



Telehealth Reimbursement and Payment Models

January, 18, 2019, 12-1pm

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Telehealth Learning Lab Webinar Series

Telehealth program design and implementation aligns with behavioral health integration activities, addresses specialty care clinician shortages and concerns identified through the primary care collaborative and transformation work, and provides options for cost savings throughout the delivery system.

All practices and partners are encouraged to join!



Recorded webinars will be posted on <https://www.choosehealthde.com/>

■ DISCLOSURE

HMA does not endorse any specific vendors for telehealth (or digital health) platforms or equipment, though we do endorse the idea that telehealth (digital health) is important and impactful in healthcare transformation. For this reason, we do work with a number of companies in the digital health space.



■ DELAWARE TELEHEALTH LEARNING LAB: Webinar Series

 WEDNESDAY, DECEMBER 19
NOON EST

**Introduction to Telehealth and Opportunities
in the Delaware Market**
<https://healthmanagement.zoom.us/j/421874303>

 THURSDAY, JANUARY 10
NOON EST

Digitally Integrated Primary Care and Behavioral Health
<https://healthmanagement.zoom.us/j/715946640>

 WEDNESDAY, JANUARY 16
NOON EST

Additional Technology Enhanced Solutions in Health Care Delivery
<https://healthmanagement.zoom.us/j/343202752>

 FRIDAY, JANUARY 18
NOON EST

Telehealth Reimbursement and Payment Models
<https://healthmanagement.zoom.us/j/368434599>

 TUESDAY, JANUARY 22
NOON EST

**Telehealth Business Plan Development
and Readiness Assessment**
<https://healthmanagement.zoom.us/j/368526663>

 THURSDAY, JANUARY 24
NOON EST

Vendor and Equipment Selection
<https://healthmanagement.zoom.us/j/562927139>

 TUESDAY, JANUARY 29
NOON EST

Use Cases from the Field
<https://healthmanagement.zoom.us/j/733628596>

■ DELAWARE TELEHEALTH LEARNING LAB: Webinar Series



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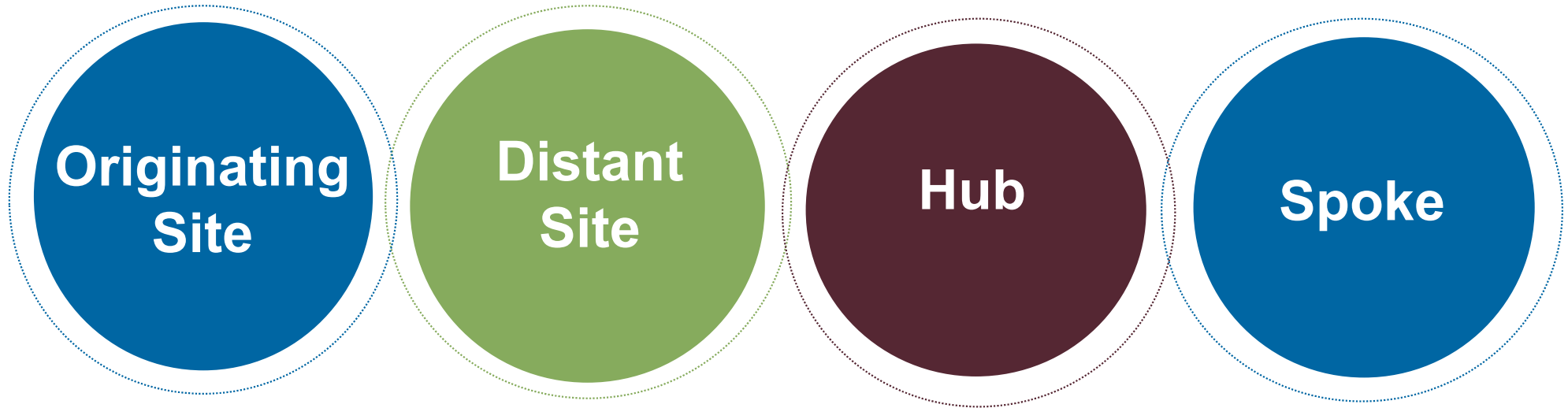


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■ Recap of Terms



More terms available at

<http://thesource.americantelemed.org/resources/telemedicine-glossary>

■ Potential Payers

Medicaid

Medicare

Private
Insurance

Consumers
(self-pay)

■ Medicaid Nationwide

As of Spring 2018:

- All states & DC have some coverage for video encounters
- 15 states cover some store-and-forward
- 20 states cover Remote Patient Monitoring (RPM)
- 9 states cover all 3 with some limitations
- <http://www.cchpca.org/telehealth-medicaid-state-policy>

■ Delaware Medicaid

Eligible **distant** site providers include:

- Inpatient/outpatient hospitals
- Physicians (or PAs under the physician's supervision)
- Certified Nurse Practitioners
- Nurse Midwives
- Licensed Psychologists
- Licensed Clinical Social Workers
- Licensed Professional Counselors of Mental Health
- Speech Language Therapists
- Audiologists
- Other providers as approved by the DMAP

■ Delaware Medicaid (continued)

- Must be enrolled provider
- At a minimum, audio and visual equipment required
- Eff. July 1, 2015, amended the Medicaid State Plan to recognize the Medicaid beneficiary's place of residence as an originating site
- “...the current approach is to cover health services to patients wherever they are, within the state of DE”

(DELAWARE REGISTER OF REGULATIONS, VOL. 19, ISSUE 3, TUESDAY, SEPTEMBER 1, 2015)

■ Private Insurance

DE HB 69

- Sec. 1. Private insurance reimbursement parity
- Sec. 2. Medical Practice Act
- Sec. 3. Patient-provider relationship
- Sec. 4-20 Various professions' language
- Sec. 23 Effective January 1, 2016 – as amended

DE HB 201

- Provided clarification on HB 69



Delaware Regulations



ABOUT ▾

LICENSES ▾

INFORMATION ▾

CONTACT



*** Professions

ALL

HEALTH CARE

COMMERCE

CONSTRUCTION

EVENTS

- Acupuncture
- Acupuncture Detoxification
- Art Therapy
- Athletic Trainers
- Audiology
- Chemical Dependency Professionals
- Chiropractic
- Controlled Substances
- Counselors of Mental Health
- Dental
- Dietitians
- Eastern Medicine
- Genetic Counselors

- Hearing Aid Dispensers
- Marriage and Family Therapy
- Massage and Bodywork
- Medical Practice
- Mental Health
- Midwife (non-Nursing)
- Nursing
- Nursing Home Administrators
- Nutritionist
- Occupational Therapy
- Optometry
- Paramedic
- Pharmacy

- Physical Therapy
- Physician
- Physician Assistant
- Podiatry
- Polysomnographer
- Psychology
- Respiratory Care
- Social Workers
- Speech Pathology
- Tamper-Resistant Prescriptions
- Veterinary Medicine

*** Latest News

<https://dpr.delaware.gov/>

■ DE Professional Associations Regulatory Examples for Telehealth

- Board of Medical Licensure & Discipline
- Board of Mental Health and Chemical Dependency Professionals
- Examining Board of Physical Therapists and Athletic Trainers
- Board of Speech Pathologists, Audiologists, and Hearing Aid Dispensers
- Board of Dietetics/Nutrition

■ Private Insurance



- Legislation (mandate)
 - Non-ERISA
- Voluntary
 - ERISA
- Employee benefits
- Worker's compensation

■ Medicare Reimbursement

- Rural only (i.e., DE not included)
- Only certain services
- Qualified facilities only
- Secondary insurance must comply
- Medicare Advantage exception
- Chronic Care Management (CCM)
- ACOs



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

■ Medicare expanded coverage

1. RPM Reimbursement (eff. Jan. 2018)
2. Expanding telestroke coverage (eff. Jan. 2019)
3. Improving access to telehealth-enabled home dialysis oversight (eff. Jan. 2019)
4. Enabling patients to be provided with free at-home telehealth dialysis technology
5. Allowing Medicare Advantage (MA) plans to include telehealth in basic benefits (public comment 9/2018; eff 2020)
6. ACOs can expand use of telehealth (Next Gen, MSSP Track II, MSSP Track III, and certain two-sided risk models). (Eff. Jan. 2020)

New!

■ Remote Patient Monitoring (RPM)

99091-Previously used to report remote patient monitoring

- “Collection & interpretation of physiologic data (i.e. ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional requiring a minimum of 30 minutes of time”
- Was never a payable service until 2018; was always bundled
- CMS proposed new RPM codes effective 2019

■ RPM Codes effective 1/1/19

- 99453-remote monitoring of physiologic parameter(s) (e.g. weight, BP, pulse ox, respiratory flow rate), initial; set-up & patient education on use of equipment
 - Billed once per patient
- 99454-remote monitoring of physiologic parameter(s) (e.g. weight, BP, pulse ox), initial: device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days
- 99457-remote physiologic monitoring treatment management services 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month

New!



■ RPM FAQ's...

- RPM (99457) billed “incident to” or “general” supervision?
 - CMS has yet to rule on whether 99457 should be billed under general supervision or incident to
 - Does RPM require a face to face exam or interactive audio-video?
 - No interactive audio-video required, as these codes are inherently non face-to face.
 - However, for new patients or patients not seen within 1 year prior to billing RPM, that provider must first conduct a face to face patient visit.
- Must the patient give consent to RPM encounters?
 - Required for 99091 but no direction in the final rule. Stay tuned; get consent to be safe
- Can RPM also be billed with CCM?
 - Yes, both 99457 and 99490 can be billed in the same month. However, billing both requires at least 40 minutes (20 minutes of CCM and 20 minutes of RPM)

■ Potential RPM Reimbursement (approximate)

1st Month

- Set up \$21
- Devices \$69
- Services \$54

TOTAL = \$144



Month 2 and thereafter

- Devices \$69
- Services \$54

TOTAL = \$123

■ More Expanded Coverage

- Brief Communication Technology-based Service, e.g. Virtual Check-in (HCPCS code G2012)
- Remote Evaluation of Pre-Recorded Patient Information (HCPCS code G2010)
- Interprofessional Internet Consultation (CPT codes 99452, 99451, 99446, 99447, 99448, and 99449)
- SUPPORT for Patients and Communities Act services (interim final rule)

New!

■ More about virtual check-ins...

G2012

- A co-pay will be required
- Consent required; verbal consent can be noted in the medical record
- Can only be billed for an established patient
- Only physicians and qualified health care professionals (i.e. NP) may bill
- No frequency limitations
- Patient may be at home and need not be located in a rural area
- Cannot bill if patient was seen within the previous 7 days (considered bundled)

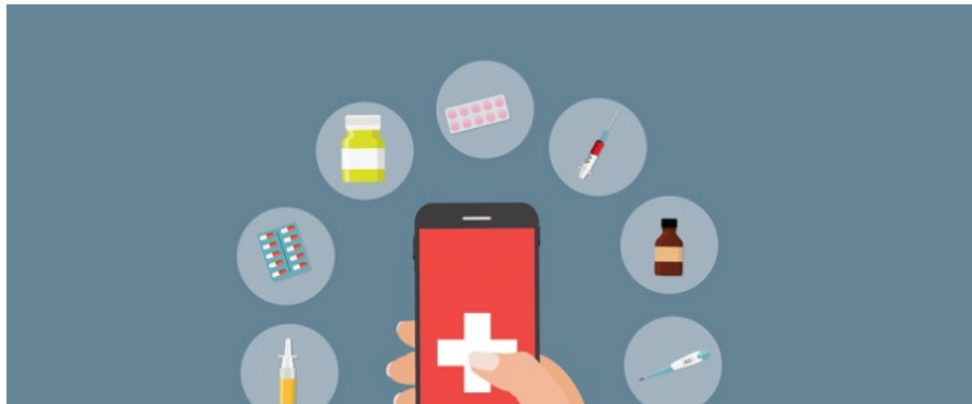
■ Additional Policy News

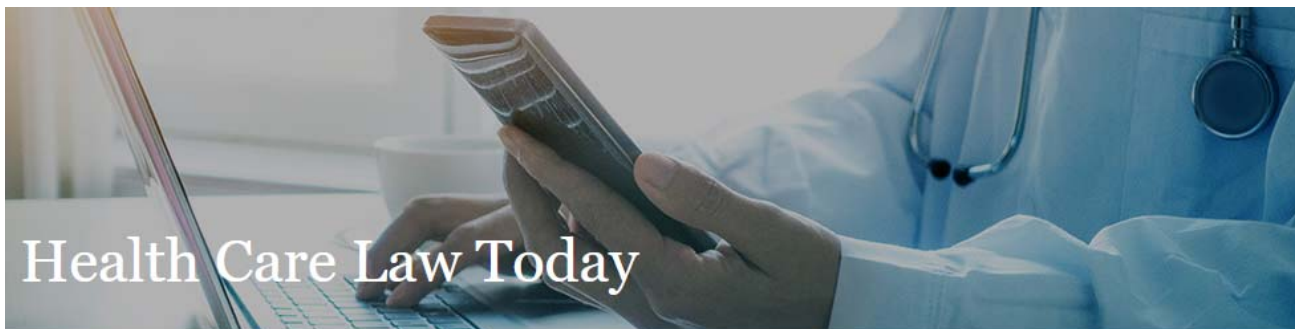


CMS Embraces mHealth With Reimbursement for Smartphone CGM Links

In a ruling announced this week, CMS will reimburse through Medicare for CGM platforms that enable diabetic patients to share data through a smartphone with their care providers.

New!





[Home](#) > [Policy](#) > American Telemedicine Association Letter Offers Recommendations on DEA Special Registration for Telemedicine Prescribing of Controlled Substances

American Telemedicine Association Letter Offers Recommendations on DEA Special Registration for Telemedicine Prescribing of Controlled Substances



POSTED BY NATHANIEL M. LACKTMAN ON 14 JANUARY 2019
POSTED IN [POLICY](#); [TELEMEDICINE & DIGITAL HEALTH](#)

Providing fresh insight and analysis into the ever-changing landscape of health care law

<https://www.healthcarelawtoday.com/2019/01/14/american-telemedicine-association-letter-offers-recommendations-on-dea-special-registration-for-telemedicine-prescribing-of-controlled-substances-2/>

■ 2018 Billing Tips



02 - place of service for telehealth encounters

(See CMS transmittal #3586 and MLN Matters #MM9726)

- Check with payers before using this new POS before implementing

Modifier 95 – indicates a telehealth visit (was GT)

Appendix P

CPT Codes That May Be Used For Synchronous Telemedicine Services

This listing is a summary of CPT codes that may be used for reporting synchronous (real-time) telemedicine services when appended by modifier 95. Procedures on this list involve electronic communication using interactive telecommunications equipment that includes, at a minimum, audio and video. The codes listed below are identified in CPT 2018 with the ★ symbol.

0188T	93271	99233
0189T	93272	99241
90791	93298	99242
90792	93299	99243
90832	96040	99244
90833	96116	99245
90834	96150	99251
90836	96151	99252
90837	96152	99253
90838	96153	99254
90845	96154	99255
90846	97802	99307
90847	97803	99308
90863	97804	99309
90951	98960	99310
90952	98961	99354
90954	98962	99355
90955	99201	99406
90957	99202	99407
90958	99203	99408
90960	99204	99409
90961	99205	99495
92227	99212	99496
92228	99213	
93228	99214	
93229	99215	
93268	99231	
93270	99232	

▲ = Revised code ● = New code ▶ ◀ = Contains new or revised text Ⓢ = Modifier 51 exempt

American Medical Association



THE OFFICIAL NEWSMAGAZINE OF THE AMERICAN ACADEMY OF PEDIATRICS

AAP News

News Articles, Administration/Practice Management, Telehealth Care, Coding Corner

CPT manual lists 79 codes that can be billed if telemedicine used

by Peter J. Dehnert M.D., FAAP

After a long period of what seemed to be little headway in the ability to use Current Procedural Terminology (CPT) codes to bill for telemedicine services, progress has been made.

The 2017 CPT manual has a new Appendix P that lists 79 standard CPT codes for which a "95" modifier can be used to indicate that the service was provided via a real-time, interactive audio and video telecommunications system. A number of these codes are used daily in most pediatric practices. For example, the list includes the commonly used office or other outpatient evaluation and management (E/M) codes for new patient (99201-99205) and established patient visits (99212-99215). A variety of consultation codes are included as well, e.g., 99241-99245. Finally, behavioral health codes also are on the list, e.g., behavioral change intervention codes 99406-99408.

If you are going to start or expand your billing for telemedicine services, it is important to keep a number of considerations in mind. Each CPT code has required elements (e.g., key components or time) that you need to document for your encounter. If it is not documented, then it did not happen and you will be at risk if your services are audited.

Time spent in direct counseling and/or coordination of care with the patient/caregiver that is greater than 50% of the total time of an E/M service can be used to justify a given CPT code. However, you must document total time and percent spent in counseling and/or coordination of care in the patient record. Since time can be

■ Additional billing code – Originating Site

- Professional service claims (1500 form) should be billed with Q3014 indicating the telehealth originating site fee.
Place of service = 11
 - Modifier GT or 95 is not applicable when billing this code
- Outpatient facility claims (UB-04) should also bill with Q3014 and revenue code 780

■ Coding Examples

Service	HCPCS Level II	CPT
Office or other outpatient Consultations, outpatient		99201-99215 99241-99245
Emergency department, Inpatient consults	G0425-G0427 (Health Options, Aetna & Unison)	99281-99285 99251-99255
Critical Care	0188T, 0189T (Aetna & Health Options)	99291, 99292
Subsequent hospital visits		99231-99233
Subsequent nursing care		99307-99310
Diabetes self-management	G0108-G0109	
Individual psychotherapy		90832-90834 90836-90838
Neurobehavioral status exam		96116
Home visits		99347-99350
Nutritional counseling		97802-97804

■ Use case coding example...

A child is seen at her pediatrician's office for a consult with a pediatric rheumatologist located 30 miles away. Lab and imaging studies were previously transmitted to the rheumatologist. A nurse at the pediatrician's office assists the patient and rheumatologist as needed during the consult. The rheumatologist spends 35 minutes in a 2-way, real time video conversation with the patient and family. Following the encounter, the rheumatologist completes the documentation and forwards a copy to the patient's pediatrician.

The rheumatologist submits a claim for:

99242 95 office consultation for a new or established patient (reported based on 35 minutes time spent counseling & coordinating care) via interactive audio & video telecommunications system

If the payer pays the originating site for the overhead expenses of this service, the p pediatrician may submit the following code

Q3014 telehealth originating site facility fee

■ Documentation Tips

Avoid copy and paste	<p>Your note should reflect the reality of the visit for that day.</p> <p>Document the exam you actually performed; this is critical for a telemedicine visit.</p> <p>If copied forwarded or templated, review the exam closely and make corrections to items you did not perform.</p>
Documentation of time	<p>RN's time to room the patient or review instructions with the patient is not counted towards the visit time.</p> <p>Only the physician's face-to-face time should be documented and counted for billing purposes.</p>

■ Telehealth Medical Record Audits Findings

- Level of service not supported
 - Levels 4 & 5 required comprehensive exam and high level medical decision making
- Billing based on time...be cautious!
- Patient needs to be present
 - Ex: Claim billed-only ortho, PT and parents were present



■ Denial Challenges...

■ Home visits

- Billing home E/M (99347-99349) with POS 02 based on the location of the patient; Highmark commercial is paying, Highmark Health options is denying .
- Not all payers are currently processing the 02 POS
- ICD-10 denials due to the usage of an unspecified code
- Q3014 denials indicating “not a covered benefit”



■ Watch for these denial edits...

- Services reported with POS 02, but no 95 modifier
 - Claim adjustment reason code (CARC) 4 “procedure code is inconsistent with the modifier used or a required modifier is missing.”
 - Remittance advice remarks code (RARC) MA130 “your claim contains incomplete and/or invalid information and no appeal rights are afforded because the claim is un-processable. Please submit a new claim with complete/correct information.”
- Conversely, a claim with modifier 95 but no POS 02
 - CARC 5 “procedure code/bill type is inconsistent with the place of service.”
 - RARC M77 “missing/incomplete/invalid/inappropriate place of service.”



Compliance Update: April 13, 2018

OIG Finds Practitioners Paid for Telehealth Services That Did Not Meet Medicare Requirements

Report from OIG Posted today April 13, 2018

Today the Office of Inspector General (OIG) announced finding that Medicare paid distant-site telehealth claims, totaling \$13.8 million, that did not have corresponding originating-site claims.

The OIG estimated that Medicare could have saved approximately \$3.7 million if practitioners had provided telehealth services in accordance with Medicare requirements. The deficiencies identified by the OIG auditors

What's next...follow up audit and possibly a Medicaid claims audit in 2019

■ Watch for Five common claims shortcomings –

Make sure you follow these requirements

- ✓ Provider is an eligible telehealth provider type
- ✓ An interactive audio & video device that supports real time communication is used
- ✓ The procedure code is listed as a covered telehealth service
- ✓ Documentation supports the telehealth encounter
- ✓ Informed consent is present in the medical record

■ Barriers and Challenges

- Limited Medicare coverage in the state
 - Understanding what is covered and what is not
 - Patients/clients spanning all age groups
- Private insurance – large self-insured employers
- Billing, coding and denial conundrums



■ The future...value-based healthcare

“Value-based healthcare is a healthcare delivery model in which providers, including hospitals and physicians, are paid based on patient health outcomes. Under value-based care agreements, providers are rewarded for helping patients improve their health, reduce the effects and incidence of chronic disease, and live healthier lives in an evidence-based way.”

-NEJM Catalyst

<https://catalyst.nejm.org/what-is-value-based-healthcare/>

■ Putting it all together...

- Determine local payer guidelines for coverage including the required technology
- Review any applicable state & federal regulatory guidance, including patient education & consent, privacy and security requirements
- Document the service as if provided in person, including important billing elements such as total face-to-face time
- Report the appropriate codes per individual payor policies

Questions? Comments?



Thank you!

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■ NEXT STEPS

- Contact us to get on our list for future webinar invites.
- Reach out to the speakers to request additional assistance.
- Look for a follow-up email:
 - Provide input for this and future sessions using the evaluation form.
 - Check the website for the webinar recording – coming soon.
- Save the dates future webinars.
 - **Telehealth Business Development and Readiness Assessment**
 - *Tuesday, January 22, Noon EST*
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Thank you!
