Medicare Telehealth Policy

gpTRAC Regional Telehealth Forum
Sioux Falls, South Dakota

April 6, 2015
Medicare Telehealth Benefit

Social Security Act Sec. 1834(m) [42 C.F.R. § 410.78]

“(T)he Secretary shall pay for telehealth services that are furnished via a telecommunications system by a physician (as defined in section 1861(r)) or a practitioner (described in section 1842(b)(18)(C)) to an eligible telehealth individual enrolled under this part notwithstanding that the individual physician or practitioner providing the telehealth service is not at the same location as the beneficiary.”

• Medicare covered services
• Approved telehealth services
• Medicare Part B beneficiary
• Authorized clinician
• Authorized patient site
• Separate physical locations
• Interactive audio and video system (federal demo sites in AK and HI may use store-and-forward technology)
Eligible Originating Sites

• Location of eligible Medicare beneficiary at time of service
  ✓ Physician office
  ✓ Rural Health Clinic
  ✓ Federally Qualified Health Center
  ✓ Community Mental Health Center
  ✓ Hospital
  ✓ Critical Access Hospital
  ✓ Hospital Based ESRD clinic
  ✓ Skilled Nursing Facility

• Located in a non-MSA county or in a rural HPSA*
  (or an entity that participates in an HHS telehealth demo as of 12/31/00)
  ✓ Check eligibility using the Medicare Telehealth Payment Eligibility Analyzer
    ❑ Medicare eligibility determined as of December 31 each year
    ❑ HRSA updates HPSAs in the Federal Register in late June each year

• Submit claim for originating fee (~$25) using code Q3014
  ❑ 20% beneficiary coinsurance applies

*As of January 1, 2014, a geographic primary care or mental health HPSA (not a population or auto HPSA) located in an area defined by FORHP as rural. (HPSA type does not limit telehealth service type.)
Eligible Distant Sites

• Location of eligible physician or practitioner at time of service

• Physician or practitioner includes:
  ✓ A physician as described in 42 CFR §410.20. [incl. MD, DO, DDS, DMD, DPM, OD, DC]
  ✓ A physician assistant as described 42 CFR §410.74
  ✓ A nurse practitioner as described in 42 CFR §410.75
  ✓ A clinical nurse specialist as described in 42 CFR §410.76
  ✓ A certified registered nurse anesthetist as described in 42 CFR §410.69
  ✓ A nurse-midwife as described in 42 CFR §410.77
  ✓ A clinical psychologist as described in 42 CFR §410.71
  ✓ A clinical social worker as described in 42 CFR §410.73
  ✓ A registered dietitian or nutrition professional as described in 42 CFR §410.134

• Physician or practitioner does NOT include an FQHC or RHC

• Claim includes appropriate modifier (GT or GQ)
  ❑ 20% beneficiary coinsurance applies
RHCs, FQHCs, and CAHs

• Originating Site Fee
  - RHCs/FQHCs address costs and revenue on cost report
    - Payment glitch if no RHC/FQHC visit on same day; to be fixed in October

• Distant Site Claims
  - FQHCs/RHCs cannot submit Medicare telehealth claims
  - Practitioner bills Medicare for telehealth visits or reassigns billing privileges to a CAH or other eligible originating site

• Some CAHs include subscription services on their cost report
Next Generation ACO

- Two-side risk model
- Waives certain Medicare telehealth requirements
  - Rural
  - Originating site
- Only available to aligned beneficiaries
- Hospital and nursing facilities services ineligible in beneficiary home (G0406-408; 99231-233; 99307-310)
- All other requirements apply (allowable services, interactive, practitioner type, etc.)
<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS/CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telehealth consultations, emergency department or initial inpatient</td>
<td>G0425–G0427</td>
</tr>
<tr>
<td>Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs</td>
<td>G0406–G0408</td>
</tr>
<tr>
<td>Office or other outpatient visits</td>
<td>99201–99215</td>
</tr>
<tr>
<td>Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days</td>
<td>99231–99233</td>
</tr>
<tr>
<td>Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days</td>
<td>99307–99310</td>
</tr>
<tr>
<td>Individual and group kidney disease education services</td>
<td>G0420 and G0421</td>
</tr>
<tr>
<td>Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training</td>
<td>G0108 and G0109</td>
</tr>
<tr>
<td>Individual and group health and behavior assessment and intervention</td>
<td>96150–96154</td>
</tr>
<tr>
<td>Individual psychotherapy</td>
<td>90832–90834 &amp; 90836–90838</td>
</tr>
<tr>
<td>Telehealth Pharmacologic Management</td>
<td>G0459</td>
</tr>
<tr>
<td>Psychiatric diagnostic interview examination</td>
<td>90791 and 90792</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment</td>
<td>90951, 90952, 90954, 90955, 90957, 90958, 90960, &amp; 90961</td>
</tr>
<tr>
<td>Individual and group medical nutrition therapy</td>
<td>G0270 and 97802–97804</td>
</tr>
<tr>
<td>Neurobehavioral status examination</td>
<td>96116</td>
</tr>
<tr>
<td>Smoking cessation services</td>
<td>G0436, G0437, 99406 &amp; 99407</td>
</tr>
<tr>
<td>Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services</td>
<td>G0396 and G0397</td>
</tr>
<tr>
<td>Annual alcohol misuse screening, 15 minutes</td>
<td>G0442</td>
</tr>
<tr>
<td>Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes</td>
<td>G0443</td>
</tr>
<tr>
<td>Annual depression screening, 15 minutes</td>
<td>G0444</td>
</tr>
<tr>
<td>High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes</td>
<td>G0445</td>
</tr>
<tr>
<td>Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes</td>
<td>G0446</td>
</tr>
<tr>
<td>Face-to-face behavioral counseling for obesity, 15 minutes</td>
<td>G0447</td>
</tr>
<tr>
<td>Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)</td>
<td>99495</td>
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<tr>
<td>Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)</td>
<td>99496</td>
</tr>
<tr>
<td>Psychoanalysis</td>
<td>90845</td>
</tr>
<tr>
<td>Family psychotherapy (without the patient present)</td>
<td>90846</td>
</tr>
<tr>
<td>Family psychotherapy (conjoint psychotherapy) (with patient present)</td>
<td>90847</td>
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<tr>
<td>Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour</td>
<td>99354</td>
</tr>
<tr>
<td>Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; ea. addl 30 min</td>
<td>99355</td>
</tr>
<tr>
<td>Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) first visit</td>
<td>G0438</td>
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<tr>
<td>Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) subsequent visit</td>
<td>G0439</td>
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</tbody>
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Source: Medicare Telehealth Services Fact Sheet
# Medicare Telehealth Claims

| Year | Distant Site | | | Originating Site | |
|------|--------------|-----------------|-----------------|-----------------|
|      | Allowed Services | Allowed Charges | Allowed Services | Allowed Charges |
| 2001 | 1,494 | $55,422 | 294 | $5,880 |
| 2002 | 5,285 | $185,086 | 1,596 | $31,836 |
| 2003 | 6,776 | $404,764 | 4,389 | $90,186 |
| 2004 | 11,266 | $765,179 | 7,841 | $161,880 |
| 2005 | 15,970 | $1,176,329 | 10,972 | $227,349 |
| 2006 | 25,461 | $2,124,881 | 15,908 | $333,138 |
| 2007 | 25,395 | $1,991,753 | 14,336 | $310,296 |
| 2008 | 23,144 | $1,613,408 | 9,247 | $208,964 |
| 2009 | 37,503 | $2,797,893 | 17,100 | $393,291 |
| 2011 | 82,701 | $5,938,090 | 32,450 | $761,230 |
| 2012 | 106,023 | $7,467,157 | 38,540 | $903,233 |
| 2013 | 136,429 | $10,689,862 | 46,147 | $1,112,446 |

Source: CMS, as reported to the Center for Telehealth and eHealth Law
Potential Barriers

- Largely limited to fee-for-service (Note: CAH service subscriptions)
- Patients must travel to an eligible originating site
- Originating site eligibility can change year-to-year (HPSA or MSA updates)
- Originating site fee copay makes telehealth more expensive (~$5)
- Approved services list isn’t exhaustive; extensive and lengthy process to add services
- Limited clinical outcomes data for some services (Note: EB Tele-Emergency Program)
- Clinician state licensure limitations (Note: FSMB interstate compact)
- Specialist credentialing/privileging required at each hospital originating site
- Most of U.S. can’t use store-and-forward to better utilize specialists’ time
- Clinician-to-clinician consultations aren’t billable
- RHC and FQHC distant site prohibition
- Different coverage policies than other payers (e.g., Medicaid, insurers, state parity laws)
- Some equipment is still expensive
- Transmission speeds, reliability, and costs
Resources

Medicare Telehealth Services Fact Sheet

Medicare telehealth regulations
☑️ http://www.ecfr.gov/cgi-bin/text-idx?SID=89f51d919ffc5b375f126c606b5b5cd3&node=se42.2.410_178&rgn=div8

Medicare Telehealth Payment Eligibility Analyzer
☑️ http://datawarehouse.hrsa.gov/telehealthAdvisor/telehealthEligibility.aspx

Medicare telehealth webpage
☑️ http://www.cms.gov/Medicare/Medicare-General-information/telehealth/index.html

Medicare Benefits Policy Manual Chapter 15 (Sec. 270)

Medicare Claims Policy Manual Chapter 12 (Sec. 190)

Medicaid telemedicine webpage
☑️ http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html
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• Natassja Manzanero, Federal Office of Rural Health Policy, HRSA
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