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Meet the Presenter…

On the topic:
Telemedicine 2016 and Beyond

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Telemedicine 2016 and Beyond

Presented by:
Pam Joslin
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Agenda

• Introduction
• Telehealth/Telemedicine Terminology
• Telehealth/Telemedicine Services/Delivery Mechanisms
• Telehealth/Telemedicine Pros and Cons
• Telehealth Coding and Billing
• Future Growth for Telehealth
• Tips, Tools, and Techniques
Introduction

- 87% of Americans now have health insurance, overwhelming co-pays, high deductibles and a lack of primary care doctors still stand in the way of healthcare for many.
- 40% of Americans cannot afford an average $2,000 deductible for an individual.
- 35% of Americans already struggle with medical debt despite that 70% of those struggling have insurance.
- By 2025, the United States faces a potential physician shortage of as many as 52,000.

(Frist, 2015)
Introduction (cont’d)

• For many, new health insurance is not providing access to affordable care, and the ACA will not address the physician shortage.

• To bridge that gap, we must find innovative ways to facilitate hassle free access to a provider that is more –cost-effective.

• Telemedicine is a growing model that is a part of the answer.

(Frist, 2015)

According to Forbes…

“Data show that telemedicine can deliver quality outcomes comparable to in person office visits. A 2011 Center for Disease Control study showed 80% of adults discharged from the emergency room – meaning patients who could be treated and sent home – said they sought care at the ER due to lack of access to a primary care provider (PCP).

However, the ER is also the most expensive and least efficient way to provide non-emergent care, costing from $1,500 to $3,000 on average compared to $130 to $190 for a PCP visit. A telemedicine visit can cost as little as $40.”

(Frist, 2015)
What Is Telehealth?

The Health Resources Services Administration defines telehealth as the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration.

Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

(HealthIT, 2014)
What Is Telemedicine?

Formally defined, **telemedicine** is the use of medical information exchanged from one site to another via electronic communications to improve a patient’s clinical health status.

Telemedicine includes a growing variety of applications and services using two-way video, email, smart phones, wireless tools, and other forms of telecommunications technology.

(American Telemedicine, n.d.)

What Is the Difference?

**Telehealth** is different from **telemedicine** because it refers to a *broader scope of remote healthcare services* than telemedicine.

While telemedicine refers specifically to remote clinical services, telehealth can refer to remote non-clinical services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services.

(HealthIT, 2014)
What Is the Difference?

Essentially, Telemedicine, or “telehealth,” is the provision of remote access to a physician via phone or videoconference to address a health care issue.

It’s not a new concept. It’s well-established in rural areas for specialty consultations, and has been widely used in many primary care practice, like pediatrics as a practical matter.

(Frist, 2015)

• Telehealth is gaining ground as an alternative to urgent care or the emergency department for more minor concerns like ear infections and colds.

• For example: Blue Cross Blue Shield of Massachusetts announced that it is offering video visits to patients within two physician groups. BCBSMA Director of Network Innovation, Greg LeGrown told MobiHealthNews that video visits have the potential to improve cost, access, quality, efficiency, as well as patient and physician satisfaction.

(Frist, 2015)
Telemedicine Terms

• **Distant or Hub site**
  – Site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system

• **Originating or Spoke site**
  – Location of the Medicaid patient at the time the service being furnished via a telecommunications system occurs

• **Asynchronous or “Store and Forward”**
  – Transfer of data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation

• **Medical codes**
  – States may select from a variety of HCPCS codes (T1014 and Q3014), CPT codes and modifiers (GT, U1-UD) in order to identify, track and reimburse for telemedicine services

(Healthcare Provider, n.d.)

For the purposes of this presentation, **telehealth** and **telemedicine** will be used interchangeably.
More Clarification

Telemedicine is not a separate medical specialty.

Products and services related to telemedicine are often part of a larger investment by healthcare institutions in either information technology or the delivery of clinical care.

There is usually no difference made between services provided on site and those provided through telemedicine. Most often, no separate coding required for billing of remote services in regards to the reimbursement fee structure.

(American Telemedicine, n.d.)
What Services Can Be Provided by Telemedicine?

• Primary care and specialist referral services
• Remote patient monitoring
• Consumer medical and health information
• Medical education

What Delivery Mechanisms Can Be Used?

• Networked programs
• Point-to-point connections
• Monitoring center links
• Web-based e-health patient services sites
TELEHEALTH PROS AND CONS

Telemedicine: Pros

✓ Convenience & Accessibility
  – Has convenient access to health management services
  – Allows more connection between patients and providers through various means of communication

✓ Less waiting time
  – Has health history more readily available for patient registration

✓ Cost-efficiency
  – Reduces healthcare costs significantly overall through remote analysis and monitoring services and electronic data storage
  – Reduces travel expenses

(Harper, 2012)
(eVisit, n.d.)
Telemedicine: Pros

✅ Better patience care quality
  – Expedites transmission of MRIs or X-rays for a second opinion
  – Allows health care to be issues addressed quickly with real-time urgent care consultations

✅ Privacy assurance
  – Complies with HIPAA laws

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(Harper, 2012)
(eVisit, n.d.)

Telemedicine: Cons

❌ Electronic glitches
  – Outages and disruptions during inclement weather and other annoyances

❌ Technical training and equipment
  – Takes time and money to buy and install equipment and train physicians

❌ Physician resistance
  – May have doctors struggling with new technology

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(Harper, 2012)
(eVisit, n.d.)
## Telemedicine: Cons

- **Inadequate assessment**
  - Cannot physically touch or feel the patient to assess condition
- **Reduction in care continuity**
  - Offers patients to connect with random, unfamiliar physicians
- **Tricky policies and reimbursement rules**
  - Causes struggles with healthcare laws, reimbursement policies, and privacy protection laws
  - May require legal advice before applying new technology

(Harper, 2012)
(eVisit, n.d.)
Reimbursement for Telemedicine

• Reimbursement for Medicaid-covered services must satisfy federal requirements of efficiency, economy, and quality of care.

• States are encouraged to use the flexibility inherent in federal law to create innovative payment methodologies for services that incorporate telemedicine technology.

• States can also reimburse any additional costs such as technical support, transmission charges, and equipment. These add-on costs can be incorporated into the fee-for-service rates or separately reimbursed as an administrative cost by the state. If they are separately billed and reimbursed, the costs must be linked to a covered Medicaid service.

(Health Care Financing Administration, n.d.)

Telehealth

• CMS has added new CPT codes to the list of services covered if furnished via telehealth. For 2016, CMS has added the following:
  – 99356 and 99357 for prolonged inpatient or observation care.
  – 90963 through 90966 for services related to home dialysis for patients with end-stage renal disease.

• CMS also has added certified registered nurse anesthetists to the list of qualified telehealth providers for healthcare services.

• Beyond these minor changes, Medicare reimbursement for telehealth services remains strictly limited by statutory requirements.

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Telehealth

Medicare pays for a limited number of Part B services furnished by a physician or practitioner to an eligible beneficiary via a telecommunications system.

For eligible telehealth services, the use of a telecommunications system substitutes for an in-person encounter.

Telehealth: Originating Sites

Medicare beneficiary at the time the service furnished via a telecommunications system occurs. Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in:

- A rural Health Professional Shortage Area (HPSA) located either outside of a Metropolitan Statistical Area (MSA) or in a rural census tract; or
- A county outside of a MSA.

(CMS, 2014)
Telehealth: Originating Sites

The Health Resources and Services Administration (HRSA) determines HPSAs, and the United States (U.S.) Census Bureau determines MSAs.

You can access HRSA's website tool to determine a potential originating site's eligibility for Medicare telehealth payment at: http://www.cms.gov/Medicare/Medicare- General-Information/Telehealth on the Centers for Medicare & Medicaid Services (CMS) website.

(CMS, 2014)

Telehealth: Originating Sites

Entities that participate in a Federal telemedicine demonstration project approved by (or receiving funding from) the Secretary of the Department of Health and Human Services as of December 31, 2000, qualify as originating sites regardless of geographic location.

Each CY, the geographic eligibility of an originating site is established based on the status of the area as of December 31st of the prior calendar year, and such eligibility continues for the full CY

(CMS, 2014)
Telehealth: Originating Sites

The originating sites authorized by law are:

• The offices of physicians or practitioners;
• Hospitals;
• Critical Access Hospitals (CAH);
• Rural Health Clinics;
• Federally Qualified Health Centers;
• Hospital-based or CAH-based Renal Dialysis Centers (including satellites);
• Skilled Nursing Facilities (SNF); and
• Community Mental Health Centers (CMHC).

Note: Independent Renal Dialysis Facilities are not eligible originating sites.

(CMS, 2014)

Telehealth: Distant Site Practitioners

Practitioners at the distant site who may furnish and receive payment for covered telehealth services (subject to State law) are:

• Physicians;
• Nurse practitioners (NP);
• Physician assistants (PA);
• Nurse-midwives;
• Clinical nurse specialists (CNS);
• Certified registered nurse anesthetists;
• Clinical psychologists (CP) and clinical social workers (CSW). CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838; and
• Registered dietitians or nutrition professionals.

(CMS, 2014)
Telehealth: Services

As a condition of payment, you must use an interactive audio and video telecommunications system that permits real-time communication between you, at the distant site, and the beneficiary, at the originating site.

Asynchronous “store and forward” technology is permitted only in Federal telemedicine demonstration programs conducted in Alaska or Hawaii.

The chart in the next few slides provides the CY 2015 list of Medicare telehealth services.

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<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>HCPCS codes G0425–G0427</td>
</tr>
<tr>
<td>Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs</td>
<td>HCPCS codes G0406–G0408</td>
</tr>
<tr>
<td>Office or other outpatient visits</td>
<td>CPT codes 99201–99215</td>
</tr>
<tr>
<td>Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days</td>
<td>CPT codes 99231–99233</td>
</tr>
<tr>
<td>Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days</td>
<td>CPT codes 99307–99310</td>
</tr>
<tr>
<td>Individual and group kidney disease education services</td>
<td>HCPCS codes 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>HCPCS codes G0108 and G0109</td>
</tr>
<tr>
<td>Individual and group health and behavior assessment and intervention</td>
<td>CPT codes 96150–96154</td>
</tr>
<tr>
<td>Individual psychotherapy</td>
<td>CPT codes 90832–90834 and 90836–90838</td>
</tr>
</tbody>
</table>
### CY2015 Medicare Telehealth Services

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<thead>
<tr>
<th>Service</th>
<th>HCPCS/ CPT Code</th>
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<tbody>
<tr>
<td>Telehealth Pharmacologic Management</td>
<td>HCPCS code G0459</td>
</tr>
<tr>
<td>Psychiatric diagnostic interview examination</td>
<td>CPT codes 90791 and 90792</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment</td>
<td>CPT codes 90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961</td>
</tr>
<tr>
<td>Individual and group medical nutrition therapy</td>
<td>HCPCS code G0270 and CPT codes 97802–97804</td>
</tr>
<tr>
<td>Neurobehavioral status examination</td>
<td>CPT code 96116</td>
</tr>
<tr>
<td>Smoking cessation services</td>
<td>HCPCS codes G0436 and G0437 and CPT codes 99406 and 99407</td>
</tr>
<tr>
<td>Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services</td>
<td>HCPCS codes G0396 and G0397</td>
</tr>
<tr>
<td>Annual alcohol misuse screening, 15 minutes</td>
<td>HCPCS code G0442</td>
</tr>
<tr>
<td>Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes</td>
<td>HCPCS code G0443</td>
</tr>
<tr>
<td>Annual depression screening, 15 minutes</td>
<td>HCPCS code G0444</td>
</tr>
</tbody>
</table>

### CY2015 Medicare Telehealth Services

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<tr>
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<tbody>
<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>HCPCS code G0445</td>
</tr>
<tr>
<td>Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes</td>
<td>HCPCS code G0446</td>
</tr>
<tr>
<td>Face-to-face behavioral counseling for obesity, 15 minutes</td>
<td>HCPCS code 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>CPT code 99495</td>
</tr>
<tr>
<td>Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)</td>
<td>CPT code 99496</td>
</tr>
<tr>
<td>Psychoanalysis (effective for services furnished on and after January 1, 2015)</td>
<td>CPT codes 90845</td>
</tr>
<tr>
<td>Family psychotherapy (without the patient present) (effective for services furnished on and after January 1, 2015)</td>
<td>CPT code 90846</td>
</tr>
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## CY2015 Medicare Telehealth Services

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</thead>
<tbody>
<tr>
<td>Family psychotherapy (conjoint psychotherapy) (with patient present)</td>
<td>CPT code 90847</td>
</tr>
<tr>
<td>(effective for services furnished on and after January 1, 2015)</td>
<td></td>
</tr>
<tr>
<td>Prolonged service in the office or other outpatient setting requiring</td>
<td>CPT code 99354</td>
</tr>
<tr>
<td>direct patient contact beyond the usual service; first hour (effective</td>
<td></td>
</tr>
<tr>
<td>for services furnished on and after January 1, 2015)</td>
<td></td>
</tr>
<tr>
<td>Prolonged service in the office or other outpatient setting requiring</td>
<td>CPT code 99355</td>
</tr>
<tr>
<td>direct patient contact beyond the usual service; each additional 30</td>
<td></td>
</tr>
<tr>
<td>minutes (effective for services furnished on and after January 1, 2015)</td>
<td></td>
</tr>
<tr>
<td>Annual Wellness Visit, includes a personalized prevention plan of</td>
<td>HCPCS code G0438</td>
</tr>
<tr>
<td>service (PPPS) first visit (effective for services furnished on and</td>
<td></td>
</tr>
<tr>
<td>after January 1, 2015)</td>
<td></td>
</tr>
<tr>
<td>Annual Wellness Visit, includes a personalized prevention plan of</td>
<td>HCPCS code G0439</td>
</tr>
<tr>
<td>service (PPPS) subsequent visit (effective for services furnished on</td>
<td></td>
</tr>
<tr>
<td>and after January 1, 2015)</td>
<td></td>
</tr>
</tbody>
</table>

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## Telehealth: Billing and Payment for Professional Services Furnished

You should submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GT, “via interactive audio and video telecommunications systems” (for example, 99201 GT).

By coding and billing the GT modifier with a covered telehealth procedure code, you are certifying that the beneficiary was present at an eligible originating site when you furnished the telehealth service.

By coding and billing the GT modifier with a covered ESRD-related service telehealth code, you are certifying that you furnished one “hands on” visit per month to examine the vascular access site.  

(CMS, 2014)  

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Telehealth: Billing and Payment for Professional Services Furnished

For Federal telemedicine demonstration programs conducted in Alaska or Hawaii, you should submit claims using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GQ if you performed telehealth services “via an asynchronous telecommunications system” (for example, 99201 GQ).

By using the GQ modifier, you are certifying that the asynchronous medical file was collected and transmitted to you at the distant site from a Federal telemedicine demonstration project conducted in Alaska or Hawaii.

(CMS, 2014)

Telehealth: Billing and Payment for Professional Services Furnished

You should bill the Medicare Administrative Contractor (MAC) for covered telehealth services. Medicare pays you the appropriate amount under the Medicare Physician Fee Schedule (PFS) for telehealth services.

When you are located in a CAH and have reassigned your billing rights to a CAH that has elected the Optional Payment Method, the CAH bills the MAC for telehealth services and the payment amount is 80 percent of the Medicare PFS for telehealth services.

(CMS, 2014)
Telehealth: Billing and Payment for the Originating Site Facility Fee

Originating sites are paid an originating site facility fee for telehealth services as described by HCPCS code Q3014. You should bill the MAC for the originating site facility fee, which is a separately billable Part B payment.

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

(CMS, 2014)
Future Growth for Telehealth

- Various market research organizations peg the telehealth market growth rate between 18-30 percent per year.

- According to Ken Research, in 2013 the market for telehealth generated annual revenue of $9.6 billion, which is 60 percent growth from 2012 when overall revenue was $6 billion.

- Their research shows that the telehealth market is expected to grow to $38.5 billion in revenue by 2018, a compound annual growth rate of 32 percent from 2013-2018.

Why the Rapid Growth?

There are several factors contributing to this rapid growth:

1. Telehealth is delivering results for patients and saving money.

2. Patient satisfaction with telehealth is very high.

3. Consumers are demanding more convenient high-quality care, which today’s telehealth providers are delivering.
Employer Opportunities

In the employer market, according to Towers Watson:

- 37% of employers surveyed in 2014 said that by this benefit year (2015) they expect to offer their employees a telemedicine benefit “as a low-cost alternative to emergency room or physician office visits for nonemergency health issues.”
- 68% increase from 2014 when 22% of employers offered the benefit.
- Another 34% are considering telemedicine for 2016 or 2017.

(Drobac, n.d.)

Tools, Tips, and Techniques

- Look at current patient services and opportunities to provide with telehealth
- Research opportunities to reach beyond your usual practice boundaries to provide care with telehealth.
- Contact telehealth vendor for instructions on HIPPA compliant environment to provide services.
- Train staff appropriately and make available to your patient population and BEYOND…
- Enjoy the new opportunities to provide quality, low-cost care to your patients!!!

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References


Frist, B. (2015, March 12). Telemedicine is a game-changer for patients, the system. Retrieved February 2, 2016, from http://www.forbes.com/sites/billfrist/2015/03/12/telemedicine-is-a-game-changer-for-patients-the-system/#45bc71f8e301


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• Contact information: pjoslin@pmimd.com