions
- Expanded population health programs

https://www.azaleahealth.com/solutions/telehealth/

877-777-7686 | Contact Us

Search... Search

Azalea HEALTH

What We Do | Who We Serve | About Azalea | AtoZ Knowledge Center | **Request Demo** | Login

Engage patients remotely and securely with Azalea Telehealth

Telehealth and remote patient monitoring are becoming increasingly important as patient consumerism continues to play a larger role in today's healthcare landscape.

Beyond that, telehealth allows healthcare providers the opportunity to receive additional reimbursement via quality incentive programs as well as save costs by enabling reduced readmission rates.

Compare Plans | Request A Demo

Telehealth Services

Azalea Health is on the forefront of innovation and is the first EHR company to successfully incorporate proprietary telehealth functionality into its solution.

It's not only fully-integrated with our certified EHR, but also with our patient portal, mobile apps and billing.

Our telehealth functionality allows physicians and healthcare providers to facilitate patient engagement, care coordination and to capitalize on chronic care management and other reimbursement guidelines.

"I've used many systems over the years and none are as user friendly as Azalea. The system is great, but the customer service is excellent. They respond immediately. Having that kind of fast service is so important."

Ellie Mendez
Certified Telehealth Specialist

How Does Telehealth Work?

Watch our short video and learn how telehealth can provide your patients with a convenient way to access care on their schedules, while opening up a new revenue stream for practices.

https://www.azaleahealth.com/solutions/telehealth/

Telehealth Benefits

- Increased accessibility, convenience and care coordination
- Additional reimbursement opportunities (CCM, remote patient monitoring and more)
- Streamlined documentation with built-in integration
- An efficient alternative to traditional office-based visits
- Opportunity to reduce readmission rates

Telehealth Features

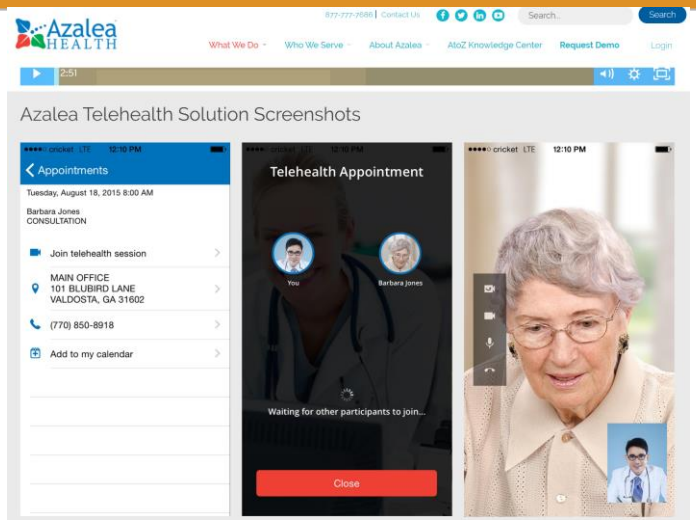
- Easy-to-use functionality
- HIPAA-compliant; completely secure
- Record a telehealth session & save to patient's health record
- Live streaming
- iPhone and Android user-friendly
- Fully-integrated with Azalea's certified EHR, patient portal, mobile apps and billing functionality

"I go for less clicks, easy to use, templates on-the-fly, and not complicated. I need my doctors spending time with patients."

Tanya Mack
Women's Telehealth

Ready To Get Started? Schedule A Demo To See Our Telehealth Platform In Action

Schedule Your Demo

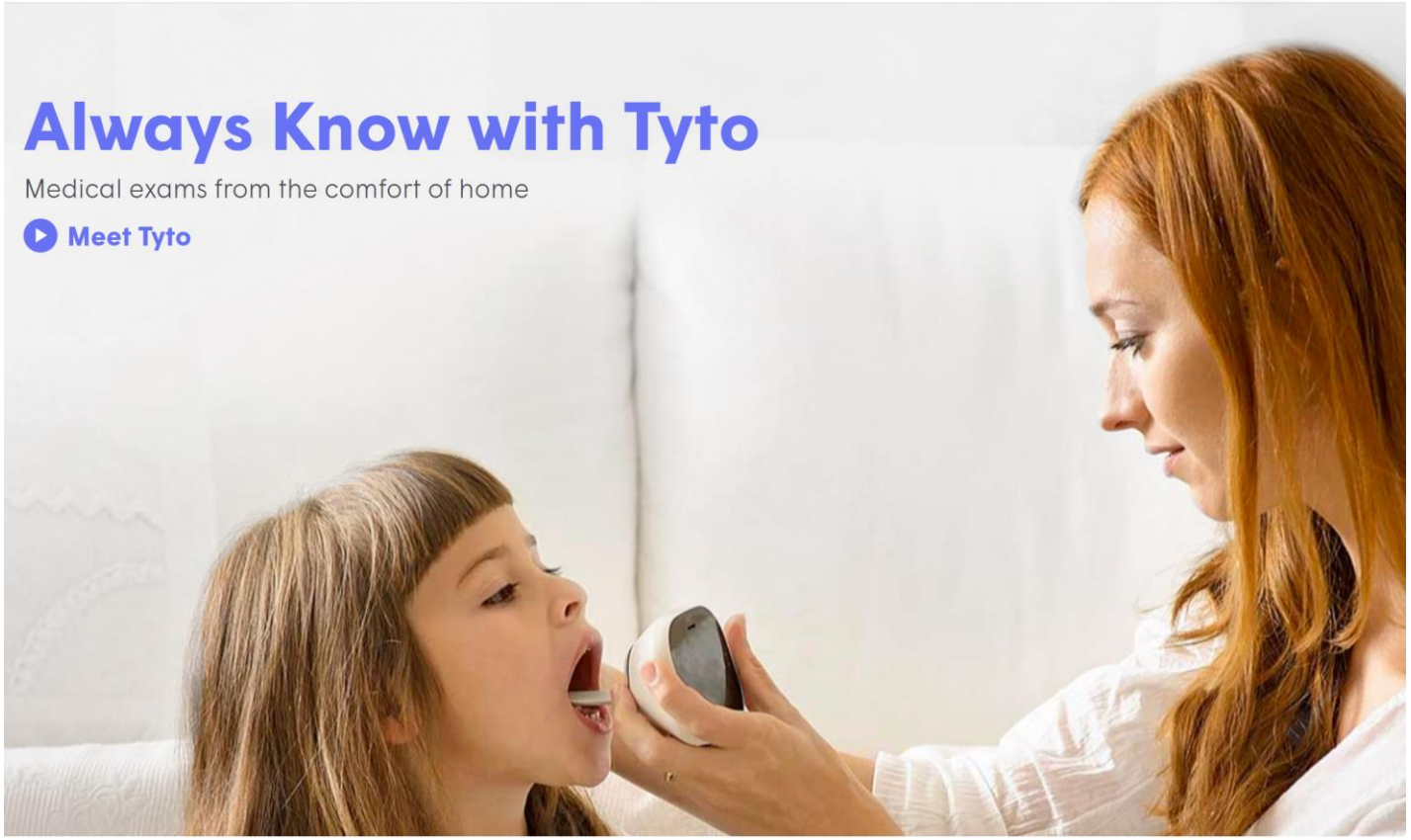


erlanger ONDEMAND

Why it Matters
Its Happening & Fast

tytocare™

How It Works | About Us | News | Contact Us | For Professionals | Get Tyto



Your On Demand Medical Exam

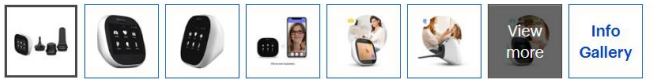
Tyto is a handheld exam kit and app that lets you perform guided medical exams with a healthcare provider, anytime, anywhere. With Tyto, you can receive a diagnosis, a treatment plan, and a prescription if needed, all from the comfort of home.

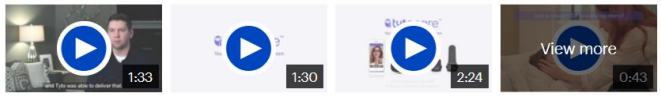
TytoCare - TytoHome Medical Exam Kit - White

Model: G 1.5 **SKU:** 6332714

4.7 (37 Reviews) | 4 Answered Questions

HSA/FSA eligible





TytoCare Customer Testimonials | TytoCare - Product Overview | See How Tytocare Works

Price Match Guaran

$299.99

FREE Shipping: Get

Shipping estimates

Store Pickup: Order Thu, Oct 24.

Compare

Cardmember Off

6 Month Financing

Get rewards

Overview

Description

Get a complete medical exam wherever you are with TytoCare TytoHome. This electronic health care device allows you to receive on-demand physical exams via live video chat with a doctor's office using an exam camera and a basal thermometer and otoscope, stethoscope and tongue depressor adapters. This HIPAA-secure TytoCare TytoHome digital device transmits test results to an electronic health record for easy monitoring.

Learn more about TytoCare ›

Features

Connect with a doctor 24/7

Download the free TytoApp™ for most iOS and Android devices to get a video consult from a licensed medical provider. Tyto goes beyond a phone or video chat with a doctor by providing an on-demand, clinic-quality medical exam right from your home.

Use the included instruments

From an otoscope (ears) and stethoscope (heart, lungs, and abdomen) to a basal thermometer and digital camera (skin and throat), Tyto is designed to provide your doctor with the same type of data they would use in the office.

Conduct your own exam

Tyto's proprietary guidance technology ensures that anyone can capture and share accurate results.

Get a diagnosis

The physician will use the data provided by Tyto and the video consult to examine, diagnose, and treat your conditions remotely. This can include a treatment plan and a prescription sent directly to your pharmacy if needed.

Treat common conditions

Including ear infections, sore throats, fever, cold and flu, allergies, pink eye, nausea, constipation, asthma, bronchitis, upper respiratory infections, bug bites and common skin conditions, including contact dermatitis, rash and diaper rash.

Keep your information secure

Tyto uses a HIPAA-secure platform that only you and the doctor can access, so you can be certain your information is safe and secure. And all TytoCare products are FDA-cleared and comply with FDA standards.

Talk to trusted physicians

Tyto works with qualified and experienced physicians around the country. Each doctor goes through a rigorous selection process to become a part of the network.

Use Tyto anywhere

Tyto is lightweight, compact, and portable so you can use it anywhere. All you need is the TytoApp, a smartphone or tablet, and a Wi-Fi connection. It is recommended that adults aged 18-65 operate the device.

Pay $59.99 or less per exam

You can use your health insurance or HSA/FSA account up front – or ask your provider or insurance company if they offer reimbursements for virtual medical exams or telehealth visits.

The health provider network will be set according to the geolocation of the device and is subject to change. Exam prices will vary depending on your health provider, your insurance or HSA/FSA provider. Reimbursements may not apply. Subject to insurance and provider term & conditions.

What's Included

Otoscope adapter

Owner's manual

Rechargeable battery

Stethoscope adapter

Tongue depressor

TytoHome device with exam camera and basal thermometer

USB cord

HIPAA Compliant Video Conferencing

https://zoom.us/healthcare

https://zoom.us/docs/doc/Zoom%20for%20Healthcare.pdf

Walmart launches telehealth initiative with Doctor On Demand

Ayla Ellison (Twitter) - Tuesday, October 23rd, 2018 Print | Email

SHARE Tweet Share 14

Walmart and RB, a global consumer health and hygiene company, have launched a telehealth initiative with Doctor On Demand.

This fall, consumers who purchase RB products, including Mucinex, Delsym and Airborne, from Walmart will be offered a free telehealth medical consultation with a Doctor On Demand physician.

"Partnering with RB and Walmart is a big step in moving the telemedicine industry forward, and ensuring that consumers are aware they can see a physician and receive high-quality care anywhere, at any time," Hill Ferguson, CEO of Doctor On Demand, said in a press release. "At Doctor On Demand, our physicians can treat 90 percent of the most common medical issues seen in the ER and urgent care, including cold and flu, skin and eye issues, allergies, back pain, and more."

More articles on telehealth:

New app focuses on connecting patients with nurses, physician assistants
Telemedicine helps extend relationships for primary care providers: 7 study insights
Apple teams up with Zimmer Biomet to support postoperative recovery

Confessions Of an RHC Consultant

1. **Medicare tends to dictate reimbursement policy in Healthcare.**

2. **RHC Consultants tend to know Medicare since it is the same throughout the country.**

3. **Because Medicare is woefully behind in reimbursement methodology for Telemedicine as well as RHC reimbursement most RHCs and RHC Consultants have avoided Telemedicine**

4. **I don't know a thing about Telehealth**

What is Telehealth/ Telemedicine?

- The Health Resources and Services Administration distinguishes telehealth from telemedicine in its scope, defining **telemedicine only as describing remote clinical services, such as diagnosis and monitoring, while telehealth includes preventative, promotive, and curative care delivery.** This includes the above-mentioned non-clinical applications, like administration and provider education.

- The United States Department of Health and Human Services states that the term telehealth includes "non-clinical services, such as provider training, administrative meetings, and continuing medical education", and that the term telemedicine means "remote clinical services".

Telehealth applications include:

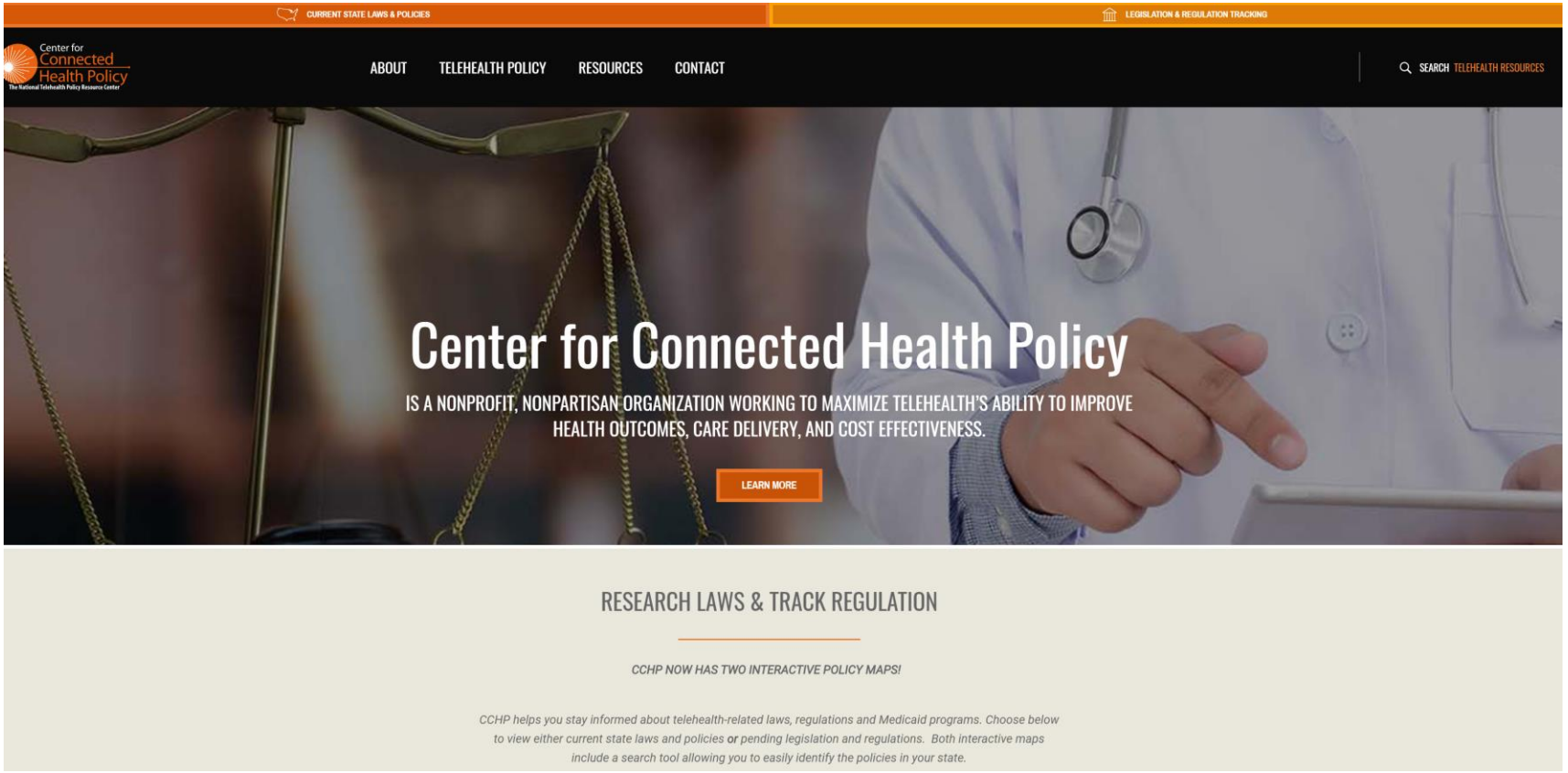
- **Live (synchronous) videoconferencing**: a two-way audiovisual link between a patient and a care provider
- **Store-and-forward (asynchronous) videoconferencing:** transmission of a recorded health history to a health practitioner, usually a specialist.
- **Remote patient monitoring (RPM):** the use of connected electronic tools to record personal health and medical data in one location for review by a provider in another location, usually at a different time.
- **Mobile health (mHealth):** health care and public health information provided through mobile devices. The information may include general educational information, targeted texts, and notifications about disease outbreaks.

When it comes to reimbursement the world is upside down with Telemedicine.

Medicare does not drive reimbursement (it is problematic)

The Center for Connected Health Policy

https://www.cchpca.org/



https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies?jurisdiction=All&category=All&topic=All

CURRENT STATE LAWS & POLICIES

LEGISLATION & REGULATION TRACKING

ABOUT TELEHEALTH POLICY RESOURCES CONTACT

CCHP helps you stay informed about telehealth-related laws, regulations and Medicaid programs. The map and search options below cover current laws and regulations for all fifty states and the District of Columbia. The information provided is only for research and informational purposes and should not be construed as legal counsel. Please consult with an attorney if you are seeking a legal opinion. To view the full report, visit the 50 State Report PDF.

Current State Laws & Reimbursement Policies

Search by Filter | Search by Keyword

All 50 States & D.C.

All Categories

All Topics

APPLY

Data Last Updated May 28, 2019

Policy Exists/Explicitly Allowed

No Policy Exists or Not Explicitly Allowed

*Key applicable only to topics indicated with an asterisk in drop down menu.

Center for Connected Health Policy
The National Telehealth Policy Resource Center

State Telehealth Laws and Reimbursement Policies
AT A GLANCE
Fall 2019

Telehealth policy trends continue to vary from state-to-state, with no two states alike in how telehealth is defined, reimbursed, or regulated. A general definition of telehealth used by CCHP is **the use of electronic technology to provide health care and services to a patient when the provider is in a different location.**

Medicaid Policy Trends

All 50 states and D.C. now reimburse for some type of live video telehealth services. Reimbursement for store-and-forward and remote patient monitoring (RPM) continues to lag behind. Fourteen state Medicaid programs reimburse for store-and-forward and twenty-one states reimburse for remote patient monitoring (RPM), with additional states having laws requiring Medicaid reimbursement for store-and-forward or RPM, yet no official written policies indicating that such policy has been implemented.

Many of the reimbursement policies that do exist continue to have restrictions and limitations, creating a barrier to utilizing telehealth to deliver services. One of the most common restrictions is a limitation on where the patient is located, referred to as the originating site. While most states have dropped Medicare's rural geographic requirement, many Medicaid programs have limited the type of facility that can serve as an originating site, often excluding a patient's home from eligibility. However, nineteen states do now explicitly allow the home to be an eligible originating site under certain circumstances.

49 states and the District of Columbia (D.C.) have a definition for telehealth, telemedicine or both.

14 Medicaid programs reimburse for S&F

50 states and D.C. reimburse for live video

22 Medicaid programs reimburse for RPM

19 states reimburse service to the home

Other Common Telehealth Restrictions

- The specialty that telehealth services can be provided for
- The types of services or CPT codes that can be reimbursed *(inpatient office, consult, etc.)*
- The types of providers that can be reimbursed *(e.g. physician, nurse, etc.)*

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The Federally Designated National Telehealth Policy Resource Center
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Center for Connected Health Policy
The National Telehealth Policy Resource Center

40 states and the District of Columbia have active laws

Private Payer Reimbursement

40 states and the District of Columbia have laws that govern private payer reimbursement of telehealth. States that passed new or revised private payer laws since Spring 2019 include Arizona, California, Georgia and Florida. Some laws require reimbursement be equal to in-person coverage, however most only require parity in covered services, not reimbursement amount. Not all laws mandate reimbursement.

38 states and D.C. include some sort of informed consent

Consent

38 States and D.C. have a consent requirement in either Medicaid policy, law, or regulation. This number has not changed since Spring 2019.

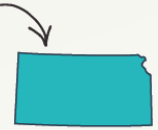
Online Prescribing

Most states consider the use of only an online questionnaire as insufficient to establish the patient-provider relationship and prescribe medication. Some states allow telehealth to be used to conduct a physical exam, while others do not. Some states have relaxed requirements for prescribing controlled substances used in medication assisted therapy (MAT) as a result of the opioid epidemic.

More and more states are passing legislation directing healthcare professional boards to adopt practice standards for its providers who utilize telehealth. Medical and Osteopathic Boards often address issues of prescribing in such regulatory standards.

Often, internet/online questionnaires are not adequate: states may require a physical exam prior to a prescription

KANSAS passed a policy in 2018 extending to telehealth the same drug prescription laws and regulations that apply to in-person prescriptions.



WEST VIRGINIA explicitly allows practitioner to provide aspects of MAT through telehealth if within their scope of practice.

Licensure

Nine state boards issue licenses related to telehealth allowing an out-of-state licensed provider to render services via telehealth. Licensure Compacts have become increasingly common. For example:

- **29** States, D.C. & Guam: Interstate Medical Licensure Compact
- **34** States: Nurse Licensure Compact
- **26** States: Physical Therapy Compact
- **12** States: Psychology Interjurisdictional Compact (PSYPACT)

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This fact sheet was possible by Grant #G22RH30365 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS.

Georgia Medicaid Telehealth Reimbursement

GEORGIA

Medicaid Telehealth Reimbursement

Summary

Georgia Medicaid reimburses for live video under some circumstances. Store-and-forward is not reimbursable as interactive telecommunications is a condition of payment; however, GA Medicaid will reimburse for the technical component of x-rays, ultrasounds, etc. as well as store-and-forward teledentistry. There is no reference to remote patient monitoring.
Read More

Definitions

Telemedicine is the use of medical information exchange from one site to another via electronic communications to improve patient's health status. It is the use of two-way, real time interactive communication equipment to exchange the patient information from one site to another via an electronic communication system. This includes audio and video communications equipment.
Read More

Live Video

Policy

Georgia Medicaid reimbursement for telehealth is specific to clinical services rendered via telemedicine. See the telemedicine guidelines for program specific policies.

Read More

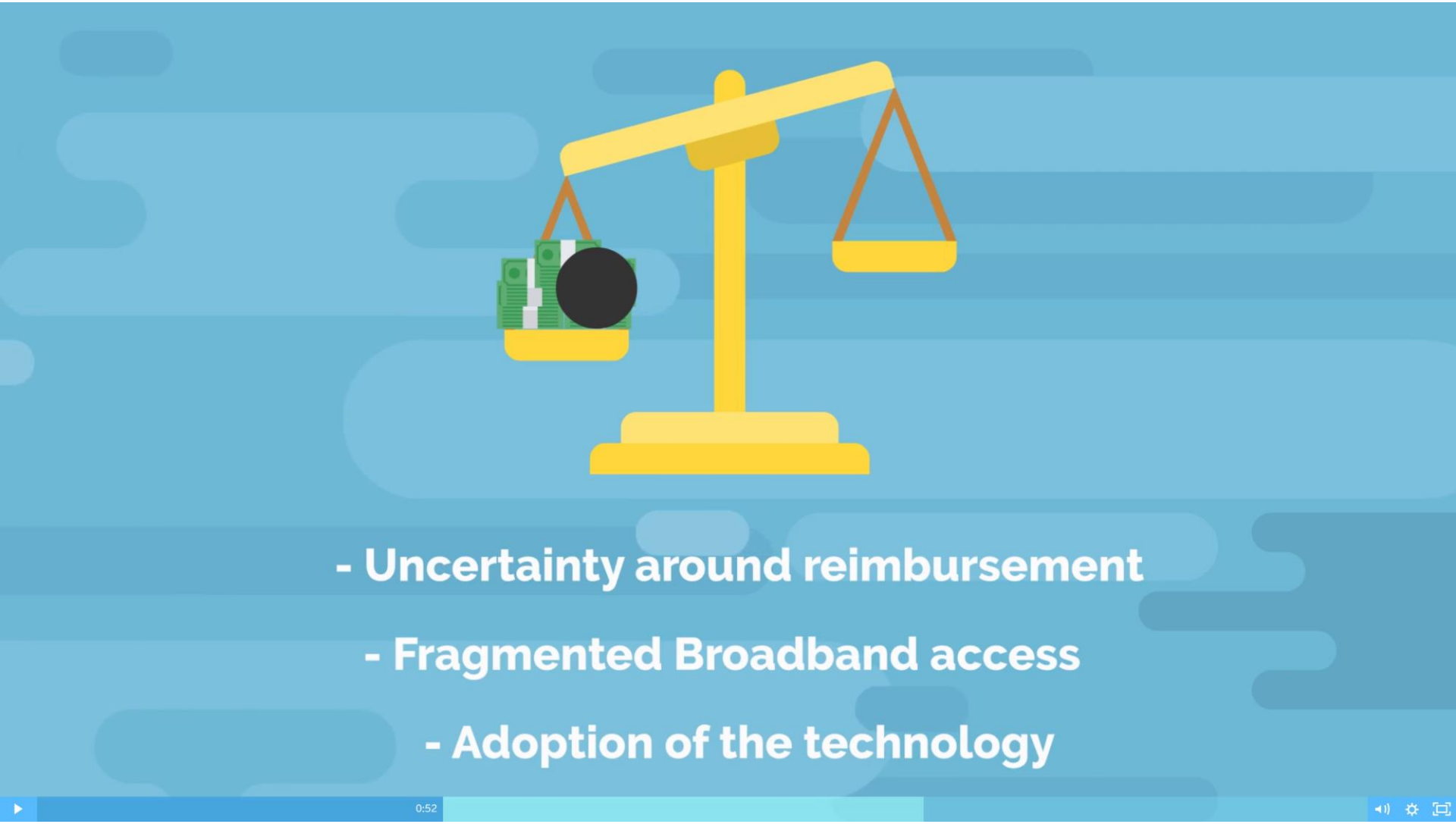
Eligible Services/Specialties

Click for a list of eligible services and specialties.
Read More

Eligible Providers

Barriers to Implementation

Telehealth Barriers



https://www.azaleahealth.com/solutions/telehealth/

Why Medicare Patients are slow to adopt Telemedicine

Medicare Telehealth & RHC Policies have lagged behind.

Medicare Policy is 10 to 20 years behind the technology.

Medicare's last big overhaul of Telehealth policy was 2008.

RHC Regulations last overhauled in 1992.

How Medicare RHC Regulations deter the growth of Telehealth

- The Patient must be located at specific originating sites
- RHCs can not be Distant Sites
- Telehealth costs are non-allowable expenses on RHC cost reports

The Telehealth Cost Center is 79 and is non-allowable

4690 (Cont.) FORM CMS-222-17

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

		COST CENTER	SALARIES	OTHER	TOTAL (col. 1 + col. 2)
			1	2	3
FACILITY OVERHEAD-ADMINISTRATIVE COSTS					
60	6000	Office Salaries			
61	6100	Depreciation-Office Equipment			
62	6200	Office Supplies			
63	6300	Legal			
64	6400	Accounting			
65	6500	Insurance			
66	6600	Telephone			
67	6700	Fringe Benefits And Payroll Taxes			
68	6800	Other (specify)			
73		Subtotal-Administrative Cost (sum of lines 60 through 68)			
74		Total Overhead (sum of lines 59 and 73)			
COST OTHER THAN RHC SERVICES					
75	7500	Pharmacy			
76	7600	Dental			
77	7700	Optometry			
78	7800	Non-allowable GME Pass Through Costs			
79	7900	Telehealth			
80	8000	Chronic Care Management			
81	8100	Other (specify)			
86		Subtotal-Cost Other Than RHC (sum of lines 75 through 81)			
NON-REIMBURSABLE COSTS					
87	8700				
88	8800				
89	8900				
90		Subtotal Non-Reimbursable Costs (sum of lines 87 through 89)			
100		TOTAL COSTS (sum of lines 39, 74, 86, and 90)			

Are there state licensing issues related to telehealth?

Licensing can be a problem for telehealth programs. Most states require physicians to be licensed to practice in the originating site's state, and some states require providers using telehealth technology across state lines to have a valid state license in the state where the patient is located.[1] Therefore, with limited exceptions, telehealth consultations with a physician across state lines require licensing paperwork.[2] If you electronically interact with patients in other states or prescribe medication across state lines, you should establish licensure in those other states.

Learn more about state licensure and telehealth with these resources:

- The Telehealth Resource Centers (TRCs) are funded to serve provides in rural and underserved communities. The TRCs website answers several frequently asked questions about Licensure and Scope of Practice and Credentialing and Licensing.
- To help physicians navigate the process of obtaining a medical license, the American Medical Association provides up-to-date information on licensure requirements across all states and jurisdictions.
- The National Council of State Boards of Nursing provides licensure information as well as information about state boards of nursing.
- The American Telemedicine Association's State Telemedicine Policy Center compiles state-specific information about telemedicine policy.

References

1. Centers for Medicare & Medicaid Services. "Telemedicine."
2. Health Resources and Services Administration. "Are there licensing issues related to telehealth?"

https://www.healthit.gov/sites/default/files/appa-1.1.pdf

President Signs New Law Allowing Telemedicine Prescribing of Controlled Substances: DEA Special Registration to Go Live

25 October 2018 | Health Care Law Today | Blog
Authors: Jacqueline N. Acosta, Nathaniel M. Lacktman

President Trump just signed into law the "Special Registration for Telemedicine Act of 2018" (the Act), requiring the Drug Enforcement Administration (DEA) to activate a special registration allowing physicians and nurse practitioners to prescribe controlled substances via telemedicine without an in-person exam. The DEA has no more than one year to complete the task.

Until now, the federal Ryan Haight Online Pharmacy Consumer Protection Act of 2008 (Ryan Haight Act) did not allow practitioners to prescribe controlled substances unless the practitioner either: (1) conducted a prior in-person exam; or (2) met one of seven "practice of telemedicine" exceptions. However, the "practice of telemedicine" exceptions are very narrow. They created an unintended barrier for legitimate practitioners seeking to use telemedicine to address practitioner shortages and deliver clinically-appropriate medical care to patients located in settings such as homes, schools, and rural areas (all common "originating sites" in contemporary direct-to-patient telemedicine service models). One of the exceptions – the special registration exception – was designed to allow telemedicine prescribing in these other settings without an in-person exam. However, for nearly ten years, the DEA never activated that special registration. The President's new law changes that.

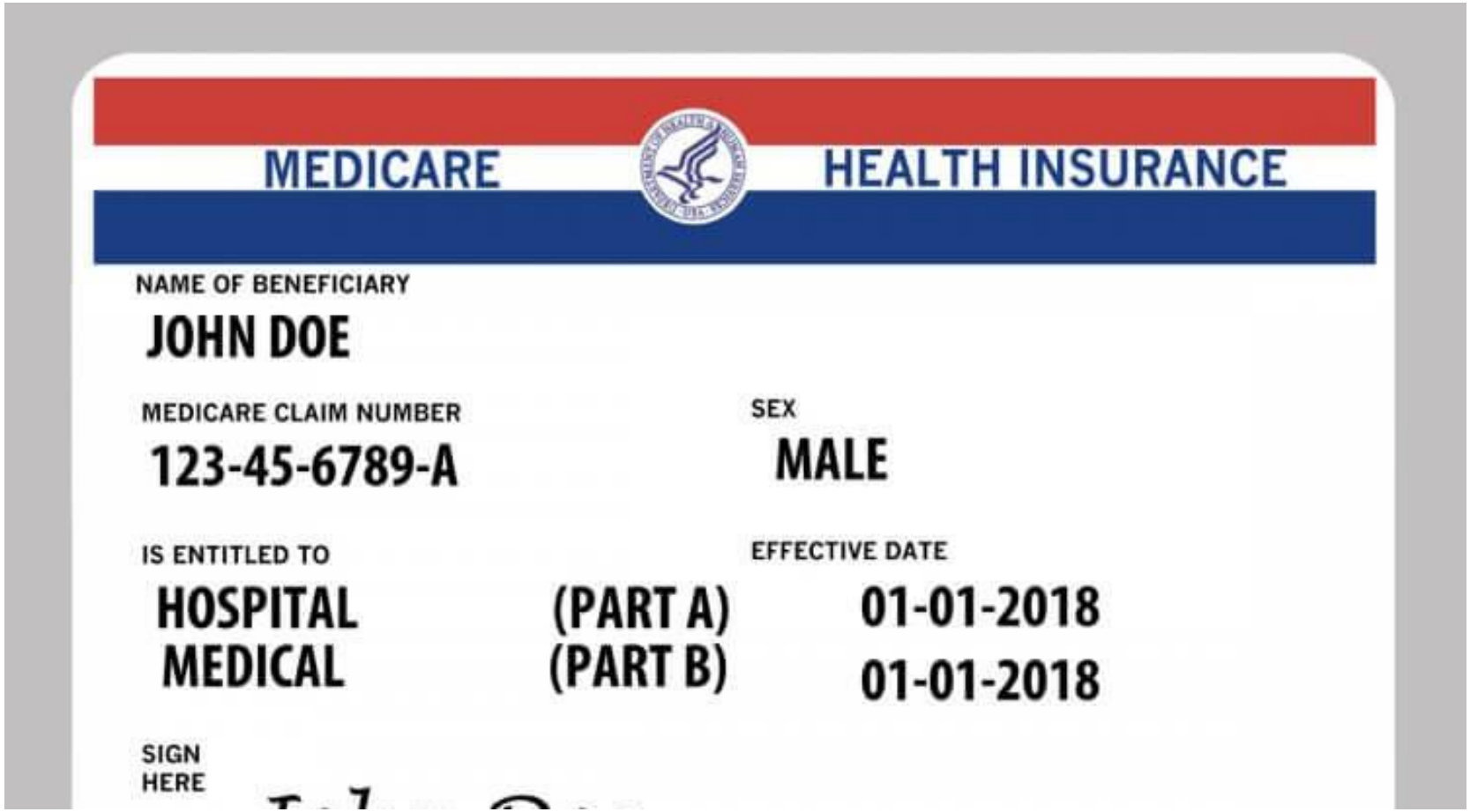
What Does the Law Actually State?

The law, which was added to Title III, Subtitle B, Chapter 4 of a larger legislation titled the "SUPPORT for Patients and Communities Act," reads as follows:

Section 311(h)(2) of the Controlled Substances Act (21 U.S.C. 831(h)(2)) is amended to read as follows:

https://www.foley.com/en/insights/publications/2018/10/president-signs-new-law-allowing-telemedicine-pres

Medicare Telehealth Reimbursement



Telehealth Medicare Fact Sheet

TELEHEALTH SERVICES

Target Audience: Medicare Fee-For-Service Providers

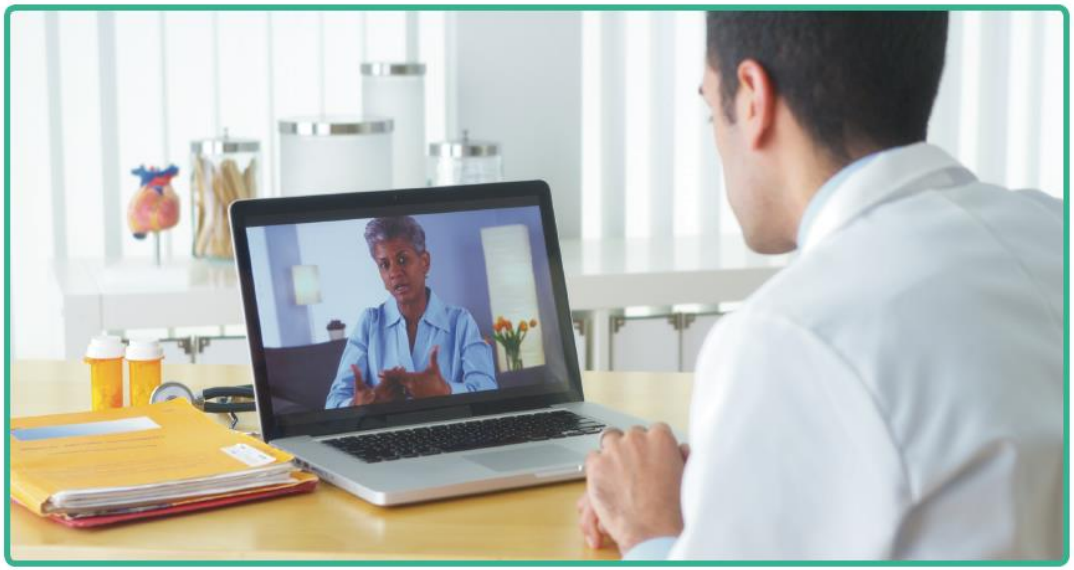
The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf

DISTANT SITE PRACTITIONERS

Distant site practitioners who can furnish and get payment for covered telehealth services (subject to State law) are:

- Physicians
- Nurse practitioners (NPs)
- Physician assistants (PAs)
- Nurse-midwives
- Clinical nurse specialists (CNSs)
- Certified registered nurse anesthetists
- Clinical psychologists (CPs) and clinical social workers (CSWs)
  - CPs and CSWs cannot bill Medicare for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services. They cannot bill or get paid for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838.
- Registered dietitians or nutrition professional



Medicare Originating Sites

ORIGINATING SITES

An originating site is the location where a Medicare beneficiary gets physician or practitioner medical services through a telecommunications system. The beneficiary must go to the originating site for the services located in either:

- A county outside a Metropolitan Statistical Area (MSA)
- A rural Health Professional Shortage Area (HPSA) in a rural census tract

The Health Resources and Services Administration (HRSA) decides HPSAs, and the Census Bureau decides MSAs. To see a potential Medicare telehealth originating site's payment eligibility, go to HRSA's Medicare Telehealth Payment Eligibility Analyzer.

Providers qualify as originating sites, regardless of location, if they were participating in a Federal telemedicine demonstration project approved by (or getting funding from) the U.S. Department of Health & Human Services as of December 31, 2000.

Beginning July 1, 2019, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act removes the originating site geographic conditions and adds an individual's home as a permissible originating telehealth services site for treatment of a substance use disorder or a co-occurring mental health disorder.

Each December 31 of the prior calendar year (CY), an originating site's geographic eligibility is based on the area's status. This eligibility continues for a full CY. Authorized originating sites include:

- Physician and practitioner offices
- Hospitals
- Critical Access Hospitals (CAHs)
- Rural Health Clinics
- Federally Qualified Health Centers
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites)
- Skilled Nursing Facilities (SNFs)
- Community Mental Health Centers (CMHCs)
- Renal Dialysis Facilities
- Homes of beneficiaries with End-Stage Renal Disease (ESRD) getting home dialysis
- Mobile Stroke Units

Note: Medicare does not apply originating site geographic conditions to hospital-based and CAH-based renal dialysis centers, renal dialysis facilities, and beneficiary homes when practitioners furnish monthly home dialysis ESRD-related medical evaluations. Independent Renal Dialysis Facilities are not eligible originating sites.

Beginning January 1, 2019, the Bipartisan Budget Act of 2018 removed the originating site geographic conditions and added eligible originating sites to diagnose, evaluate, or treat symptoms of an acute stroke. Go to MLN Matters® article, New Modifier for Expanding the Use of Telehealth for Individuals with Stroke to learn how to use the new modifier for billing.

TELEHEALTH ORIGINATING SITES BILLING AND PAYMENT

HCPCS Code Q3014 describes the Medicare telehealth originating sites facility fee. Bill your MAC f
the separately billable Part B originating site facility fee.

Note: The originating site facility fee does not count toward the number of services used to determir
payment for partial hospitalization services when a CMHC serves as an originating site.

Some Relief on the Originating Site Requirement from Medicare

- 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.**

HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or $26.15. Payment would be $20.92.

Procedure Code	Description	Effective Date	Modifier	
Q3014	Telehealth facility fee	01/01/2019		Display

	01/01/2019	**Locality:**	35
	Tennessee	**Modifier:**	
e	Q3014		

	Non-Facility	Facility	OPPS Cap Non-Facility	OPPS Cap Facility	Reduced Th
mount:	$0.00	$0.00	$0.00	$0.00	
ing Amount:	$0.00	$0.00	$0.00	$0.00	
e Amount:	$0.00	$0.00	$0.00	$0.00	

Telehealth in a Rural Health Clinic

- **Case example**
- A Medicare patient presents to a rural health clinic complaining of a headache, nausea and vomiting. A clinical staff employee at the originating site escorts the patient to a room where the patient can interact with the provider using audiovisual equipment. The provider performs the necessary history, and a clinical staff employee obtains the clinical information, such as vital signs, requested by the provider.

If the clinic has the appropriate equipment and personnel, diagnostic tests ordered by the provider are performed onsite. The provider renders the patient assessment and plan to be discussed with the patient. During this new patient encounter, the provider performs and documents a detailed history, an expanded problem-focused exam and moderate medical decision-making. Also included in the documentation is information stating that the service was provided through telehealth, the location of the patient and the provider, and the names of any other staff involved in the service.

For the distant site in this example, CPT code 99202 is billed with POS code 02 for the professional provider's service. The originating site should report HCPCS code Q3014 for the services provided.

Virtual Communication Services

- Effective January 1, 2019 RHCs can receive payment for Virtual Communication Services. **2019 Reimbursement = $13.69**
- At least 5 minutes of communication technology-based or remote evaluation services are furnished by an RHC practitioner to a patient who has had an RHC billable visit within the previous year, and;
- The medical discussion or remote evaluation is for a condition not related to an RHC service provided within the previous 7 days and;
- The medical discussion or remote evaluation does not lead to an RHC visit within the next 24 hours or at the soonest available appointment.

Virtual Communication Services

- To receive payment for Virtual Communication services, RHCs must submit an RHC claim with HCPCS code G0071 (Virtual Communication Services) either alone or with other payable services. Payment for G0071 is set at the average of the national non-facility PFS payment rates for HCPCS code G2012 (communication technology-based services) and HCPCS code G2010 (remote evaluation services) and is updated annually based on the PFS national non-facility payment rate for these codes.

- RHC face-to-face requirements are waived when these services are furnished to an RHC patient, and coinsurance and deductibles apply.

Who can perform virtual communication services?

The services cannot be performed by ancillary staff or nursing staff.

The services must be provided by a qualified RHC provider:

- Physician
- NP
- PA
- CNM
- Clinical Psychologist
- Licensed Clinical Social Worker

Virtual Communication Services must be documented.

Other Considerations

- RHCs must report the RHC-specific HCPCS® Code G0071. No other virtual or remote codes can be billed.
- No limit to the number of virtual communication services per beneficiary as long as the conditions are met.
- Deductible and Co-Insurance apply. The Coinsurance is 20% of the lesser of the charge or the payment amount. Coinsurance cannot be waived.
- Communication must be initiated by the patient.
- Consent must be obtained prior to providing virtual communication services.
- The cost of providing virtual services is an allowable cost.
- Telemedicine is a synchronous, live service that replaces a face-to-face. In Contrast, Virtual Communication is a screening service to determine if a face-to-face is necessary.

Virtual Communication Services Resources/Citations:

- CMS RHC Virtual Communication Services FAQ
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf

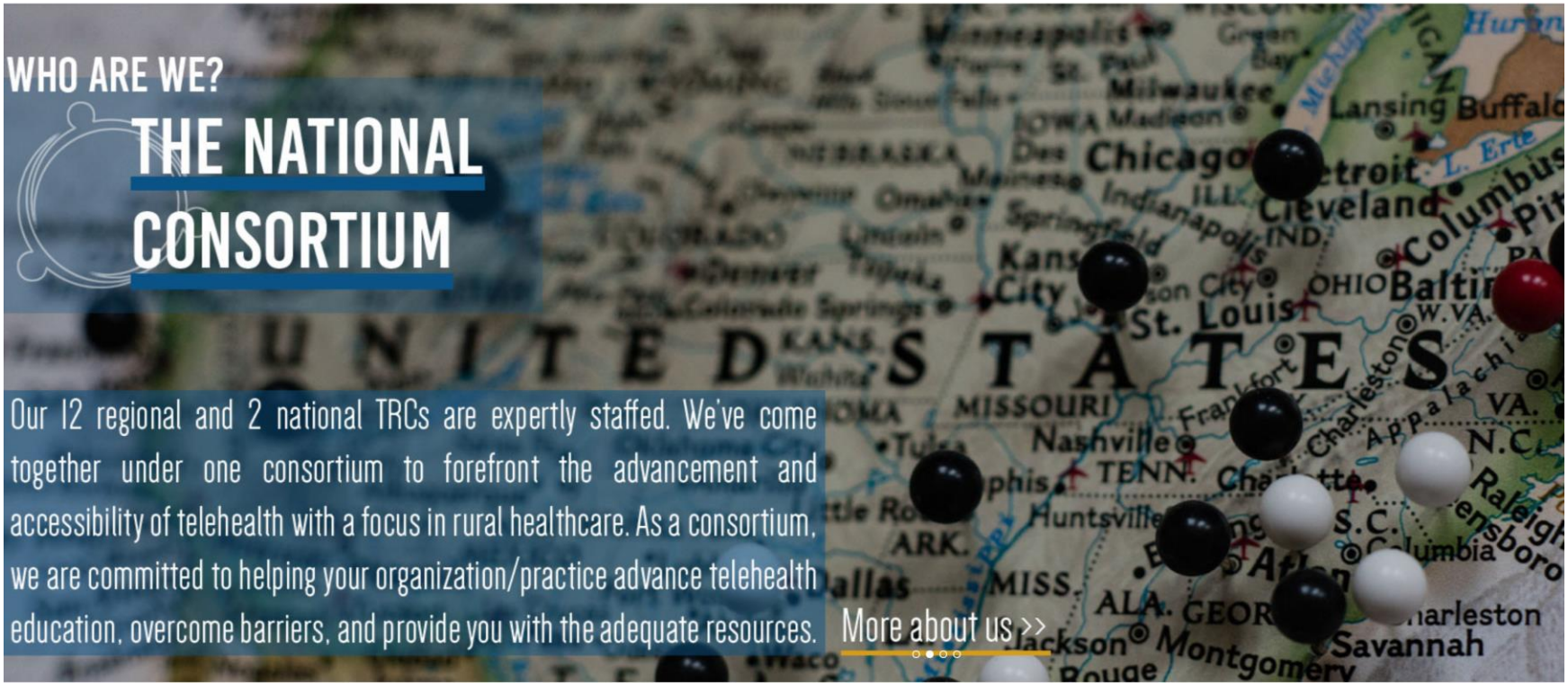
- Medlearn Matters Article: MM11019
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11019.pdf

- CMS IOM Policy Benefit Manual Updates for 2019
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/RHC-FQHC-bp102c13.pdf

Telehealth Resources

Where to get help…

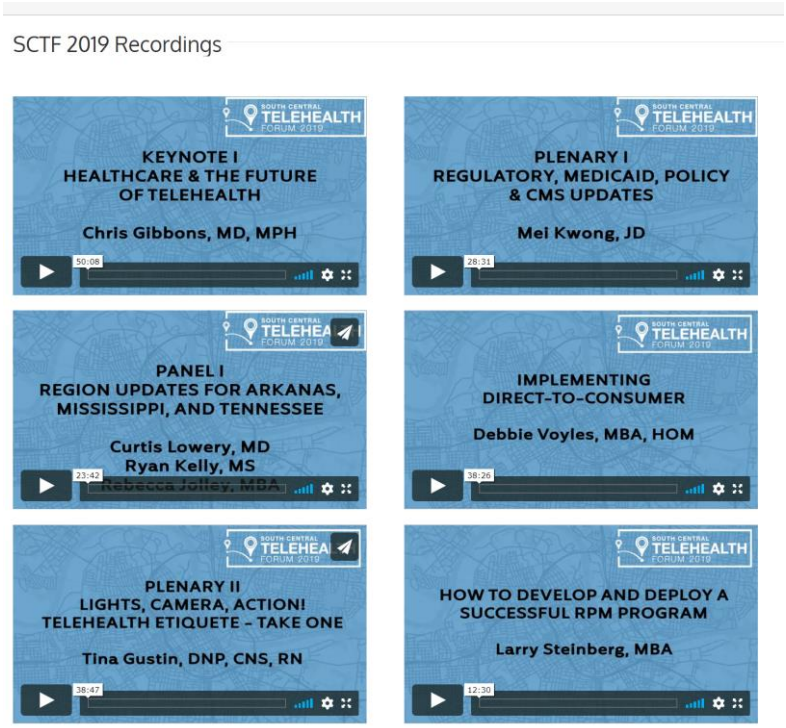
National Consortium of Telehealth Resource Centers

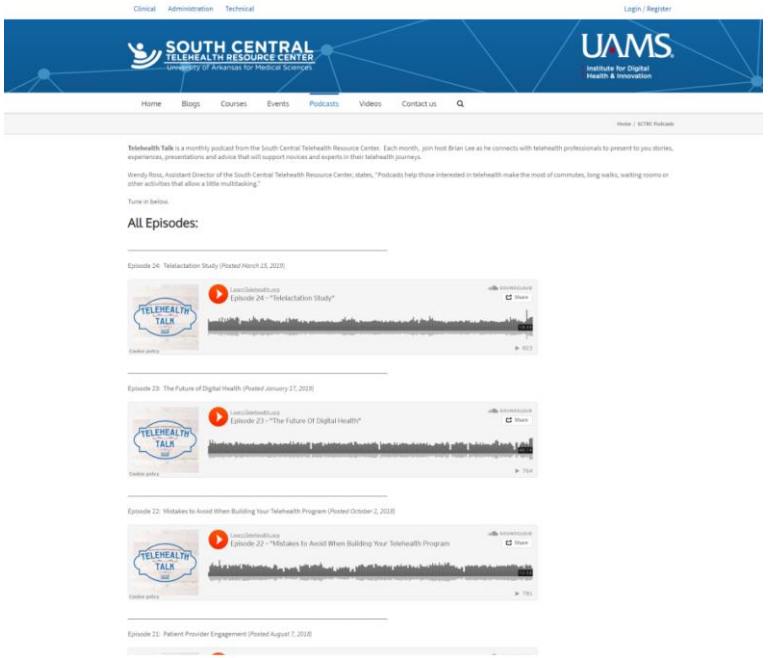


https://www.telehealthresourcecenter.org/

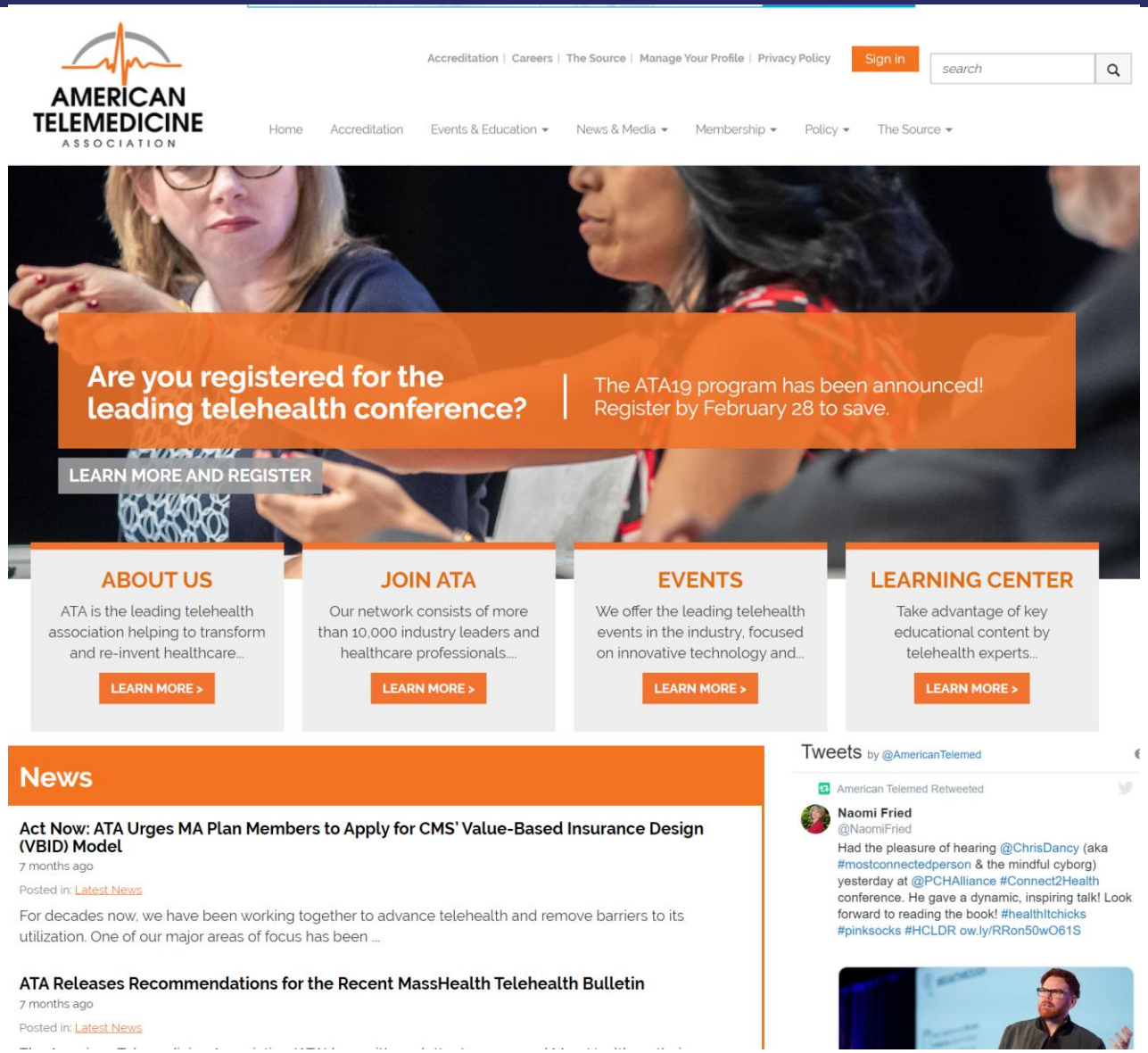
SOUTH CENTRAL TELEHEALTH RESOURCE CENTER
University of Arkansas for Medical Sciences

http://learntelehealth.org/videos/





http://learntelehealth.org/event/telehealth-101-easy-basics-telehealth-telemedicine-12/2019-10-08/



http://legacy.americantelemed.org/home

AMERICAN TELEMEDICINE ASSOCIATION

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TELEMEDICINE ACCREDITATION

AMERICAN TELEMEDICINE ASSOCIATION

ClearHealth Quality Institute

ATA-CHQI Now Accrediting Safe, Online Healthcare Services

ATA's Accreditation Program for Online Patient Consultations which was developed in 2015 recognizes organizations providing online, real-time patient health services that comply with operational, clinical and consumer-related standards. The program promotes patient safety, transparency of operations and adherence to all relevant laws and regulations. Recognition through the accreditation program is an organizational benchmark to assure patients, payers and consumers that the organization's online patient consultative services meets the industry standards and organizational for the program.

In May 2017, ATA executed a strategic partnership agreement with ClearHealth Quality Institute (www.chqi.com) in Annapolis, MD to manage the day-to-day operations of the program, its committees, and stakeholders. The transfer of operations to an independent third party entity enhances the integrity of the program and the grant of accreditation earned by successful applicants.

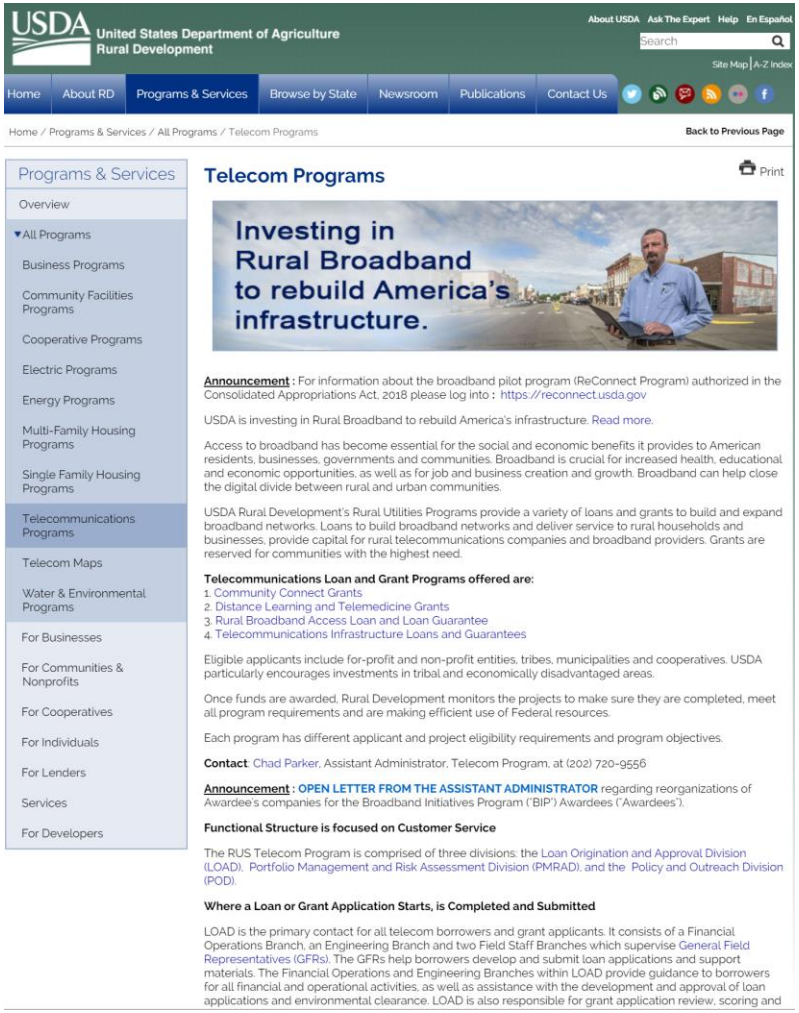
For more information about the ATA-CHQI accreditation program, future telemedicine accreditation and certification to be offered through CHQI, or to register for the accreditation program, contact a staff member at CHQI through one of the following means:

326 First Street, Suite 29
Annapolis, Maryland 21403
info@chqi.com
(410) 696-7634

Quick Links

- Program Home
- Directory of Accredited Services
- Accredited Training Programs

Grant Funding for Telehealth Costs



https://www.rd.usda.gov/programs-services/all-programs/telecom-programs

Takeaways from this session

TELEMEDICINE IS HERE WHETHER YOU ARE ONBOARD OR NOT.

DON’T LET MEDICARE REIMBURSEMENT DRIVE YOUR DECISION MAKING

MEDICAID & PRIVATE INSURANCE WILL DRIVE TELEMEDICINE REIMBURSEMENT

Expert Care. Proven Solutions.

Emerging Issues in Rural Health Center Reimbursement: Remote Patient Monitoring

Bonnie Britton *MSN, RN, ATA Fellow*

CO-FOUNDER & PRESIDENT

Reconnect4Health.com

Presentation Goals

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

- **Discuss the role of RPM in patient management.**
- **Articulate CMS's new RPM CPT Codes.**
- **Identify key elements for reimbursement.**
- **Discuss RPM Outcomes.**

Reconnect 4 Health

Remote Patient Monitoring

The goals of RPM are:

- **Patients make long term behavior change.**
- **Improve patient clinical outcomes.**
- **Lower health care costs.**

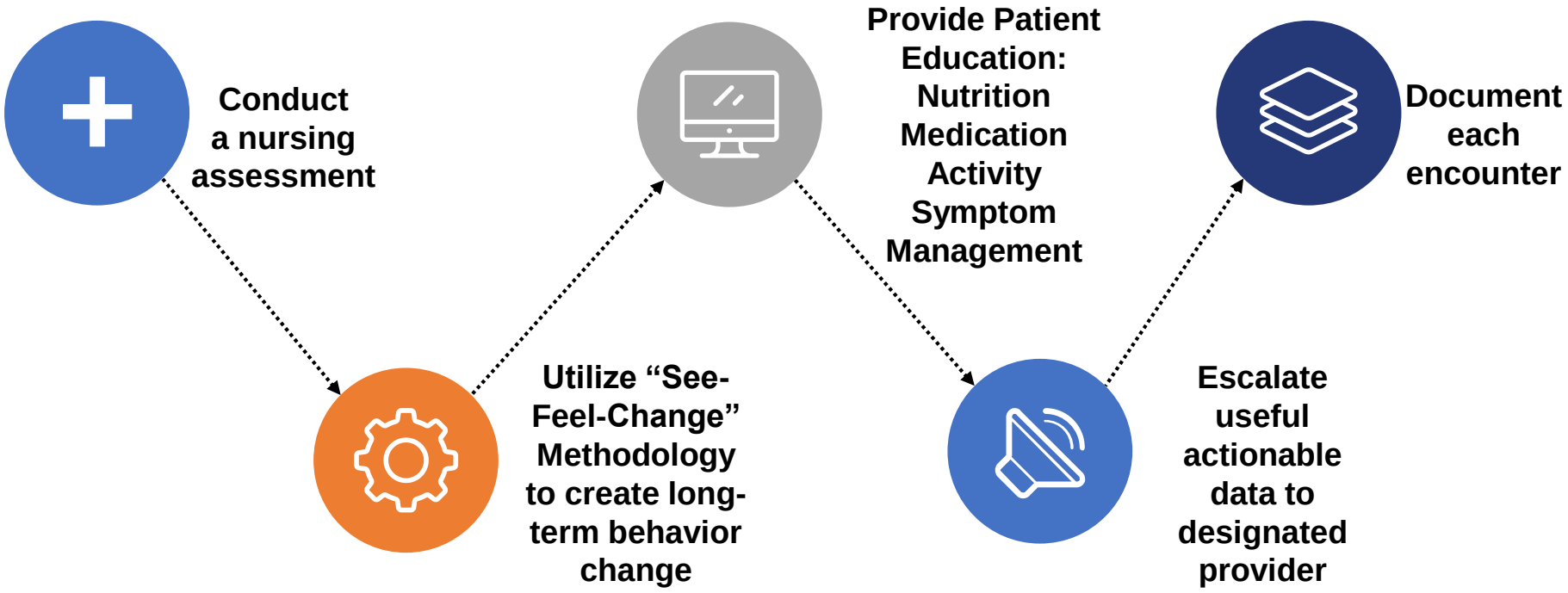
Reconnect 4 Health

Devices

Reconnect 4 Health

CLINICAL MONITORING WORKFLOWS: NURSING INTERVENTIONS AND EDUCATION

When alerts are valid, an RN will:



Medicare Telehealth Services vs RPM Services

Medicare Telehealth Services- interaction between a provider and a patient via communications technology.

- Billed as an in-person encounter
- Must meet geographic restrictions
- Must meet originating site restrictions

RPM are services that are defined by and involve the use of communication technology.

RPM are services that are not provided during an in-patient visit.

No geographic or originating site restrictions

Reconnect 4 Health

Remote Physiologic Monitoring

Patients collect bio-metric data remotely

- Weight
- Blood Pressure
- Heart Rate
- Pulse Oximetry

Data is transmitted for review.

Medicare patients with chronic condition(s).

RPM CPT Code 99453

Remote monitoring of physiologic parameters

Initial device set
Patient education on device use

Reimbursement: $21 (average national rate per set up)

Reconnect 4 Health

Rural Health Clinics will have to perform Remote Monitoring services as Non-RHC services. An RHC will need Non-RHC time to set up the Remote Monitoring system.

If an RHC does not have non-RHC time, the RHC may be able to just not charge the initial setup fee.

RPM CPT Code 99454

Device Supply

Minimum of 16 days of transmitted day each 30 days.

Reimbursement $ 69 PPPM (average national rate)

Reconnect 4 Health

RPM CPT Code 99457

Remote physiologic monitoring treatment management services:

Collection, analysis, & interpretation of digitally collected data

Development of a treatment plan
20 minutes or more time in a calendar month managing patient

Direct supervision required now
General supervision 1-1-20

Reimbursement: $54 PPPM (average national rate)

Reconnect 4 Health

RPM CPT Code 994XO

Remote physiologic monitoring treatment management services:

20 additional minutes or more of time in a calendar month requiring interactive communication with the patient/caregiver during the month

Reimbursement: $TBD PPPM

Reconnect 4 Health

RPM CPT Code Take Aways

General supervision of RPM clinical services

- **Opens up for huge uptake in RPM.**
- **Now business model for outsourcing RPM services.**

CPT Codes 99457 and 994X0 should be included as designated care management services.

Reconnect 4 Health

Contact Information

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www.reconnect4health.com

Reconnect 4 Health

Behavioral Health in the RHC Setting: A Nine Year Perspective

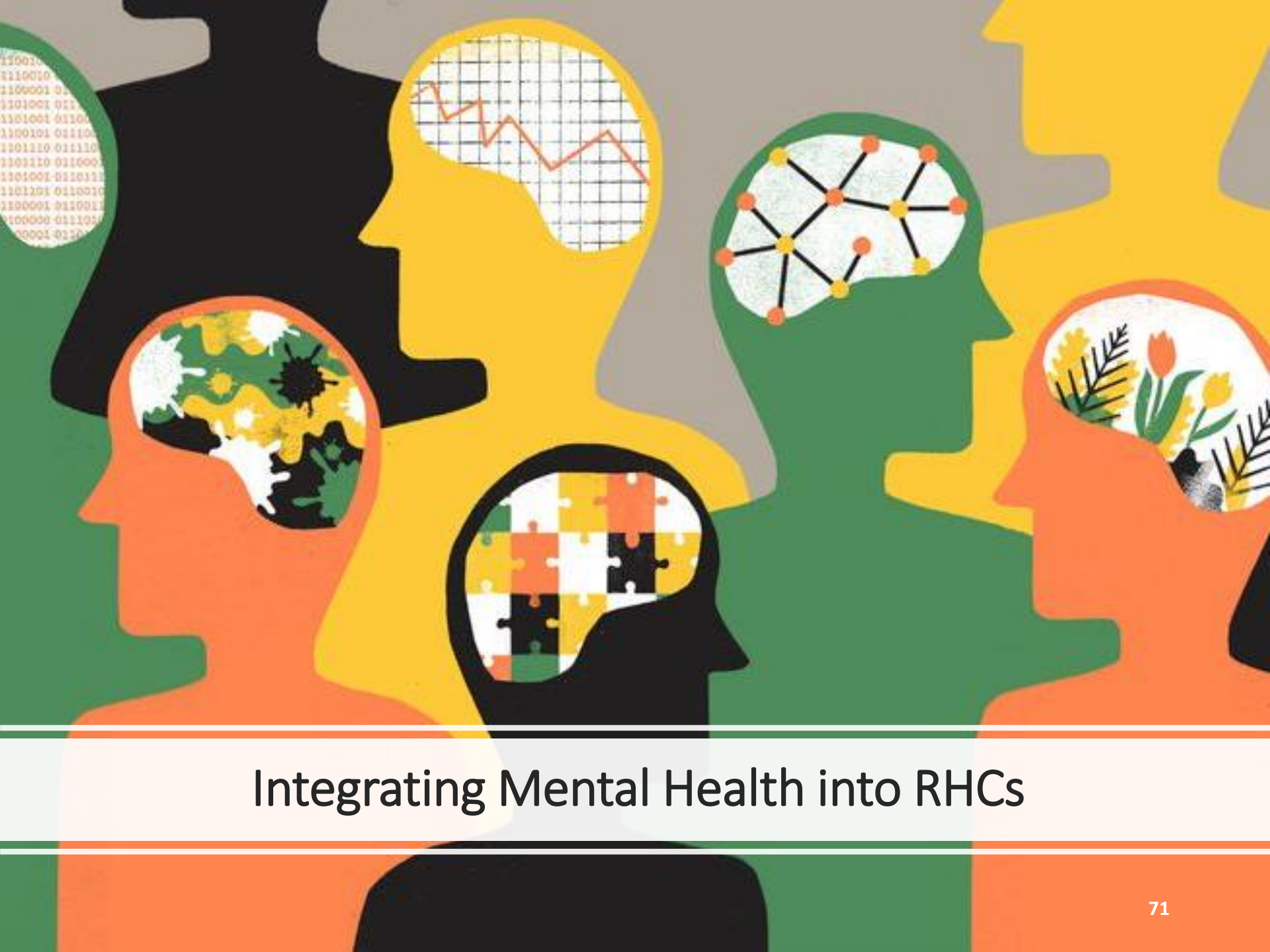
Azalea HEALTH

Agenda

I. Basic encounters and the Co-occuring Issues Dimension

II. The Billing Dimension

III. Real Integration in spite of Complexity



Integrating Mental Health into RHCs

R- Relationships!!!
U- Understanding
R- Reimbursement considerations
A- Adapt...constantly
L- Love your Location (as a provider)

Mental Health Providers

150 - Clinical Psychologist (CP) and Clinical Social Worker (CSW) Services

(Rev. 252, Issued: 12- 07-18, Effective: 01-01-19, Implementation: 01- 02-19)

A CP is an individual who:

- Holds a doctoral degree in psychology, and
- Is licensed or certified, on the basis of the doctoral degree in psychology, by the state in which he or she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

A CSW is an individual who:

- Possesses a master's or doctor's degree in social work;
- After obtaining the degree, has performed at least 2 years of supervised clinical social work; and
- Is licensed or certified as a clinical social worker by the state in which the services are performed; or, in the case of an individual in a state that does not provide for licensure or certification, meets the requirements listed in 410.73(a)(3)(i) and (ii).

Mental Health Visits – Per Chapter 13

170 - Mental Health Visits
(Rev. 239, Issued: 01-09-18, Effective: 1-22-18, Implementation: 1-22-18)

A mental health visit is a medically-necessary face-to-face encounter between an RHC or FQHC patient and an RHC or FQHC practitioner during which time one or more RHC or FQHC mental health services are rendered. Mental health services that qualify as stand-alone billable visits in an FQHC are listed on the FQHC center website, http://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html. Services furnished must be within the practitioner's state scope of practice.

Medicare-covered mental health services furnished incident to an RHC or FQHC visit are included in the payment for a medically necessary mental health visit when an RHC or FQHC practitioner furnishes a mental health visit. Group mental health services do not meet the criteria for a one-one-one, face-to-face encounter in an FQHC or RHC.

A mental health service should be reported using a valid HCPCS code for the service furnished, a mental health revenue code, and for FQHCs, an appropriate FQHC mental health payment code. For detailed information on reporting mental health services and claims processing, see Pub. 100-04, Medicare Claims Processing Manual, chapter 9,

Mental Health Visits – Per Chapter 13 (p.2)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c09.pdf

Medication management, or a psychotherapy "add on" service, is not a separately billable service in an RHC or FQHC and is included in the payment of an RHC or FQHC medical visit. For example, when a medically-necessary medical visit with an RHC or FQHC practitioner is furnished, and on the same day medication management or a psychotherapy add on service is also furnished by the same or a different RHC or FQHC practitioner, only one payment is made for the qualifying medical services reported with a medical revenue code. For FQHCs, an FQHC mental health payment code is not required for reporting medication management or a psychotherapy add on service furnished on the same day as a medical service.

Psychiatric Codes for Behavioral Health Services

Figure 1: Psychiatric codes for behavioral health services

- 90791: Psychiatric diagnostic evaluation-no medical services
- 90792: Psychiatric diagnostic evaluation-with medical services
- 90832: Psychotherapy, 30 min. (16-37 min.) - patient or family member
- 90834: Psychotherapy, 45 min. (38-52 min.) - patient or family member
- 90837: Psychotherapy, 60 min. (53+ min.) - patient or family member
- 90839: Psychotherapy for crisis, 1st 60 min. (high distress patients with complex/life threatening circumstances requiring immediate attention)
- 90845* Psychoanalysis
- 90846* Family psychotherapy without the patient present
- 90847* Family psychotherapy, psychotherapy with patient present
- 90849* Multiple-family group psychotherapy
- 90853* Group psychotherapy

Psychotherapy provided in combination with E/M services (Psychotherapy service must be "significant and separately identifiable" from the E/M service provided)

- 90833: 30-minute psychotherapy add-on code (may be used for 16-37 minutes)
- 90836: 45-minute psychotherapy add-on code (may be used for 38-52 minutes)
- 90838, 60-minute psychotherapy add-on code (may be used for 53 + minutes)

Add-on psychiatric codes

- 90785: Interactive complexity (factors are present that that complicate the delivery of the evaluation or session). Used in combination with diagnostic evaluation and psychotherapy codes for primary service: psychiatric diagnostic evaluation (90791); psychotherapy (90832, 90834, 90837); group psychotherapy (90853) (Interactive complexity)
- 90863: Pharmacologic management when used in combination psychotherapy services (90832, 90834, 90837)
- 90840: Add-on for each additional 30 minutes of psychotherapy for crisis, used in conjunction with code 90839

E & M Codes

Figure 2: Evaluation and Management Codes

Physicians (including psychiatrists) are now expected to bill using the appropriate E/M code and a timed add-on code for the psychotherapy instead of using the previous psychotherapy codes with E/M services (90805, 90807).

Office/outpatient services

- 99201-99205, New patient office visit
- 99211-99215, Established patient office visit

Inpatient/hospital services

- 99221-99223, Initial hospital care
- 99231-99233, Subsequent hospital care

Nursing facility services

- 99304-99306, Initial nursing facility care
- 99307-99310, Subsequent nursing facility care

Domiciliary, rest home, or custodial care services

- 99324-99328, Domiciliary or rest home visit for a new patient
- 99334-99337, Domiciliary or rest home visit for an established patient

Home services

- 99341-99345, Home visit for a new patient
- 99347-99350, Home visit for an established patient

Assessment and Intervention Codes

Figure 3: Behavioral health assessment and intervention codes

- 96150: Initial health and behavior assessment. Health-focused clinical interview, behavioral observations, psycho-physiological monitoring, health-oriented questionnaires, each 15 minute face-to-face with the patient: initial assessment to determine the biological, psychological, and social factors affecting the patient's physical health and any treatment problems
- 96151: Health and behavior re-assessment. Each 15-minutes face-to-face with the patient.
  96152: Health and behavior intervention service. Modify psychological, behavioral, cognitive, and social factors affecting the patient's physical health and well-being. Examples: Increasing the patient's disease awareness; using cognitive/behavioral approaches to initiate prescribed diet and exercise regimens. Each 15-minutes, face-to- face; individual.

Reimbursement

Behavioral health services provided in the RHC by the eligible providers listed previously (physicians, nurse practitioners, physician assistants, certified nurse midwives, doctoral-level clinical psychologists, and clinical social workers) are covered as part of the RHC benefit and are reimbursed under cost-based reimbursement. State Medicaid agencies are required to reimburse RHCs and FQHCs for behavioral health services provided by the Medicare eligible providers practicing within the scope of their licenses under applicable state law. Commercial insurance reimbursement policies vary by carrier.

Although RHCs are reimbursed under a cost-based rate per visit under Medicare Part A, it is important to note that until 2014, outpatient behavioral health services covered under Medicare Part B under the Fee for Service fee schedule were reimbursed at a rate lower than the rate for medical services. Effective January 1, 2014, behavioral health services have parity in reimbursement with medical services.

It is also important to note that Medicare policies allow for the provision and reimbursement of both a physical health and behavioral health service on a single day (except for HBAI services). The extent to which this is allowed by Medicaid and commercial insurers varies considerably. As has been discussed previously, it is important to investigate and verify payment policies of the clinic's primary payers before making implementing integrated services.

For the use of time based psychiatric procedure codes, most third-party payers require a face to face encounter with the patient for the service to be eligible for reimbursement. The level of coding for evaluation and management codes are based on the service provided and intensity of encounter.

AIMS CENTER
UNIVERSITY of WASHINGTON
Psychiatry & Behavioral Sciences

Cheat Sheet on CMS Medicare Payments for Behavioral Health Integration Services Federally Qualified Health Centers and Rural Health Clinics

Updated: April 4, 2019

Medicare pays for services provided to patients receiving collaborative care services (CoCM) or other behavioral health integration (BHI) services. The payment structure may be used for patients with any behavioral health condition being addressed by the treating provider, including substance use disorders.

The codes described below are for Federally Qualified Health Centers or Rural Health Clinics and are billed under the treating medical provider. For information on BHI codes for other practices; see https://aims.uw.edu/resource-library/cms-collaborative-care-payment-cheat-sheet.

Useful online resources describing the CMS Medicare codes include the following:

- *Fact Sheet*: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10175.pdf
- *FAQ*: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf

G0511 – General Care Management Services: Minimum of 20 minutes per calendar month. G0511 may only be billed once per month per beneficiary and may not be billed if other care management services such as transitional care management or home health care supervision are billed for the same time period.

Service elements must include:

- Initial assessment or follow-up monitoring, including use of applicable validated rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team.

G0512 – Psychiatric Collaborative Care Model services: Minimum of 70 minutes in the first calendar month and at least 60 minutes in subsequent calendar months. Minutes counted towards the time threshold are those of the behavioral health care manager only. The valuation of the codes includes the time of the psychiatric consultant and treating medical provider, who bill usual codes for any E/M or evaluation services. G0512 may only be billed once per month per beneficiary and may not be billed at the same time as G0511.

Service elements must include:

- Outreach and engagement of patients;
- Initial assessment, including administration of validated scales and resulting in a treatment plan;
- Entering patients into a registry for tracking patient follow-up and progress;
- Participation in weekly caseload review with psychiatric consultant and modifications to treatment, if recommended;
- Provision of brief interventions using evidence-based treatments such as behavioral activation, problem-solving treatment, and other focused treatment activities;
- Tracking patient follow-up and progress using validated rating scales;
- Ongoing collaboration and coordination with treating FQHC and RHC providers; and
- Relapse prevention planning and preparation for discharge from active treatment.

Initiating Visit, Consent and Co-Payments

All services billed under the two codes require a separately billable initiating visit (E/M, AWV, or IPPE) for new patients or for those who have not been seen within year prior to commencement of these services. The beneficiary must provide consent for the service, including permission to consult with a psychiatric consultant and relevant specialists. Advance consent must also include information on cost sharing for both face-to-face and non-face-to-face services, and acceptance of these requirements must be documented in the medical record.

Medicare Codes and Payments Summary 2019*

Code	Description	Payment
G0511	General Care Management Services - Minimum 20 min/month	$67.03
G0512	Psychiatric CoCM - Minimum 70 min initial month and 60 min subsequent months	$145.96

**Please note actual payment rates may vary. Check with your billing/finance department.*

Treating providers may bill only one code for an individual Medicare beneficiary in the same month.

Psychiatric CoCM Team and Qualifications

The psychiatric CoCM team in an RHC or FQHC must include, at a minimum, the treating provider, a behavioral health care manager, and a psychiatric consultant. Specific qualifications are as follows:

Treating (Billing) Provider

The RHC or FQHC treating provider may be a primary care physician, NP, PA, or Certified Nurse Midwife.

Behavioral Health Care Manager

The behavioral health care manager must have a minimum of a bachelor's degree in a behavioral health field such as in social work or psychology or be a clinician with behavioral health training, including nurses. The behavioral health care manager furnishes both face-to-face and non-face-to-face services under the general supervision of the treating provider. The behavioral health care manager need not be licensed to bill traditional psychotherapy codes.

Psychiatric Consultant

The psychiatric consultant is a medical professional trained in psychiatry and qualified to prescribe the full range of psychotropic medications. The psychiatric consultant can work remotely, is not required to be on site or to have direct contact with the patient, and does not prescribe medications or furnish treatment directly to the beneficiary.

Provision of Psychotherapy in addition to Psychiatric CoCM

Behavioral health care managers that are qualified to bill traditional psychiatric evaluation and therapy codes for Medicare recipients are allowed to bill for additional psychiatric services in the same month as billing G0512. However, time spent on activities for services reported separately may not be included in the time applied to G0512.

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