Telemedicine Research and Opportunities for Family Practice Physicians

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Disclosure

The author is the founder of a telemedicine software company. Otherwise, there are no financial relationships with commercial interests to disclose.
Objectives

Upon completion of this session, the participant should be able to:

1. Understand the relationship between physician shortages in the U.S. and telehealth adoption
2. Describe legal, ethical, and reimbursement concepts related to telemedicine.
3. Describe COVID 19 specific telemedicine changes for reimbursement.

What is Telemedicine

TRANSMISSION OF PATIENT DATA ACROSS DISTANCE

4 Basic Types
- Live video conferencing
- Store and forward
- Health applications on smart phones
- Remote patient monitoring

Examples
- InTouch, Teledoc, Telepsychiatry
- Dermatology
- AliveCor (Mobile ECG)
- CHF post-discharge monitoring
What is Driving Telemedicine

- Improved Outcomes
- Reduced Costs

Enablers
- Growth of Broadband Services
- Growth of Mobile Technology/5G
- Growth of Tech Savvy Customers
- 3rd Party Reimbursement
- Remote patient monitoring
- Clinician Shortage
- Grant Funding
- Patient Satisfaction
- Health Outcomes

What is Driving Telemedicine Today

- Improved Outcomes
- Reduced Costs
- COVID 19 and the 1135 Waiver
Is Telehealth the Answer?

No

But it can be part of the solution

Ryan Haight Act

✓ According to HHS, where controlled substances are prescribed by means of the Internet, requirement is that the clinician must have conducted at least one in-person medical evaluation of the patient. U.S.C. § 829(e).

✓ However, the Act provides an exception to this requirement. 21 USC § 829 (e)(3)(A).

✓ A DEA-registered Practitioner acting within the US is exempt from an in-person medical evaluation as a prerequisite to prescribing if:
  • the Practitioner is engaged in the practice of telemedicine and
  • is acting in accordance with the requirements of 21 U.S.C. § 802(54). (patient in a hospital or a DEA registered outpatient clinic).

HealthCare Industry

- Number of physicians is no longer keeping up with population growth just as more demand is placed on the system by an aging baby-boomer population (Lakhan & Laird, 2009)
- Physician baby boomers retiring and younger physicians prefer not to work the number of hours their predecessors did (Coile, 2003; Cooper, Getzen, McKee, & Laud, 2002; MAG, 2008; Merrit, Hawkins, & Miller, 2004)

Telemedicine Outcomes

- Telemedicine physicians were confident they identified patients’ real concerns, got the pertinent physical exam information, and appropriately treated patients’ problems (4.66 on a 5 point scale) (Young & Ireson, 2003)
- Teledoc prescribers ordered fewer diagnostic tests and had poorer performance in appropriate antibiotic treatment vs face-to-face. [Link](http://online.liebertpub.com/doi/abs/10.1089/tmj.2015.0079) (2015)
Telemedicine Outcomes


- Telemedicine greatly improves diabetic treatment results over traditional care ([Izquierdo et al., 2009](#))

- 98% of the medical telemedicine consults required no follow up exams and 92% of patients would use the system again ([Young & Ireson, 2003](#))

HealthCare Industry
1st Quarter 2019 Report from the Center for Connected Health Policy:

50 survey of state telehealth laws and Medicaid program policies key findings:

- **50 states and Washington, DC** provide reimbursement for live video Medicaid (increased by one state since Fall 2018).
- **11 states** provide reimbursement for store-and-forward. No change since Fall 2018.
- **21 state Medicaid programs** provide reimbursement for remote patient monitoring (RPM). No change.
- **23 states** limit the type of facility that can serve as an originating site. No change.


1st Quarter 2019 Report from the Center for Connected Health Policy (continued):

50 survey of state telehealth laws and Medicaid program policies key findings:

- **34 state Medicaid programs** offer a facility fee when telehealth is used. No change.
- **39 states and DC** currently have a law that governs private payer telehealth reimbursement policy. No change.
- **14 states** allow the home as an eligible originating site, an increase of four states since Fall 2018.

Traditional Requirements for Payment for Telehealth:

CMS has required the patient be located in a CMS approved facility and be in a designated rural and underserved area

• Facilities could be a physician office, rural hospital, critical access hospital, etc.

• Best way to identify whether the location is rural and qualifies was to go to https://data.hrsa.gov/tools/shortage-area/hpsa-find

• Visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.

Billing for Telehealth Services:

In 2019, Medicare started making payment for brief communications or Virtual Check-Ins.

• Could not be within 24 hours of an office visit
• Done over the phone typically
• Medicare Part B separately pays clinicians for E-visits, which are non-face-to-face patient-initiated communications through an online patient portal.
Traditional Requirements for Payment for Telehealth 2020:

**New CPT® codes for online digital E/M**

**99421** Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 5-10 minutes

**99422** 11—20 minutes

**99423** 21 or more minutes

These codes are for use when E/M services are performed, of a type that would be done face-to-face, through a HIPAA compliant secure platform. These are for **patient-initiated communications**, and may be billed by clinicians who may independently bill an E/M service. They may not be used for work done by clinical staff or for clinicians who do not have E/M services in their scope of practice.

### Traditional Requirements for Payment for Telehealth 2020:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>National non-facility payment</th>
<th>National facility payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>99421</td>
<td>Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes</td>
<td>$15.52</td>
<td>$13.35</td>
</tr>
<tr>
<td>99422</td>
<td>11-20 minutes</td>
<td>$31.04</td>
<td>$27.43</td>
</tr>
<tr>
<td>99423</td>
<td>21 or more minutes</td>
<td>$50.16</td>
<td>$43.67</td>
</tr>
<tr>
<td>G2061</td>
<td>(Qualified non-physician health care professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes)</td>
<td>$12.27</td>
<td>$12.27</td>
</tr>
<tr>
<td>G2062</td>
<td>11-20 minutes</td>
<td>$21.65</td>
<td>$21.65</td>
</tr>
<tr>
<td>G2063</td>
<td>21 or more minutes</td>
<td>$33.92</td>
<td>$33.56</td>
</tr>
</tbody>
</table>

Billing for Telehealth Services:

CPT codes 99201-99215

- Most common codes are similar for telemedicine (99211, 99212, 99213).
- 99213 could be billed through a video conference:
  - Expanded Problem Focused History
  - Expanded Problem Focused Exam
  - Low Complexity Medical Decision Making
  OR
  - 15 minutes spent face to face with the patient if coding based on time

GT MODIFIER:
- In 2018, CMS replaced the GT modifier with POS 02. Some private payers still recognize and prefer the GT modifier.

MODIFIER 95:
- Modifier 95 is a fairly new modifier and used when billing to private payers to indicate services were rendered via synchronous telecommunication.

PLACE OF SERVICE 02:
- According to CMS, POS 02 is defined as “the location where health services and health-related services are provided or received, through a telecommunication system.”
- CMS has replaced the GT modifier with POS 02. POS 02 can be used when billing CMS claims for synchronous telemedicine visits.
How does a qualified provider bill for telehealth services?:

• Medicare telehealth services are generally billed as if the service had been furnished in-person. For Medicare telehealth services, the claim should reflect the designated Place of Service (POS) code02-Telehealth, to indicate the billed service was furnished as a professional telehealth service from a distant site.

How much does Medicare pay for telehealth services?

• Medicare pays the same amount for telehealth services as it would if the service were furnished in person.


Life After Emergency Declaration COVID 19

Waiver 1135

• Medicare can pay for office, hospital, and other visits furnished via telehealth across the country and including in patient’s places of residence starting March 6, 2020.
• Doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to their patients.
• You can bill for service through telehealth including evaluation and management visits (common office visits), mental health counseling and preventive health screenings.
Waiver 1135

- The provider must use an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient at home.
- Eligible clinicians:
  - physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals.
- Ryan Haight Act:
  - To the extent the waiver (section 1135(g)(3)) requires that the patient have a prior established relationship with a particular practitioner, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency. [https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet](https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet)

How is telehealth different from virtual check-ins and e-visits?

- A virtual check-in pays professionals for brief (5-10 min) communications that mitigate the need for an in-person visit, whereas a visit furnished via Medicare telehealth is treated the same as an in-person visit, and can be billed using the code for that service.

Will CMS require specific modifiers to be applied to the existing codes typical of family practice physicians?

- CMS is not requiring additional or different modifiers associated with telehealth services furnished under these waivers.

Changes in Telehealth Coverage with COVID 19

Medicare reimburses telemedicine services at the same rate as the comparable in-person medical service, based on the current Medicare physician fee schedule. Plus, the facility serving as the originating site can charge an additional facility fee.

Medicaid

In response to the COVID-19 State of Emergency, the Department of Community Health is waiving certain policies. Expansion of the use of telehealth will be supported in the following manner:

- Waving the telehealth services originating site limitations. Originating sites are listed below.

- Allowing telehealth services to be provided during the period of COVID-19 emergency response by the following modalities:
  - Telephone communication
  - Use of webcam or other audio and video technology
  - Video cell phone communication

- Originating site can be a member’s home.
Medicaid

During the period of COVID-19 emergency response, providers should make every effort to ensure that communication is secure and that HIPPA requirements are met for the privacy and confidentiality of Medicaid members.

The patient must initiate the service and provide consent to be treated virtually, and the consent must be documented in the medical record with date, time and consenting/responsible party before initiation of the service;

The codes that will be billed must be identified as “telehealth services” by utilizing a telehealth Place of Service (POS) code or a telehealth modifier (e.g., GT).

- For example, evaluation and management (E/M) codes must have a telehealth Place of Service (POS) code. Other codes may have a modifier. The codes and modifiers are identified in the Telehealth Guidance which is located on the GAMMIS website. Providers may locate the Telehealth Guidance manual by accessing the following link: www.mmis.georgia.gov.
Extra Slides for Potential Questions

Ensure Privacy
- no one other than you can see the patient on the screen.

Work the same way you do when seeing patients in the office –
- schedule telehealth patients interspersed with traditional patients
- MAs get patients online before you get to the appointment. If patients are unable to figure out software, give up quickly and have them come in.

Sit back from screen so they see your shoulders and head.
Community Challenges

✓ Psychiatrist are in short supply, and the shortage is worsening as they age and retire more heavily than other medical disciplines. (Center for Workforce Studies, 2012)

✓ Currently the oldest physician demographic and have seen a significant drop in those younger than 40 years of age (from 24% under 40 in 1989 to only 8% under 40 in 2002)

✓ Child and Adolescent Psychs are in critical shortage
**Telemedicine Adherence and Outcome Study**

Study of treatment adherence and longitudinal outcomes in patients with a serious mental illness by using telemedicine

✓ Medication side effects 50% lower
✓ Medication adherence was 3 times greater
✓ 50% decrease in psychiatric hospitalizations
✓ Patient treatment satisfaction 4 times higher


**COLLABORATIVE CARE RESEARCH**

Medical inpatients with behavioral health diagnoses

✓ 35-50% of all inpatients have psychiatric diagnoses (both known and unknown) and most are not detected by hospitalists (Kishi et al. 2004, Desan et al. 2011)
✓ Even mild psychiatric diagnoses demonstrate significant increases in LOS Bourgeois et al 2005 and Gater et al. 2005
✓ 2.6 times more likely to be readmitted Burke, 2013
✓ After Discharge – for every day patients that are unable to see a psych, no-show rates increase by 12% and will be 2x more likely to be readmitted (Nelson, Maruish, Axler, 2010)
Collaborative Care Models

Medical inpatients with behavioral health diagnoses
✓ The earlier psych eval the shorter the length of stay (Laderman, 2016)
✓ When psychiatrists review admits with hospitalists, LOS decrease by 24% and saw a reduction in costs of $900 per patient for an ROI of 4:1 (Dasan et al. 2005)
✓ Use of telepsychiatry for neurological admission diagnoses shortened length of stays (Craig et al. 2004)
✓ Inpatient telepsychiatry was preferred to face consultation (Sorvariemi et al. 2005)

WHAT ARE YOUR TELEMEDICINE OPPORTUNITIES?
Workplace Telemedicine

Do you see workman’s comp patients?

Patients are frustrated with long waits, short consultation times, and high cost (R. T. Anderson et al., 2007; Cole et al., 2001; Kernick et al., 2000; E. S. Williams et al., 2007)

Employers and employees know that medical visit commutes and waits cost money (Kernick et al., 2000)

Waits may worsen as clinician supply worsens (Cole, 2003; Cooper et al., 2002; MAG, 2008; Merrit et al., 2004)
Absenteeism, due to health risks and illness, cost business (Wright, Beard, & Edington, 2002)

Improved health and reduction of health risks saves companies money (Schultz et al., 2002)

Worksite clinics cost less than sending employees to traditional clinics (Chenoweth & Garrett, 2006)

Absenteeism vs Presenteeism

<table>
<thead>
<tr>
<th>Condition</th>
<th>Absentee Hours</th>
<th>Presenteeism Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>2.2</td>
<td>11.5</td>
</tr>
<tr>
<td>Smoking</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Low Activity</td>
<td>1</td>
<td>3.2</td>
</tr>
<tr>
<td>Stress</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Hypertension</td>
<td>1.5</td>
<td>4.5</td>
</tr>
<tr>
<td>Overweight</td>
<td>8</td>
<td>5.6</td>
</tr>
</tbody>
</table>

(Wright, Beard, & Edington, 2002)
WHAT ARE THE FAMILY PHYSICIAN TELEMEDICINE OPPORTUNITIES?

FAMILY PRACTICE TELEMEDICINE

How many of you have thought about using telemedicine for follow-ups?
FAMILY PRACTICE TELEMEDICINE

• Patients are increasingly using the phone to avoid the office
• Patient no-shows decrease practice efficiency and revenue
• Need to improve patient engagement and outcomes without significantly increasing costs
• COVID 19, patient safety, telemedicine Triage

Changes in Telehealth Coverage with COVID 19

Telehealth and other Communication Based Technology Services Medicare Advantage plans may provide their enrollees with access to Medicare Part B services via telehealth in any geographic area and from a variety of places, including beneficiaries’ homes. With this flexibility, it is possible that beneficiaries in Medicare Advantage plans can receive clinically appropriate services for treatment of COVID-19 via telehealth.
