

WHITE PAPER

Advancing Telehealth in Hawaii: Issues and Challenges

August 2015 (Updated)

The purpose of this white paper is to outline the opportunities, challenges, and to solicit possible solutions and recommendations for advancing telehealth in the State of Hawaii. The Pacific Basin Telehealth Resource Center (PBTRC) and Advisory Board prepared this paper with input from health care stakeholders regarding long-standing and most frequently cited telehealth barriers in the State of Hawaii.

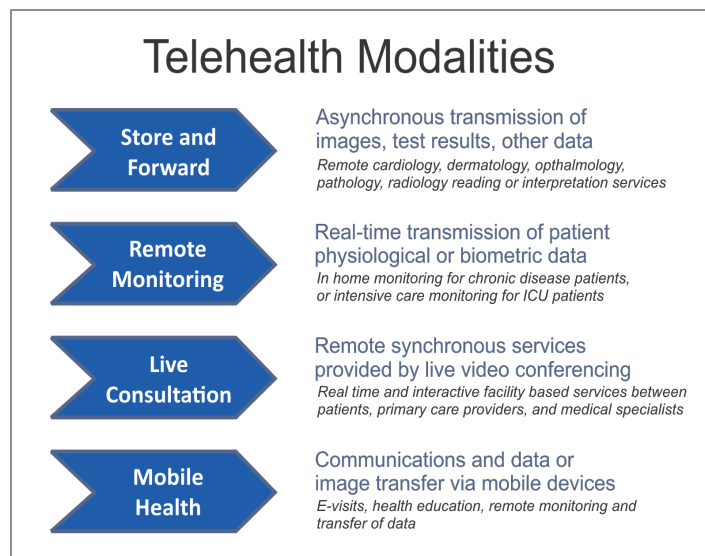
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TELEHEALTH DEFINITION

There are varying definitions of telehealth. The National Consortium of Telehealth Resource Centers defines telehealth as “a collection of means or methods for enhancing health care, public health, and health education delivery and support using telecommunication technologies.” This definition encompasses four modalities: live consultation (synchronous), store-and-forward (asynchronous), remote patient monitoring (RPM); and mobile Health (mHealth).

Telemedicine or Telehealth?

The term “telemedicine” is used primarily in reference to clinical services whereas “telehealth” is used more broadly to include clinical services, education, public health, etc. There are several definitions of ‘telehealth’ in the Hawaii Revised Statutes. Attachment 1 provides a list of the various Hawaii Revised Statute definitions. However, Senate Bill 2469 amends references to “telemedicine” in the Hawaii Revised Statutes to “telehealth” for consistency.



TELEHEALTH IN HAWAII – GAPS AND OPPORTUNITIES

There are many opportunities for improving health care access in our State where there is a shortage of health care providers in rural areas. Telehealth provides an opportunity to access specialists and services otherwise not available on island. It also provides much value in cost savings and improved quality of care for follow-up visits. To mention few health care shortages, stakeholders report that there is no surgeon on Molokai, there are not enough nephrologists to serve the Big Island communities, and there is a shortage of behavioral mental health providers for all neighbor islands. Although the potential value of telehealth is clear in terms of improved access, quality of care, lowered cost, and increased patient

satisfaction; telehealth utilization is relatively low in the State of Hawaii in comparison to other states. There are many health services that are not available to our neighbor island communities. Key barriers and challenges include: reimbursement, liability, credentialing/licensure, change management, need for new payment structure, and business models. This paper summarizes the most prominent barriers.

REIMBURSEMENT

Not all telehealth services are reimbursed. Policies and practices for telehealth reimbursement by Medicare, Medicaid, and private payers are not clear. Providers often do not know if they will get reimbursed for a service because they do not know if the service is covered and or if the service is provided under eligible conditions for payment (e.g., eligible for reimbursement if the patient is in a rural health professional shortage area (HPSA) or not classified as metropolitan statistical area (MSA)). Further, it is not clear how much a provider will be reimbursed and the reimbursement amount in many cases, specifically from Medicare and Medicaid, is considered very low and often requires subsidization from the health care provider. Generally, this is only feasible and sustainable by government agencies or grant-funded programs.

Senate Bill 2469 (See Attachment 2): Relating to Telehealth, introduces a parity law that requires the equivalent reimbursement for services provided through telehealth as for the same services provided through an in-person consultation. However, Senate Bill 2469 requires further clarification, see issues outlined below.

Senate Bill 2469: Relating to Telehealth (June 30, 2014)

The State of Hawaii is 1 of 24 states in the country with parity laws for insurance coverage of telemedicine. Senate Bill 2469, signed into law on June 30, 2014, requires equivalent reimbursement for services, including behavioral health services, provided through telehealth as for the same services provided via face-to-face contact between a health care provider and a patient. It also clarifies that health care providers for purposes of telehealth defined as provider of medical and other health services as defined in 42 U.S.C. 1895x(u) and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians, advanced practice registered nurses, psychologists, and dentists. The law changes statutory references to “telemedicine” to “telehealth” for consistency.

Clarifications and Challenges with Senate Bill 2469

Clarifications, Challenges & Barriers:

- Section 2 (Referencing Section 209E-2). Statement in legislation is unclear: “Medical and health care services means medical research, clinical trials, and telehealth, but not routine medical treatment or services.” The reference to “not routine medical treatment or services” can be interpreted to exclude most medical health care services.
- HRS 453-1.3 (f), (b). States “A physician shall not use telehealth to establish a physician-patient relationship with a patient in this State without a license to practice medicine in Hawaii.” This could be interpreted as any licensed provider can establish a physician-patient relationship using telehealth in the state. Yet, HRS 431:10A-116.3 (d), explicitly states that, “a telehealth mechanism may be used to establish a health care provider-patient relationship.”

Stakeholders have expressed that HRS 453-1.3 (f), (b) is not clear, and it would be prohibiting if there is a requirement to establish prior provider-patient relationship through a face-to-face encounter. This is especially problematic for services delivered in emergency departments; such as telestroke services where the nature of the emergency generally means that patient/provider do not have prior established relationships. Stakeholders have suggested that this could be addressed by eliminating the requirement for prior patient relationship or provide an exception to patients receiving emergency department services.

- HRS 431:10A-116.3, 432:1-601.5, 432D-23.5. Patients must be accompanied by a treating health care provider (except for behavioral health services). A medical provider at the patient site is defined as, but not limited to: primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians, advanced practice registered nurses, psychologists, and dentists. This is considered a limiting factor because it increases the workload of the provider at the patient's site. The lack of specialists in remote and rural areas is the very reason that they need telehealth services. So, if these specialists were available to accompany the patient they would not need a telehealth consult. Further, if there were a provider available to accompany the patient there currently is no or low reimbursement for the accompanying provider. It is also unclear as to how accompanying providers get reimbursed for their time.
- Although not addressed directly in the parity bill, the requirement of an accompanying provider at the remote site essentially eliminates the delivery of services via telehealth to patients in their homes or other non-medical environments (i.e., school, university setting, work, etc.).
- Nonstandard criteria across Hawaii payers for a remote-site fee. In many states a remote site fee is standard practice, enshrined in law. Across Hawaii payers, there is significant variation in allowances for, requirements, and payment of remote site fees. A remote site fee allows the originating provider practice to recover a portion of costs, and bolsters the case for committing to regular use of telehealth to enhance patient services. Medicaid currently permits state-to-state variation in these telehealth reimbursement practice standards.

Medicare Reimbursement (Federal Responsibility)

Medicare will reimburse for a limited set of telehealth-delivered services under specific conditions. See Attachment 3.

Medicare Eligibility Conditions

- Requires a Distant Site Practitioner (the consulting site)
A distant site practitioner is defined as: physicians, nurse practitioners, physician assistants, nurse midwives, clinical nurse specialists, certified registered nurse anesthetists, clinical psychologists and clinical social workers, registered dietitians or nutrition professionals.

The Medicare statutes does not specify which facilities may serve as distant sites, though CMS has excluded rural health clinics and federally qualified health centers (FQHCs).

- Limitation on Originating Site Location (location of the patient)

Telepresenter Requirement. A medical professional is not required to present the patient to the physician or practitioner at the Distant Site unless medically necessary. The decision for medical necessary will be made by the provider at the Distant Site. (Reference Medicare Benefit Policy Manual, Chapter 15, see Attachment 4)

Location of Patient. Medicaid beneficiaries must be located in:

- Offices of physicians or practitioners
- Facility - Hospitals, CAHs, RHC, FQHCs, Hospital-based or CAH-based Renal Dialysis Centers (including satellites), SNF, CMHC (Independent Renal Dialysis Facilities are not eligible originating sites)
- Geographic Location – Rural Health Professional Shortage Area defined by Section 332 (a)(1)(A) of the Public Health Service Act, a county outside of a MSA, or 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 (Reference: Medicare Benefits Policy Manual, Medicare Claims Processing Manual, DHSS Rural Health Fact Sheet Telehealth Services in Attachment 3)

This requirement is a significant limitation as it essentially eliminates the delivery of services via telehealth to patients in their homes or other non-medical environments (i.e., school, university setting, work, etc.). Thus concerns relating to fraud, waste, and abuse have limited payment for, and thus utilization of telehealth that can reduce inpatient stays for frail or elderly patients. By defining administrative oversight procedures and reporting, CMS has the opportunity to increase telehealth utilization, while controlling for overuse.

Medicare Services

Real Time - Medicare reimburses for:

- Interactive audio and video telecommunications
- Patient must be present and participating

Store and Forward

- Includes: video clips, still images, x-rays, MRIs, EKGs, EEGs, lab results, audio clips, email with images specific to the patient's condition and adequate for rendering or confirming a diagnosis or treatment plan
- Does not include telephone calls, images transmitted via fax machines, email without images of the patient
- Physician/ practitioner reviews case without patient present
- Must be part of Hawaii/Alaska Federal Telemedicine Demonstration Project

The CMS Medicare store-and-forward reimbursement exemption for the State of Hawaii and the State of Alaska affords special opportunities for providers in our respective states. However, there have been uncertainties about the specific rules and procedures for obtaining reimbursement. Specifically, there is no historical guidance on the definition of a "Federal Telemedicine Demonstration Project" that is one of the eligibility criteria. Some have understood the Medicare Claims Processing Manual reference to Federal Telemedicine Demonstration Project in Alaska or Hawaii, as a broad definition

meaning that store-and-forward services are covered if provided to beneficiaries in Hawaii and Alaska. This lack of CMS clarity in program rules and oversight is understood to have reduced physician participation.

The PBTRC has worked to get clarification on the eligibility criteria for this reimbursement and worked with a provider in Hawaii to track the process from eligibility to reimbursement. An initial intent of the criteria to be part of a Federal Telemedicine Demonstration Project was for the Federal government to have oversight of the number of store-and-forward claims as to have some control of the overall impact of program cost. PBTRC is developing a proposal to establish an administrative mechanism where the store-and-forward provider would register with the regional HRSA funded TRCs (PBTRC and NRTRC). This would enable the TRCs to track and report to the Federal government the store-and-forward usage and Medicare claims. It is important to continue to work on this clarification, as providers in Hawaii and Alaska are hesitant to initiate store-and-forward services without clear understanding of the reimbursement policies.

Medicare Billing & Payment

- Providers utilize CPT or HCPCS “GT” modifiers for interactive audio and video with a covered telehealth procedure code. (Reference: Attachment 3)

CMS consideration of new Medicare-eligible telehealth services On an annual basis the US Department of Health and Human Services considers submissions for new telehealth-delivered services to be approved. Submissions are allowed from providers, advocacy organizations, and other interested parties. As an example the American Telemedicine Association (ATA) submitted a request to CMS for inclusion of critical care and evaluation CPT codes 99291 and 99292 (this change is needed for telestroke network services reimbursement). (Reference: Attachment 5)

Medicaid Reimbursement (State Responsibility)

The State of Hawaii Med-QUEST Division (MQD) will reimburse for a limited set of telehealth-delivered services under specific conditions as per HAR §17-1737-51.1 Telehealth services. (See Attachment 6). This administrative rule is almost a complete facsimile of Medicare policies for telehealth reimbursement (as done by many other states). Further, the Hawaii MQD administrative rules for telehealth services are based on a dated version of Medicare rules. For example originating site definitions under the MQD program does not include SNF and CMHC that Medicare updated. Additionally, the Hawaii Medicaid telehealth reimbursement rules do not expressly allow reimbursement for store-and-forward services; whereas Medicare has a special provision allowing store-and-forward services for Federal Telemedicine Demonstration Projects in Alaska and Hawaii. The 50-state variations in telehealth program rules increase uncertainty and comprehensively reduce use of proven, effective, lower-cost telehealth services.

Medicaid Eligibility Conditions

Distant Site Practitioner (the consulting site) Location:

According to the Hawaii Medicaid Provider Manual Chapter 2, under the State program, provider services are reimbursable only when performed in the provider’s office, a hospital, a clinic or in an emergency situation in the patient’s home and appropriately indicated on the provider’s claim for service. This suggests no specific reference to telehealth services. Stakeholders have indicated problems processing claims when the provider at the consulting site was not in a place of clinical service. There are no clear policies defining this requirement, presenting a barrier to growth of appropriate telehealth services.

Limitation on Originating Site Location (location of the patient- Medicaid beneficiary)

Patient/beneficiary must be located in the following:

- Rural Health Professional Shortage Area defined by Section 332 (a)(1)(A) of the Public Health Service Act
- County outside of a Metropolitan Statistical Area (MSA) defined by Social Security Act; or
- From an entity that participates in a Federal Telemedicine Demonstration Project that has been approved by the Secretary of Health and Human Services as of December 31, 2000.

Medicaid Issues with Requirements for Geographic Location (urban or rural) of Beneficiary:

- Stakeholders question the limitation on the geographic location of the patient/beneficiary. MQD might consider that all Medicaid beneficiaries be eligible for receiving telehealth services as this would increase overall access, potentially increasing quality and reducing overall chronic care management costs of serving this population.
- According to a survey conducted by the American Telemedicine Association, there is a growing national trend to allow statewide Medicaid coverage of telehealth, instead of focusing solely on geographic location of the patient. For example, the New Mexico Medicaid program has no geographic restrictions for reimbursement of telehealth service (e.g., the patient does not need to be located in a rural area).
- Reference to “Federal Telemedicine Demonstration Project” is problematic. There is no federal guidance on how to validate this participation and comprehend or develop the specific projects that it references.

Limitations on Originating Site (the place where the patient- Medicaid beneficiary is receiving services)

The location of the patient must be in:

- (1) The office of a physician or practitioner;
- (2) A hospital;
- (3) A critical access hospital;
- (4) A rural health clinic; and
- (5) A federally qualified health center
- (6) Or an entity participating in a Federal Telehealth Demonstration Project that is approved by or is receiving funding from the Secretary of Health and Human Services as of December 31, 2000. An entity participating in a Federal Telehealth Demonstration Project qualifies as an originating site regardless of geographic location.

Medicaid Issues with Requirements for Patient Setting of Beneficiary:

- These requirements severely constrain telehealth use, particularly for remote and rural areas that do not have easy access to any of the specified and authorized types of sites. For example, a behavioral health provider in Hilo has said that she provides counseling services via a secured interactive video teleconferencing service to patients in Keaau or Pahoā. She is however not able to get Medicaid reimbursement for these services as her patients receive tele-consultations in their homes. This provider’s patients, more often than not, do not have a car or easy transportation to the nearest authorized site. In addition, many of these patients are not physically well enough to leave their homes to travel to an authorized site. The current laws prohibit Medicaid payment to this provider, limiting much needed services for these Medicaid beneficiaries.

- Although modeled after Medicare policies, the Hawaii MQD program does not include SNF and CMHC as eligible originating sites even though Medicare currently includes these sites.
- According to a survey conducted by the American Telemedicine Association, 24-states and D.C. do not specify patient setting as a condition for payment of telehealth; 25-states and D.C. recognize the home as an originating site, 16 states recognize schools and/or school-based health centers as an originating site, and 17-states cover remote patient monitoring. (Reference: ATA State Telemedicine Toolkit, 2015)
- Again, reference to “Federal Telemedicine Demonstration Project” is problematic. No one knows what it means.

Medicaid Services

Real Time - Med-QUEST Division will reimburse for:

- Interactive audio and video telecommunications
- Telephone, fax, email expressly do not meet requirements of interactive telecommunication systems
- As a condition of payment the patient must be “present and participating”

Store and Forward

- Hawaii Med-QUEST requires the patient to be “present and participating in the telehealth visit” and “interactive audio & video telecommunications systems must be used,” therefore excluding store-and-forward from reimbursement. Source: Code of HI Rules 17-1737 (2012).
- Store-and-forward is not mentioned in the law as an eligible service.
- Medicare has a special provision allowing store-and-forward services in Alaska and Hawaii.
- There are 13 states that specifically authorize store-and-forward service reimbursement: Alaska, Arizona, California, Illinois, Minnesota, Mississippi, Nebraska, New Mexico, Oklahoma, Oregon, Tennessee, Texas, and Virginia.

Medicaid Issues with Service Eligibility: Stakeholders would like see more flexibility in the Hawaii Med-QUEST telehealth rules. At a minimum, store-and-forward services should be covered. The geographic and site restrictions for where the patient receives services should be removed. Providers should get reimbursed for providing telehealth services to any Medicaid beneficiary regardless of geographic and site location.

Medicaid Billing

Providers are to utilize the CPT procedure code with the modifier code “TM” indicating the services were provided via telehealth according to the Medicaid provider manual. Reimbursements are based on the Hawaii Medicaid fee schedule.

Medicaid Issues with Reimbursement Amounts: Stakeholder feedback indicates the Medicaid reimbursement amount is considered very low, and often requires subsidization by the health care provider. Generally, this is only currently feasible and sustainable in practices run by government agencies or grant-funded programs.

Medicaid Issues with Approval Process: Stakeholders recognize that Med-QUEST needs to establish a consistent process for telehealth services. It has been suggested that pilots programs to test these

processes should be conducted by Med-QUEST. These pilots could measure and allow weighing the costs to Med-QUEST and any putative gains in long-term patient outcomes.

Private Medical Insurance

According to the American Telemedicine Association report, 29-states and D.C. have enacted laws mandating coverage of health-provided services under private health insurance plans. Hawaii is 1 of 29 states that mandate private insurance coverage (*HI Revised Statutes § 431:10A-116.3 Coverage for Telehealth, see Attachment 7*).

Parity Law Requirement for Accompanying Provider: Patients need to be accompanied by a treating health care provider (except for behavioral health services). A medical provider at the originating patient site is defined as, but not limited to: primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians, advanced practice registered nurses, psychologists, and dentists. This is a limiting factor as it increases the originating site provider's workload. The significant lack of specialists in remote and rural areas of Hawaii is the very reason for high demand for telehealth services. Thus if these plentiful numbers of specialists were available to visit patients, telehealth consults would not be in demand. Furthermore, if and when primary care providers are available to accompany patients, there is currently low payments and irregular reimbursement standards for the accompanying providers.

Issues with Private Medical Insurance Policies: In addition to the parity law concerns, stakeholders have expressed needs for standardization and clear, published policies for telehealth services paid by private insurers.

Liability and Malpractice

PBTRC contacted the three major malpractice insurance providers in Hawaii to get clarification on their telehealth policies. These include: Medical Insurance Exchange of California (MIEC), HAPI, and the Doctor's Company. Historically, this has been a gray area for providers with mixed messages, and few direct references to further understanding of telehealth is coverage under malpractice insurance policies. All three major malpractice companies in Hawaii with prior approval, may cover telehealth services, depending on the circumstance. Of the three major companies, only Medical Insurance Exchange of California (MIEC) has specific and standardized references to telehealth in their policies.

Prior Provider-Patient Relationship (face-to-face requirement): An added problematic requirement is for a prior face-to-face encounter to establish a provider-patient relationship. Hawaii telehealth stakeholders expressed the desire to eliminate this requirement, especially for emergency telehealth service situations where a prior provider-patient relationship is both unusual and infeasible. For example, many families who reside on the outer islands cannot and do not travel to Honolulu, and thus have no way to establish a prior in-person provider-patient relationship. This malpractice standard contradicts the State of Hawaii Law (HRS 453.1.3 Section (b), (f)) that permits the establishment of a prior patient-provider relationship through the use of telehealth (for State of Hawaii licensed providers).

Providers in Private Practice or Contracted to Large Organizations: Most providers in the State of Hawaii must purchase their own malpractice insurance. Although doctors who are employees of large health care organizations may be covered by these organization's insurance policies, contractors to these medical centers are not covered. Providers in private practice, or contracted to large organizations must

purchase malpractice insurance and are deeply concerned with risks and lack of clarity on telehealth coverage.

Risk of Failure to Use Telehealth: The liability discussions are often focused on risks of provisioning of telehealth services. Despite widespread use in many other states, there have been extremely few lawsuits brought for the use of telehealth services, with the exception of Internet drug prescriptions. There have been however, a number of suits brought for failures to use telehealth services. Two lawsuits were filed in New Mexico for the failure to use tele-radiology. While both cases were settled out-of-court, and thus do not have the weight of case law; it should be clear that the national trend is for telehealth to become a standard of care.

The following are summary findings from PBTRC's discussions with the carriers:

HAPI: HAPI is not a traditional insurance company. It is established in the framework of a general partnership, where all members share personal liability and are at financial risk for the entire pool of members. The HAPI general guidance regarding telehealth is prior established provider-patient relationship are required. This must be an in-office, face-to-face visit and not a virtual visit via telecommunications. Even with this established relationship, providers must use their professional judgment and risk assessment regarding decisions to use telehealth as a means of services. Telehealth may be used, for example, for follow-up and consultations, however the provider must review the medical severity, patient condition, etc. to assess whether or not telehealth services are an appropriate and safe means of delivering patient services on a case by case basis. HAPI operates on a 'facts and circumstances' basis, so should issues arise, each case is to be reviewed individually. HAPI has no formalized policy stating telehealth services are, or are not covered. The general position, however, is that telehealth services, as any other medical services, should be within the provider's medical specialty and for the good of the patient.

Medical Insurance Exchange of California (MIEC): MIEC has a clear policy regarding telehealth coverage. Providers must provide prior notification, in writing, to MIEC that they intend to provide telehealth services and describe the services. They must indicate their principal place of practice, and describe the services within the state of principal place of practice as declared in the policy.

The Doctor's Company (TDC): The Doctor's Company's standard policy excludes services via the Internet or media, meaning telehealth services are not covered if no prior relationship is established between the provider and patient. Once a prior relationship is established, the provider must contact a TDC underwriter to provide specific information (e.g., patient location, type of services, etc.). TDC makes determinations on a case-by-case basis as to whether or not the service is covered under the provider's plan.

Health Professional Licensure

An added burden for providers practicing telehealth in the State of Hawaii, and across borders, is the need for medical licenses and the processes to obtain licensure in different states. A number of interstate initiatives have been proposed, maintaining acceptable standards and protocols present barriers. The Federation of State Medical Boards' (FSMB) initiative to streamline medical licensure, special state licenses for telehealth, and specialized companies exist that will assist providers in processing the required documentation for state medical licensure and credentialing.

Federation of State Medical Boards (FSMB) Initiative to Streamline Medical Licensure: On September 5, 2014, the Federation of State Medical Boards (FSMB) released the final version of their proposed interstate medical licensure compact (Compact) language. This provides a framework for a new licensing option under which qualified physicians seeking to practice in multiple states would be eligible for expedited licensure in all Compact states. As of August 2015, 11 states enacted legislation to adopt the Compact; and 8-states have introduced bills to their state legislatures to adopt the Compact. The majority of states, including Hawaii, have yet to enact legislation.

11 states have entered the compact: Alabama, Idaho, Illinois, Iowa, Minnesota, Montana, Nevada, South Dakota, Utah, West Virginia, and Wyoming

8 states have introduced bills to enter the compact: Maryland, Michigan, Nebraska, Oklahoma, Rhode Island, Texas, Vermont and Wisconsin

Special License for Telehealth: The State of Hawaii does not have a special license or certificate for telehealth. Across the nation, 10 states issue special licenses or telehealth certificates. These special licenses/certificates allow out of state providers to render services via telehealth in a state under certain conditions, such as agreeing to not open an office in that state..

10 states with special telehealth licenses or certificates are: Alabama, Louisiana, Montana, Nevada, New Mexico, Ohio, Oregon, Tennessee, Texas, and Oklahoma

Attachment 1

References to Telehealth/ Telemedicine in Hawaii Revised Statutes:

- The State of Hawaii Senate Bill 2469, signed into law on June 30, 2014 defines telehealth as “The use of telecommunications...including but not limited to real-time video teleconferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purposes of delivering enhanced health care services and information to parties separated by distance, establishing a physician-patient relationship, evaluating a patient, or treating a patient.”
Source: HI Revised Statutes § 453-1.3.
- According to state insurance law, “Telehealth means the use of telecommunications services, including but not limited to, real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information to parties separated by distance. Standard telephone contacts, facsimile transmissions, or email text, in combination or by itself, does not constitute a telehealth service for the purposes of this chapter.”
Source: HI Revised Statutes § 431:10A-116.3.
- According to state business law, “Telehealth means the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration, to the extent that it relates to nursing.”
Source: HI Revised Statutes § 457-2.
- According to state business law, “Telemedicine means the use of telecommunications services, including real-time video or web conferencing communication or secure web-based communication to establish a physician-patient relationship, to evaluate a patient, or to treat a patient. ‘Telehealth’ as used in chapters 431, 432, and 432D, includes ‘telemedicine’ in its definition.”
Source: HI Revised Statutes § 453-1.3.

Attachment 2

THE SENATE
TWENTY-SEVENTH LEGISLATURE,
2014
STATE OF HAWAII

S.B. NO. 2469
S.D. 2
H.D. 3
C.D. 1

A BILL FOR AN ACT

RELATING TO TELEHEALTH.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The legislature finds that one of the challenges faced by the country's health care system is providing quality care to segments of the population who do not have access to essential services because of geographic limitations. Using telehealth to deliver health care from a distance is an effective way of overcoming certain barriers to accessing care, particularly for communities located in rural and remote areas. This is especially important in Hawaii, where residents on the neighbor islands and in rural areas do not have the same level of access to care as residents in urban areas of Oahu.

The legislature further finds that telehealth services are used extensively across the country with no compromise in quality of care when the services are within the scope of practice of a provider. However, reimbursement policies vary between health plans, leading to confusion among health care providers and restrictions on patient access to quality health care.

The legislature additionally finds that requiring parity for telehealth services will empower consumer choice, reduce disparities in access to care, enhance health care provider availability, and

improve quality of care.

The legislature also finds that various sections of the Hawaii Revised Statutes contain different definitions for or references to "telemedicine" and "telehealth" and notes that these definitions and references should be harmonized for consistency.

Accordingly, the purpose of this Act is to:

- (1) Require equivalent insurance reimbursement for services, including behavioral health services, provided by a health care provider to a patient regardless of whether the service is provided through telehealth or via face-to-face contact between health care provider and patient;
- (2) Clarify that health care providers for purposes of telehealth include primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians, advanced practice registered nurses, psychologists, and dentists; and
- (3) Change references to "telemedicine" in the Hawaii Revised Statutes to "telehealth" for consistency.

SECTION 2. Section 209E-2, Hawaii Revised Statutes, is amended by amending the definition of "medical and health care services" to read as follows:

"Medical and health care services" means medical research, clinical trials, and ~~[telemedicine]~~ telehealth, but not routine medical treatment or services."

SECTION 3. Section 431:10A-116.3, Hawaii Revised Statutes, is amended by amending subsection (c) to read as follows:

"(c) Reimbursement for services provided through telehealth shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient. There shall be no reimbursement for a telehealth consultation between health care providers unless a health care provider-patient relationship exists between the patient and one of the health care providers involved in the telehealth interaction~~[.]~~ and the patient is accompanied by a treating health care provider at

the time telehealth services are provided by the consulting health care provider; provided that when behavioral health services are provided, a second health care provider shall not be required to accompany the patient.

For the purposes of this section, "health care provider" means a provider of services, as defined in 42 U.S.C. 1395x(u), a provider of medical and other health services, as defined in 42 U.S.C. 1395x(s), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business[~~;~~], including but not limited to primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians licensed under chapter 453, advanced practice registered nurses licensed under chapter 457, psychologists licensed under chapter 465, and dentists licensed under chapter 448."

SECTION 4. Section 432:1-601.5, Hawaii Revised Statutes, is amended by amending subsection (c) to read as follows:

"(c) Reimbursement for services provided through telehealth shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient. There shall be no reimbursement for a telehealth consultation between health care providers unless a health care provider-patient relationship exists between the patient and one of the health care providers involved in the telehealth interaction[~~;~~] and the patient is accompanied by a treating health care provider at the time telehealth services are provided by the consulting health care provider; provided that when behavioral health services are provided, a second health care provider shall not be required to accompany the patient.

For the purposes of this section, "health care provider" means a provider of services, as defined in 42 U.S.C. 1395x(u), a provider of medical or other health services, as defined in 42 U.S.C. 1395x(s), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business~~[7]~~, including but not limited to primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians licensed under chapter 453, advanced practice registered nurses licensed under chapter 457, psychologists licensed under chapter 465, and dentists licensed under chapter 448."

SECTION 5. Section 432D-23.5, Hawaii Revised Statutes, is amended by amending subsection (c) to read as follows:

"(c) Reimbursement for services provided through telehealth shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient. There shall be no reimbursement for a telehealth consultation between health care providers unless an existing health care provider-patient relationship exists between the patient and one of the health care providers involved in the telehealth interaction~~[7]~~ and the patient is accompanied by a treating health care provider at the time telehealth services are provided by the consulting health care provider; provided that when behavioral health services are provided, a second health care provider shall not be required to accompany the patient.

For the purposes of this section, "health care provider" means a provider of services, as defined in 42 U.S.C. 1395x(u), a provider of medical or other health services, as defined in 42 U.S.C. 1395x(s), and any other person or organization who furnishes, bills, or is paid

for health care in the normal course of business~~[-]~~, including but not limited to primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians licensed under chapter 453, advanced practice registered nurses licensed under chapter 457, psychologists licensed under chapter 465, and dentists licensed under chapter 448."

SECTION 6. Section 440G-11.5, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"~~[+]~~ (a) ~~[+]~~ In conjunction with broadband services, the director shall:

(1) Promote and encourage use of telework alternatives for public and private employees, including appropriate policy and legislative initiatives;

(2) Advise and assist state agencies, and upon request of the counties, advise and assist the counties, in planning, developing, and administering programs, projects, plans, policies, and other activities to promote telecommuting by employees of state and county agencies;

(3) Support the efforts of both public and private entities in Hawaii to enhance or facilitate the deployment of, and access to, competitively priced, advanced electronic communications services, including broadband and its products and services and internet access services of general application throughout Hawaii;

(4) Make recommendations to establish affordable, accessible broadband services to unserved and underserved areas of Hawaii and monitor advancements in communications that will facilitate this goal;

(5) Advocate for, and facilitate the development and deployment of, expanded broadband applications, programs, and services, including telework, ~~[telemedicine,]~~ telehealth, and e-learning, that will bolster the usage of and demand for broadband level telecommunications;

(6) Serve as a broadband information and applications clearinghouse for the State and a coordination point for federal American Recovery and Reinvestment Act of 2009 broadband-related services and programs; and

(7) Promote, advocate, and facilitate the implementation of the findings and recommendations of the Hawaii broadband task force established by Act 2, First Special Session Laws of Hawaii 2007."

SECTION 7. Section 453-1.3, Hawaii Revised Statutes, is amended to read as follows:

"§453-1.3 Practice of ~~[telemedicine-]~~ telehealth. (a) Subject to section 453-2(b), nothing in this section shall preclude any

physician acting within the scope of the physician's license to practice from practicing ~~[telemedicine]~~ telehealth as defined in this section.

(b) For the purposes of this section, ~~["telemedicine"]~~ "telehealth" means the use of telecommunications ~~[services,]~~ as that term is defined in section 269-1, including but not limited to real-time video ~~[or web conferencing]~~ conferencing-based communication ~~[or],~~ secure interactive and non-interactive web-based communication ~~[to establish],~~ and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purposes of delivering enhanced health care services and information to parties separated by distance, establishing a physician-patient relationship, [to evaluate] evaluating a patient, or [to treat] treating a patient. ["Telehealth" as used in chapters 431, 432, and 432D, includes "telemedicine" as defined in this section.]

(c) ~~[Telemedicine]~~ Telehealth services shall include a documented patient evaluation, including history and a discussion of physical symptoms adequate to establish a diagnosis and to identify underlying conditions or contraindications to the treatment recommended or provided.

(d) Treatment recommendations made via ~~[telemedicine,]~~ telehealth, including issuing a prescription via electronic means, shall be held to the same standards of appropriate practice as those in traditional physician-patient settings that do not include a face-to-face visit but in which prescribing is appropriate, including on-call telephone encounters and encounters for which a follow-up visit

is arranged. Issuing a prescription based solely on an online questionnaire is not treatment for the purposes of this section and does not constitute an acceptable standard of care. For the purposes of prescribing a controlled substance, a physician-patient relationship shall be established pursuant to chapter 329.

(e) All medical reports resulting from [~~telemedicine~~] telehealth services are part of a patient's health record and shall be made available to the patient. Patient medical records shall be maintained in compliance with all applicable state and federal requirements including privacy requirements.

(f) A physician shall not use [~~telemedicine~~] telehealth to establish a physician-patient relationship with a patient in this State without a license to practice medicine in Hawaii. Once a provider-patient relationship is established, a patient or physician licensed in this State may use [~~telemedicine~~] telehealth for any purpose, including consultation with a medical provider licensed in another state, authorized by this section[7] or as otherwise provided by law.

(g) Reimbursement for behavioral health services provided through telehealth shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient."

SECTION 8. Section 453-2, Hawaii Revised Statutes, is amended by amending subsection (b) to read as follows:

"(b) Nothing herein shall:

- (1) Apply to so-called Christian Scientists; provided that the Christian Scientists practice the religious tenets of their church without pretending a knowledge of medicine or surgery;
- (2) Prohibit service in the case of emergency or the domestic administration of family remedies;
- (3) Apply to any commissioned medical officer in the United States armed forces or public health

service engaged in the discharge of one's official duty, including a commissioned medical officer employed by the United States Department of Defense, while providing direct ~~[telemedicine]~~ telehealth support or services to neighbor island beneficiaries within a Hawaii National Guard armory on the island of Kauai, Hawaii, Molokai, or Maui; provided that the commissioned medical officer employed by the United States Department of Defense is credentialed by Tripler Army Medical Center;

(4) Apply to any practitioner of medicine and surgery from another state when in actual consultation, including in-person, mail, electronic, telephonic, fiber-optic, or other ~~[telemedicine]~~ telehealth consultation with a licensed physician or osteopathic physician of this State, if the physician or osteopathic physician from another state at the time of consultation is licensed to practice in the state in which the physician or osteopathic physician resides; provided that:

- (A) The physician or osteopathic physician from another state shall not open an office, or appoint a place to meet patients in this State, or receive calls within the limits of the State for the provision of care for a patient who is located in this State;
- (B) The licensed physician or osteopathic physician of this State retains control and remains responsible for the provision of care for the patient who is located in this State; and
- (C) The laws and rules relating to contagious diseases are not violated;

(5) Prohibit services rendered by any person certified under part II of this chapter to provide emergency medical services, or any physician assistant, when the services are rendered under the direction and control of a physician or osteopathic physician licensed in this State except for final refraction resulting in a prescription for spectacles, contact lenses, or visual training as performed by an oculist or optometrist duly licensed by the State. The direction and control shall not be construed in every case to require the personal presence of the supervising and controlling physician or osteopathic physician. Any physician or osteopathic physician who employs or directs a person certified under part II of this chapter to provide emergency medical services, or a physician assistant, shall retain full professional and personal responsibility for any act that constitutes the practice of medicine when performed by the certified person or physician assistant;

(6) Prohibit automated external defibrillation by:

- (A) Any first responder personnel certified by the department of health to provide automated external defibrillation when it is rendered under the medical

oversight of a physician or osteopathic physician
licensed in this State; or

(B) Any person acting in accordance with section 663-1.5(e);
or

(7) Prohibit a radiologist duly licensed to practice medicine and provide radiology services in another state from using ~~[telemedicine]~~ telehealth while located in this State to provide radiology services to a patient who is located in the state in which the radiologist is licensed. For the purposes of this paragraph:

"Radiologist" means a doctor of medicine or a doctor of osteopathy certified in radiology by the American Board of Radiology or the American Board of Osteopathy.

~~["Telemedicine"]~~ "Telehealth" means the use of telecommunications ~~[services]~~, as that term is defined in section 269-1, including but not limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, ~~[such as]~~ including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, ~~[and deliver]~~ for the purpose of delivering enhanced health care services and information to parties separated by distance. Standard telephone contacts, facsimile transmissions, or email texts, in combination or by themselves, do not constitute a telehealth service for the purposes of this paragraph.

SECTION 9. Section 455-1.5, Hawaii Revised Statutes, is amended to read as follows:

"~~[§]~~**§455-1.5**~~[§]~~ **Exceptions; scope of chapter.** Nothing in this chapter shall be construed to prohibit or restrict:

(1) The practice of a profession by individuals who are licensed, certified, or registered under the laws of this State who are performing services within their authorized scope of practice;

(2) The practice of naturopathic medicine by an individual employed by the government of the United States while the individual is engaged in the performance of duties required of the individual by the laws and regulations of the United States;

(3) The practice of naturopathic medicine by students enrolled in a school that meets the requirements of section 455-3. The performance of naturopathic medicine by students shall be pursuant to a course of instruction or assignments from an instructor and under the supervision of an instructor who is a naturopathic physician licensed pursuant to this chapter; and

(4) The practice by a doctor of naturopathic medicine duly registered or licensed in another state, territory, or the District of Columbia who is called into this State for consultation with a licensed naturopathic physician, including in-person, mail, electronic, telephonic, fiber-optic, or other ~~[telemedicine]~~ telehealth consultation; provided that:

(A) The naturopathic physician from another state shall not

open an office, appoint a place to meet patients, or receive calls within this State for the provision of care for a patient who is located in this State; and

(B) The licensed naturopathic physician of this State retains control and remains responsible for the provision of care for the patient who is located in this State."

SECTION 10. Section 457-2.7, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"(a) Practice as an advanced practice registered nurse means the scope of nursing in a category approved by the board, regardless of compensation or personal profit, and includes the registered nurse scope of practice. The scope of an advanced practice registered nurse includes but is not limited to advanced assessment; telehealth; and the diagnosis, prescription, selection, and administration of therapeutic measures including over the counter drugs, legend drugs, and controlled substances within the advanced practice registered nurse's role and specialty-appropriate education and certification."

SECTION 11. Section 466J-6, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"(a) Any provision in this chapter to the contrary notwithstanding, a license shall not be required for:

- (1) A licensed medical practitioner in radiology;
- (2) A licensed practitioner of nuclear medicine;
- (3) A licensed physician assistant;
- (4) A licensed doctor of dentistry;
- (5) A licensed dental technician;
- (6) A licensed dental hygienist;

(7) A student in an approved school for radiographers, radiation therapists, or nuclear medicine technologists, or in a school of medicine, podiatry, dentistry, or a chiropractic school; provided that the student is operating x-ray machines under the direct supervision of a licensed radiographer, licensed radiation therapist, licensed nuclear medicine technologist, or a qualified person pursuant to this chapter; and

(8) A radiologist duly licensed to practice medicine and radiology services in another state who uses ~~[telemedicine]~~ telehealth while located in this State to provide radiology services to a patient who is located in the state in which the radiologist is licensed. For the purposes of this paragraph:

"Radiologist" means a doctor of medicine or a doctor of osteopathy certified in radiology by the American Board of Radiology or the American Board of Osteopathy.

~~["Telemedicine"]~~ "Telehealth" means the use of telecommunications ~~[services]~~, as that term is defined in section 269-1, including but not limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, ~~[such as]~~ including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, ~~[and deliver]~~ for the purpose of delivering enhanced health care services and information to parties separated by distance. Standard telephone contacts, facsimile transmissions, or email texts, in combination or by themselves, do not constitute a telehealth service for the purposes of this paragraph."

SECTION 12. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 13. This Act shall take effect upon its approval.

Report Title:

Telehealth; Insurance; Health Care Providers; Reimbursement

Description:

Requires equivalent reimbursement for services, including behavioral health services, provided through telehealth as for the same services provided via face-to-face contact between a health care provider and a patient. Clarifies that health care providers for purposes of telehealth include primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians, advanced practice registered nurses, psychologists, and dentists. Changes statutory references to "telemedicine" to "telehealth" for consistency. (CD1)

The summary description of legislation appearing on this page is for informational purposes only and is not legislation or evidence of legislative intent.

DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services



Telehealth Services



RURAL HEALTH FACT SHEET SERIES

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

This publication provides the following information on calendar year (CY) 2015 Medicare telehealth services:

- ❖ Originating sites;
- ❖ Distant site practitioners;
- ❖ Telehealth services;
- ❖ Billing and payment for professional services furnished via telehealth;
- ❖ Billing and payment for the originating site facility fee;
- ❖ Resources; and
- ❖ Lists of helpful websites and Regional Office Rural Health Coordinators.

When “you” is used in this publication, we are referring to physicians or practitioners at the distant site.

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.



ORIGINATING SITES

An originating site is the location of an eligible 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.

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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.

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.

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.

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.

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 on pages 3 and 4 provides the CY 2015 list of Medicare telehealth services.

CY 2015 Medicare Telehealth Services

Service	Healthcare Common Procedure Coding System (HCPCS)/CPT Code
Telehealth consultations, emergency department or initial inpatient	HCPCS codes G0425–G0427
Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs	HCPCS codes G0406–G0408
Office or other outpatient visits	CPT codes 99201–99215
Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days	CPT codes 99231–99233
Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days	CPT codes 99307–99310
Individual and group kidney disease education services	HCPCS codes G0420 and G0421
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	HCPCS codes G0108 and G0109
Individual and group health and behavior assessment and intervention	CPT codes 96150–96154
Individual psychotherapy	CPT codes 90832–90834 and 90836–90838
Telehealth Pharmacologic Management	HCPCS code G0459
Psychiatric diagnostic interview examination	CPT codes 90791 and 90792
End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment	CPT codes 90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961
Individual and group medical nutrition therapy	HCPCS code G0270 and CPT codes 97802–97804
Neurobehavioral status examination	CPT code 96116
Smoking cessation services	HCPCS codes G0436 and G0437 and CPT codes 99406 and 99407
Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services	HCPCS codes G0396 and G0397
Annual alcohol misuse screening, 15 minutes	HCPCS code G0442
Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	HCPCS code G0443
Annual depression screening, 15 minutes	HCPCS code G0444
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	HCPCS code G0445
Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes	HCPCS code G0446
Face-to-face behavioral counseling for obesity, 15 minutes	HCPCS code G0447
Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)	CPT code 99495
Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)	CPT code 99496
Psychoanalysis (effective for services furnished on and after January 1, 2015)	CPT codes 90845
Family psychotherapy (without the patient present) (effective for services furnished on and after January 1, 2015)	CPT code 90846

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CY 2015 Medicare Telehealth Services (cont.)

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

For ESRD-related services, a physician, NP, PA, or CNS must furnish at least one “hands on” visit (not telehealth) each month to examine the vascular access site.

BILLING AND PAYMENT FOR PROFESSIONAL SERVICES FURNISHED VIA TELEHEALTH

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.

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.

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.

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.

RESOURCES

The chart below provides telehealth services resource information.

Telehealth Services Resources

For More Information About...	Resource
Telehealth Services	<p>http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth on the CMS website</p> <p>Chapter 15 of the “Medicare Benefit Policy Manual” (Publication 100-02) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf on the CMS website</p> <p>Chapter 12 of the “Medicare Claims Processing Manual” (Publication 100-04) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf on the CMS website</p>
Health Professional Shortage Areas	<p>Medicare Learning Network® (MLN) publication titled “Health Professional Shortage Area (HPSA) Physician Bonus, HPSA Surgical Incentive Payment, and Primary Care Incentive Payment Programs” located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HPSAfctsht.pdf on the CMS website</p>
All Available MLN Products	<p>“MLN Catalog” located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf on the CMS website or scan the Quick Response (QR) code on the right</p> 
Provider-Specific Medicare Information	<p>MLN publication titled “MLN Guided Pathways: Provider Specific Medicare Resources” located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website</p>
Medicare Information for Beneficiaries	<p>http://www.medicare.gov on the CMS website</p>



HELPFUL WEBSITES

American Hospital Association Rural Health Care

<http://www.aha.org/advocacy-issues/rural>

Critical Access Hospitals Center

<http://www.cms.gov/Center/Provider-Type/Critical-Access-Hospitals-Center.html>

Disproportionate Share Hospital

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html>

Federally Qualified Health Centers Center

<http://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html>

Health Resources and Services Administration

<http://www.hrsa.gov>

Hospital Center

<http://www.cms.gov/Center/Provider-Type/Hospital-Center.html>

Medicare Learning Network®

<http://go.cms.gov/MLNGenInfo>

National Association of Community Health Centers

<http://www.nachc.org>

National Association of Rural Health Clinics

<http://narhc.org>

National Rural Health Association

<http://www.ruralhealthweb.org>

Rural Assistance Center

<http://www.raonline.org>

Rural Health Clinics Center

<http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html>

Swing Bed Providers

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPSP/SwingBed.html>

Telehealth

<http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth>

U.S. Census Bureau

<http://www.census.gov>

REGIONAL OFFICE RURAL HEALTH COORDINATORS

To find contact information for CMS Regional Office Rural Health Coordinators who provide technical, policy, and operational assistance on rural health issues, refer to <http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/Downloads/CMSRuralHealthCoordinators.pdf> on the CMS website.



This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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monitoring at midnight of the day on which the surgical procedure is performed (overnight stay).

Procedures that are included on the inpatient list used under Medicare's hospital outpatient prospective payment system and procedures that can only be reported by using an unlisted Category I CPT code are deemed to pose significant safety risk to beneficiaries in ASCs and are not eligible for designation and coverage as covered surgical procedures.

260.5.3 - Rebundling of CPT Codes

(Rev. 1, 10-01-03)

B3-2266.3

Instructions regarding the Correct Coding Initiative apply to coverage of ASC facility services.

270 - Telehealth Services

(Rev. 140, Issued: 02-28-11, Effective: 01-01-11, Implementation: 01-03-11 A/B MACs, Carriers/04-04-11 A/B MACs, FIs)

Background

Section 223 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) - Revision of Medicare Reimbursement for Telehealth Services amended §1834 of the Act to provide for an expansion of Medicare payment for telehealth services.

Effective October 1, 2001, coverage and payment for Medicare telehealth includes consultation, office visits, individual psychotherapy, and pharmacologic management delivered via a telecommunications system. Eligible geographic areas include rural health professional shortage areas (HPSA) and counties not classified as a metropolitan statistical area (MSA). Additionally, Federal telemedicine demonstration projects as of December 31, 2000, may serve as the originating site regardless of geographic location.

An interactive telecommunications system is required as a condition of payment; however, BIPA does allow the use of asynchronous "store and forward" technology in delivering these services when the originating site is a Federal telemedicine demonstration program in Alaska or Hawaii. BIPA does not require that a practitioner present the patient for interactive telehealth services.

With regard to payment amount, BIPA specified that payment for the professional service performed by the distant site practitioner (i.e., where the expert physician or practitioner is physically located at time of telemedicine encounter) is equal to what would have been paid without the use of telemedicine. Distant site practitioners include only a physician as described in §1861(r) of the Act and a medical practitioner as described in

§1842(b)(18)(C) of the Act. BIPA also expanded payment under Medicare to include a \$20 originating site facility fee (location of beneficiary).

Previously, the Balanced Budget Act of 1997 (BBA) limited the scope of Medicare telehealth coverage to consultation services and the implementing regulation prohibited the use of an asynchronous ‘store and forward’ telecommunications system. The BBA of 1997 also required the professional fee to be shared between the referring and consulting practitioners, and prohibited Medicare payment for facility fees and line charges associated with the telemedicine encounter.

The BIPA required that Medicare Part B (Supplementary Medical Insurance) pay for this expansion of telehealth services beginning with services furnished on October 1, 2001.

Section 149 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended §1834(m) of the Act to add certain entities as originating sites for payment of telehealth services. Effective for services furnished on or after January 1, 2009, eligible originating sites include a hospital-based or critical access hospital-based renal dialysis center (including satellites); a skilled nursing facility (as defined in §1819(a) of the Act); and a community mental health center (as defined in §1861(ff)(3)(B) of the Act). MIPPA also amended §1888(e)(2)(A)(ii) of the Act to exclude telehealth services furnished under §1834(m)(4)(C)(ii)(VII) from the consolidated billing provisions of the skilled nursing facility prospective payment system (SNF PPS).

NOTE: MIPPA did not add independent renal dialysis facilities as originating sites for payment of telehealth services.

The telehealth provisions authorized by §1834(m) of the Act are implemented in 42 CFR 410.78 and 414.65.

270.1 - Eligibility Criteria

(Rev. 178, Issued: 12-30-13; Effective: 01-01-14, Implementation: 01-06-14)

Beneficiaries are eligible for telehealth services **only** if they are presented from an originating site located either in a rural HPSA or in a county outside of an MSA.

Effective January 1, 2014, rural HPSAs include HPSAs located outside of a county outside of an MSA as well as those located in rural census tracts as determined by the Office of Rural Health Policy. Also effective January 1, 2014, geographic eligibility for an originating site is established for each calendar year based upon the status of the area as of December 31st of the prior calendar year.

Entities participating in a Federal telemedicine demonstration project that were approved by or were receiving funding from the Secretary of Health and Human Services as of December 31, 2000, qualify as originating sites regardless of geographic location. Such entities are not required to be in a rural HPSA or non-MSA.

An originating site is the location of an eligible Medicare beneficiary at the time the service being furnished via telecommunications system occurs. Originating sites authorized by law are listed below.

- The office of a physician or practitioner;
- A hospital;
- A critical access hospital (CAH);
- A rural health clinic (RHC);
- A federally qualified health center (FQHC);
- A hospital-based or critical access hospital-based renal dialysis center (including satellites) (Effective January 1, 2009.);
- A skilled nursing facility (SNF) (Effective January 1, 2009.);
- A community mental health center (CMHC) (Effective January 1, 2009.).

NOTE: Independent renal dialysis facilities are not eligible originating sites.

270.2 – List of Medicare Telehealth Services

(Rev. 178, Issued: 12-30-13; Effective: 01-01-14, Implementation: 01-06-14)

The use of a telecommunications system may substitute for an in-person encounter for professional consultations, office visits, office psychiatry services, and a limited number of other physician fee schedule (PFS) services. These services are listed below.

Consultations (Effective October 1, 2001- December 31, 2009)

Telehealth consultations, emergency department or initial inpatient (Effective January 1, 2010)

Follow-up inpatient telehealth consultations (Effective January 1, 2009)

Office or other outpatient visits

Subsequent hospital care services (with the limitation of one telehealth visit every 3 days) (Effective January 1, 2011)

Subsequent nursing facility care services (with the limitation of one telehealth visit every 30 days) (Effective January 1, 2011)

Individual psychotherapy

Pharmacologic management (Effective March 1, 2003)

Psychiatric diagnostic interview examination (Effective March 1, 2003)

End stage renal disease related services (Effective January 1, 2005)

Individual and group medical nutrition therapy (Individual effective January 1, 2006; group effective January 1, 2011)

Neurobehavioral status exam (Effective January 1, 2008)

Individual and group health and behavior assessment and intervention (Individual effective January 1, 2010; group effective January 1, 2011)

Individual and group kidney disease education (KDE) services (Effective January 1, 2011)

Individual and group diabetes self-management training (DSMT) 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) (Effective January 1, 2011)

Smoking Cessation Services (Effective January 1, 2012)

Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services (Effective January 1, 2013)

Annual alcohol misuse screening (Effective January 1, 2013)

Brief face-to-face behavioral counseling for alcohol misuse (Effective January 1, 2013).

Annual Depression Screening (Effective January 1, 2013)

High-intensity behavioral counseling to prevent sexually transmitted infections (Effective January 1, 2013)

Annual, face-to-face Intensive behavioral therapy for cardiovascular disease (Effective January 1, 2013)

Face-to-face behavioral counseling for obesity (Effective January 1, 2013)

Transitional Care Management Services (Effective January 1, 2014)

NOTE: Beginning January 1, 2010, CMS eliminated the use of all consultation codes, except for inpatient telehealth consultation G-codes. CMS no longer recognizes office/outpatient or inpatient consultation CPT codes for payment of office/outpatient or inpatient visits. Instead, physicians and practitioners are instructed to bill a new or established patient office/outpatient visit CPT code or appropriate hospital or nursing facility care code, as appropriate to the particular patient, for all office/outpatient or inpatient visits. For detailed instructions regarding reporting these and other telehealth services, see Pub. 100-04, Medicare Claims Processing Manual, chapter 12, section 190.3.

The conditions of payment for Medicare telehealth services, including qualifying originating sites and the types of telecommunications systems recognized by Medicare, are subject to the provisions of 42 CFR 410.78. Payment for these services is subject to the provisions of 42 CFR 414.65.

270.3 – Conditions of Payment **(Rev. 1, 10-01-03)**

Furnished by CMS

For Medicare payment to occur, interactive audio and video telecommunications must be used, permitting real-time communication between the distant site physician or practitioner and the Medicare beneficiary. As a condition of payment, the patient must be present and participating in the telehealth visit.

Exception to the Interactive Telecommunications Requirement

In the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii, Medicare payment is permitted for telemedicine when asynchronous “store and forward technology,” in single or multimedia formats, is used as a substitute for an interactive telecommunications system. The originating site and distant site practitioner must be included within the definition of the demonstration program.

For the purposes of this instruction, store and forward means the asynchronous transmission of medical information to be reviewed at a later time by a physician or practitioner at the distant site. A patient’s medical information may include but not limited to, video clips, still images, x-rays, MRIs, EKGs and EEGs, laboratory results, audio clips, and text. The physician or practitioner at the distant site reviews the case without the patient being present. Store and forward substitutes for an interactive encounter with the patient present; the patient is not present in real-time.

NOTE: Asynchronous telecommunications system in single media format does not include telephone calls, images transmitted via facsimile machines and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patients’ condition and adequate for rendering or confirming a diagnosis or a treatment plan. Dermatological photographs, e.g., photographs of a skin lesion, may be considered to meet the requirement of a single media format under this instruction.

Telepresenters: A medical professional is not required to present the beneficiary to the physician or practitioner at the distant site unless medically necessary. The decision of medical necessity will be made by the physician or practitioner located at the distant site.

270.4 – Payment – Physician/Practitioner at a Distant Site **(Rev. 140, Issued: 02-28-11, Effective: 01-01-11, Implementation: 01-03-11 A/B** **MACs, Carriers/04-04-11 A/B MACs, FIs)**

The term “distant site” means the site where the physician or practitioner providing the professional service is located at the time the service is provided via a telecommunications system.

The payment amount for the professional service provided via a telecommunications system by the physician or practitioner at the distant site is equal to the current physician fee schedule amount for the service. Payment for telehealth services (see section 270.2 of this chapter) should be made at the same amount as when these services are furnished without the use of a telecommunications system. For Medicare payment to occur, the service must be within a practitioner’s scope of practice under State law. The beneficiary is responsible for any unmet deductible amount and applicable coinsurance.

Medicare Practitioners Who May Receive Payment at the Distant Site (i.e., at a Site Other Than Where the Beneficiary is Located)

As a condition of Medicare Part B payment for telehealth services, the physician or practitioner at the distant site must be licensed to provide the service under State law. When the physician or practitioner at the distant site is licensed under State law to provide a covered telehealth service (see section 270.2 of this chapter) then he or she may bill for and receive payment for this service when delivered via a telecommunications system.

Medicare practitioners who may bill for a covered telehealth service are listed below (subject to State law):

Physician;
Nurse practitioner;
Physician assistant;
Nurse midwife;
Clinical nurse specialist;
Clinical psychologist;
Clinical social worker; and
Registered dietitian or nutrition professional.

* Clinical psychologists and clinical social workers cannot bill for psychotherapy services that include medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for the following CPT codes: 90805, 90807, and 90809.

**270.4.1 – Payment for ESRD-Related Services as a Telehealth Service
(Rev. 97, Issued: 11-14-08, Effective: 01-01-09, Implementation: 01-05-09)**

The ESRD-related services included in the monthly capitation payment (MCP) with 2 or 3 visits per month and ESRD-related services with 4 or more visits per month may be paid as Medicare telehealth services. However, at least 1 visit must be furnished face-to-

face “hands on” to examine the vascular access site by a physician, clinical nurse specialist, nurse practitioner, or physician assistant. An interactive audio and video telecommunications system may be used for providing additional visits required under the 2-to-3 visit MCP and the 4-or-more visit MCP. The medical record must indicate that at least one of the visits was furnished face-to-face “hands on” by a physician, clinical nurse specialist, nurse practitioner, or physician assistant.

The MCP physician, for example, the physician or practitioner who is responsible for the complete monthly assessment of the patient and establishes the patient’s plan of care, may use other physicians and practitioners to furnish ESRD-related visits through an interactive audio and video telecommunications system. The non-MCP physician or practitioner must have a relationship with the billing physician or practitioner such as a partner, employees of the same group practice or an employee of the MCP physician, for example, the non MCP physician or practitioner is either a W-2 employee or 1099 independent contractor. However, the physician or practitioner who is responsible for the complete monthly assessment and establishes the ESRD beneficiary’s plan of care should bill for the MCP in any given month.

Clinical Criteria

The visit including a clinical examination of the vascular access site must be conducted face-to-face “hands on” by a physician, clinical nurse specialist, nurse practitioner or physician’s assistant. For additional visits, the physician or practitioner at the distant site is required, at a minimum, to use an interactive audio and video telecommunications system that allows the physician or practitioner to provide medical management services for a maintenance dialysis beneficiary. For example, an ESRD-related visit conducted via telecommunications system must permit the physician or practitioner at the distant site to perform an assessment of whether the dialysis is working effectively and whether the patient is tolerating the procedure well (physiologically and psychologically). During this assessment, the physician or practitioner at the distant site must be able to determine whether alteration in any aspect of the beneficiary’s prescription is indicated, due to such changes as the estimate of the patient’s dry weight.

270.4.2 – Payment for Subsequent Hospital Care Services and Subsequent Nursing Facility Care Services as Telehealth Services (Rev. 140, Issued: 02-28-11, Effective: 01-01-11, Implementation: 01-03-11 A/B MACs, Carriers/04-04-11 A/B MACs, FIs)

Subsequent hospital care services are limited to one telehealth visit every 3 days. The frequency limit of the benefit is not intended to apply to consulting physicians or practitioners, who should continue to report initial or follow-up inpatient telehealth consultations using the applicable HCPCS G-codes.

Similarly, subsequent nursing facility care services are limited to one telehealth visit every 30 days. Furthermore, subsequent nursing facility care services reported for a Federally-mandated periodic visit under 42 CFR 483.40(c) may not be furnished through

telehealth. The frequency limit of the benefit is not intended to apply to consulting physicians or practitioners, who should continue to report initial or follow-up inpatient telehealth consultations using the applicable HCPCS G-codes.

Inpatient telehealth consultations are furnished to beneficiaries in hospitals or skilled nursing facilities via telehealth at the request of the physician of record, the attending physician, or another appropriate source. The physician or practitioner who furnishes the initial inpatient consultation via telehealth cannot be the physician or practitioner of record or the attending physician or practitioner, and the initial inpatient telehealth consultation would be distinct from the care provided by the physician or practitioner of record or the attending physician or practitioner. Counseling and coordination of care with other providers or agencies is included as well, consistent with the nature of the problem(s) and the patient's needs. Initial and follow-up inpatient telehealth consultations are subject to the criteria for inpatient telehealth consultation services, as described in Pub. 100-04, Medicare Claims Processing Manual, chapter 12, section 190.3.

270.4.3 – Payment for Diabetes Self-Management Training (DSMT) as a Telehealth Service

(Rev. 140, Issued: 02-28-11, Effective: 01-01-11, Implementation: 01-03-11 A/B MACs, Carriers/04-04-11 A/B MACs, FIs)

Individual and group DSMT services may be paid as a Medicare telehealth service; however, at least 1 hour of the 10 hour benefit in the year following the initial DSMT service must be furnished in-person to allow for effective injection training. The injection training may be furnished through either individual or group DSMT services. By reporting the –GT or –GQ modifier with HCPCS code G0108 (Diabetes outpatient self-management training services, individual, per 30 minutes) or G0109 Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes), the distant site practitioner certifies that the beneficiary has received or will receive 1 hour of in-person DSMT services for purposes of injection training during the year following the initial DSMT service.

As specified in 42 CFR 410.141(e) and stated in section 300.2 of this chapter, individual DSMT services may be furnished by a physician, individual, or entity that furnishes other services for which direct Medicare payment may be made and that submits necessary documentation to, and is accredited by, an accreditation organization approved by CMS. However, consistent with the statutory requirements of section 1834(m)(1) of the Act, as provided in 42 CFR 410.78(b)(1) and (b)(2) and stated in section 270.4 of this chapter, Medicare telehealth services, including individual DSMT services furnished as a telehealth service, could only be furnished by a licensed physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), certified nurse-midwife (CNM), clinical psychologist, clinical social worker, or registered dietitian or nutrition professional.

270.5 - Originating Site Facility Fee Payment Methodology

(Rev. 151, Issued: 11-18-11, Effective: 01-01-12, Implementation: 01-03-12)

The term originating site means the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. For asynchronous, store and forward telecommunications technologies, an originating site is only a Federal telemedicine demonstration program conducted in Alaska or Hawaii. The originating site facility fee is a separately billable Part B payment. The contractor pays it outside of other payment methodologies. This fee is subject to post payment verification.

For telehealth services furnished from October 1, 2001, through December 31, 2002, the originating site facility fee is the lesser of \$20 or the actual charge. For services furnished on or after January 1 of each subsequent year, the originating site facility fee is updated by the Medicare Economic Index. The updated fee is included in the Medicare Physician Fee Schedule (MPFS) Final Rule, which is published by November 1 prior to the start of the calendar year for which it is effective. The updated fee for each calendar year is also issued annually in a Recurring Update Notification instruction for January of each year.

The originating site facility fee is a separately billable Part B payment. The payment amount to the originating site is the lesser of 80 percent of the actual charge or 80 percent of the originating site facility fee, except CAHs. The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.

The originating site facility fee payment methodology for each type of facility is clarified below:

When the originating site is a hospital outpatient department, payment for the originating site facility fee must be made as described above and not under the outpatient prospective payment system (OPPS). Payment is not based on the OPPS payment methodology.

For hospital inpatients, payment for the originating site facility fee must be made outside the diagnostic related group (DRG) payment since this is a Part B benefit, similar to other services paid separately from the DRG payment.

When the originating site is a critical access hospital, contractors make payment separately from the cost-based reimbursement methodology. For CAH's, the payment amount is 80 percent of the originating site facility fee.

The originating site facility fee for telehealth services is not an FQHC and RHC service. When an FQHC or RHC serves as the originating site, the originating site facility fee must be paid separately from the center or clinic all-inclusive rate.

When the originating site is a physician's or practitioner's office, the payment amount, in accordance with the law, is the lesser of 80 percent of the actual charge or 80 percent of the originating site facility fee regardless of geographic location. The geographic cost index (GPCI) should not be applied to the originating site facility fee. This fee is

statutorily set and is not subject to the geographic payment adjustments authorized under the MPFS.

When a hospital-based or critical access hospital-based renal dialysis center (or their satellites) serves as the originating site, the originating site facility fee is covered in addition to any composite rate or MCP amount.

The originating site facility fee is outside the SNF prospective payment system bundle and, as such, is not subject to SNF consolidated billing. The originating site facility fee is a separately billable Part B payment.

When a CMHC serves as an originating site, the originating site facility fee is not a partial hospitalization service. The originating site facility fee does not count towards the number of services used to determine payment for partial hospitalization services. The originating site facility fee is not bundled in the per diem payment for partial hospitalization. The originating site facility fee is a separately billable Part B payment.

270.5.1 - Originating Site Facility Fee Payment (ESRD-Related Services)

(Rev. 105, Issued: 04-24-09; Effective: 01-01-09; Implementation: 05-26-09)

With regard to ESRD-related services included in the MCP, the originating site facility fee payment may be made for each visit furnished through an interactive telecommunications system. When the physician or practitioner at the distant site furnishes an ESRD-related patient visit(s) included in the MCP through an interactive telecommunications system, the originating site facility may bill for a telehealth facility fee.

EXAMPLE: A 70 year old ESRD beneficiary receives 2 ESRD-related visits through an interactive telecommunications system and the required face-to-face visit (to examine the vascular access site) during the month of November. In this scenario the originating site should bill for two originating site facility fees as described by HCPCS code Q3014 and the MCP physician at the distant site should bill for ESRD-related services with 2 to 3 visits as a telehealth service with the “GT” modifier.

For more information on telehealth claims processing see Pub. 100-04, chapter 12, section 190 (Medicare telehealth claims processing).

280 – Preventive and Screening Services

(Rev. 93; Issued: 07-25-08; Effective Date: 04-28-08; Implementation Date: 08-25-08)

See section 50.4.4.2 for coverage requirements for PPV, hepatitis B vaccine, and Influenza Virus Vaccine.

Attachment 5



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AMERICAN TELEMEDICINE ASSOCIATION 2014 CPT CODE REQUEST FOR MEDICARE TELEHEALTH SERVICES

Proposed 2016 Physician Fee Schedule Changes

December 31, 2014

Division of Practitioner Services
Mail Stop: C4-03-06
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850
Attention: Telehealth Review Process

Contact Information:

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The American Telemedicine Association is requesting four items for consideration by the Centers for Medicare and Medicaid Services (CMS). These include several CPT codes to be added to the approved list of telehealth related services for 2016 and other clarifications of existing CMS policy. This request is being submitted by December 31, 2014 for consideration in the next physician fee schedule process.

In 2015 CMS has an opportunity to take the next step in healthcare reform related to the delivery of care. But the steps we recommend are not revolutionary. In fact, the four areas where we request changes have already been adopted by many private providers, employers and numerous state Medicaid programs. They all have widespread support by leading medical societies and health systems across the country. The use of health care technologies that support telehealth and other interactions between a practitioner and a Medicare eligible beneficiary, can transform Medicare by increasing access, improving care and reducing costs.

1. Cover, when performed by video visits--

- **99291, Critical Care and Evaluation – first 30 min**
- **99292, Critical Care and Evaluation – each additional 30 min**

ATA is asking for the addition of these codes which are especially useful in the provision of remote stroke and ICU care.

Telestroke - For many years the federal government has funded and promoted telestroke initiatives, linking neurologists in comprehensive stroke centers to smaller hospitals emergency departments and ICUs for the purposes of improving the treatment rates for persons experiencing acute ischemic stroke. The national American Heart Association's annual initiatives have included a focus on improving education, medical systems' response, and treatment with tissue plasminogen activator (tPA) for the treatment of stroke, one of the most debilitating and highest utilization of federal dollars conditions that plague the U.S. population.

Most patients present to emergency departments within a "golden period" of treatment, and have precious little time to be transported to another facility where a neurologist may be located. Due to federal funding initiatives, many stroke networks have been put in place to solve the problem of neurologist coverage, and many of the programs include the use of telemedicine. A local emergency department or attending physician manages and maintains control of the patient, while the stroke neurologist assists in making the determination of the safety and efficacy in each patient situation, of administration of tPA, to open the cerebral artery within five hours of onset, and reduce the morbidity and mortality associated with acute ischemic stroke (AIS). As the majority of patients with AIS survive, and most have disabilities so severe that inpatient rehabilitation facility (IRF) or skilled nursing facility (SNF) care is required initially, and many who return home requiring round the clock support, the drain on the public health and government payer system is considerable. Estimates of the impact of stroke care on Social Security benefits are as high as 17 percent being used for stroke and post-stroke disability care.

Based on estimates from leading providers and vendors, ATA estimates that this past year approximately 100,000 patients suffering from a stroke were seen by a specialist via telemedicine. However, the lack of reimbursement for telestroke has prevented even greater use of this technology to save lives and improve outcomes.

The benefits of telestroke networks have been proven by several hallmark studies. A study by Demaerschalk et al. was conducted to analyze literature regarding the cost-effectiveness of telestroke programs. The study was a systematic literature review of 748 studies from 2003 to 2008, analyzing cost-effectiveness or cost savings with the use of tPA stroke centers, telemedicine centers for acute ischemic stroke. Twenty-four studies were included that reflected cost-effectiveness or cost-analysis data. Results indicated that long-term cost savings due to decreased nursing facility and rehabilitation needs. Stroke centers were shown to reduce hospital length of stay and both stroke centers and telemedicine programs demonstrated increased rates of tPA administration within 3 hours of onset of symptoms.¹

A more recent survey of research studies was conducted by Bashshur et al.²

¹ Demaerschalk BM, Whang HM, Leung G. 2010. Cost analysis review of stroke centers, telestroke, and rt-PA. Department of Neurology, Mayo Clinic Hospital. Am J Manag Care 2010. Jul; 16(7): 537-44.

² Bashshur RL, et al. The empirical foundations of telemedicine interventions for chronic disease management. Telemed J E Health. 2014 Sep;20(9):769-800. doi: 10.1089/tmj.2014.9981. Epub 2014 Jun 26.

The REACH TeleStroke program is one of the oldest in the United States, serving rural Georgia hospitals from the Medical College of Georgia's Emergency Communications Center and Neurosciences program. An early study by Switzer et al. was designed to determine the safety, effectiveness, and treatment times for telemedicine assisted stroke care in rural Georgia. Systems used computer broad-band internet access with one-way video and two-way audio. Real-time video was used in combination with DICOM transmitted CT images of the brain. Eight hospitals participated with only one hospital having a stroke protocol and only two stocking tPA prior to the onset of the study. Implementation of the study itself automatically improved access to the treatment.³

There were 258 consultations and 42 IV tPA treatments as a result of implementing a telestroke program in the first year. Mean onset-to-treatment time (OTT) was 125.8 minutes. Fifty-two percent of the patients were treated in less than two hours from onset of symptoms with 17 percent within 90 minutes of OTT. The mean NIHSS at time of treatment was 14.6 and the NIHSS at 24 hours after treatment was 8.4. As remarkable as the results were, the true value in the study was the disposition of patients. At discharge, 48 percent of the treated patients went home, and 31 percent of the treated patients went to an IRF or SNF.

Subsequent studies show clearly that early findings in telestroke systems are borne out over and over and support cost savings, decrease in utilization of IRFs and SNFs, and over decreases in morbidity and mortality rates associated with acute ischemic stroke. Considering the millions of dollars the federal government has spent on developing telestroke networks, the implementation of telestroke by many states, and the clinical and cost evidence that supports the use of telestroke in decreasing the cost of acute ischemic stroke to the Medicare system, ATA is encouraging CMS to add the codes 99291 and 99292 for critical care to the list of approved Medicare telehealth codes.

In addition, critical care codes can be used by trauma surgeons to assist attending emergency physicians in stabilizing trauma victims prior to transfer, for cardiologist in collaboration with emergency physicians, in determining disposition for a patient with acute ischemic syndrome, and for physicians assisting remote ICU services until the local hospitalist or attending responds to a patient emergency. All situations described involve a high risk, high cost situation in which the introduction of a specialist into the process of care in collaboration with an on-site attending greatly increases the likelihood of a better clinical outcome, thus reducing long-term costs to Medicare.

In another example of research focused on the use of telemedicine for critical care, Brennan, et al., conducted a randomized control trial involving emergency physicians and nurses who were trained in telemedicine techniques in two emergency departments, one rural low volume and one suburban high volume. The suburban emergency physician diagnosed and treated the control patients. Experimental patients presenting to the high-volume emergency department were evaluated and treated by the telemedicine nurse in person and the rural emergency physician via the telemedicine link. Immediately before discharge all telemedicine patients were re-evaluated by the suburban emergency physician. Data collected on each patient included: diagnosis; treatment; return visits within 72 hours; need for additional care; and satisfaction of patient, physicians and nurses. There were no significant differences ($P < 0.05$) for occurrence of return

³ Switzer J et al. 2006 AAN Enterprises, Vol 66(5) Supp 2, Mar, p. A354

visits within 72 hours, need for additional care or overall patient satisfaction. The average patient throughput time from admission to discharge was 106 minutes for the telemedicine group and 117 minutes for the control group. Telemedicine was a satisfactory technique for the chosen group of patients in the emergency department and was acceptable to the participants.⁴

TeleICU - The use of teleICU has provided more safe and timely care for Medicare beneficiaries that are hospitalized in facilities without 24 hour in-house critical care providers. TeleICU is the use of an off-site command center in which a critical care team (intensivists and critical care nurses) is connected with patients in distant ICUs to exchange health information through real-time audio, visual, and electronic means. Approximately 13 percent of the nation's adult ICU beds have teleICU coverage with a majority of coverage in academic and private hospitals (NEHI, 2013).

This patient population has the highest cost impact in any organization. The patients are critically ill with many concurrent and emergent needs that occur throughout their ICU stay. The teleICU team is comprised of clinical experts such as an intensivist and critical care nurses. By using advanced communication technologies, these teams are able to leverage clinical expertise across a spectrum of patients in a variety of clinical settings. The model of care depends upon several factors including the number of patients requiring teleICU services, patient acuity, existing bedside resources (includes both human and technology/equipment resources), and contractual arrangements.

The models of care described below are general; specific programs may include various combinations of each:

- 1) Continuous Care Model: Continuous care is monitoring of the patient without interruption for a defined period of time (e.g. on an 8, 12, or 24 hour basis).
- 2) Episodic Care Model: Episodic care occurs intermittently with a periodic consultation on a pre-determined schedule (e.g. during patient rounds) or at unscheduled times.
- 3) Responsive Care Model: In this model virtual visits are prompted by an alert (e.g., telephone call, page, monitor alarm)⁵

These teleICU clinical models function as a safety net for patients, nurses, and physicians. Using remote video and voice technology, teleICU leverages critical care expertise while striving to improve patient outcomes through the consistent use of evidence-based medicine in collaboration with the ICU clinical teams.

Due to the prevalence and adoption of teleICU and a model of care delivery that improves access to intensivist expertise, improved clinical outcomes, decreased mortality and morbidity as well as length of stay, ATA developed clinical guidelines for practitioners using teleICU to care for critical care patients. The guidelines are designed to aid in the development of effective, safe and sustainable teleICU practices and are intended to promote standardization of teleICU care delivery thus impacting clinical outcomes. Starting with an extensive review and scoring of

⁴J A Brennan, J A Kealy, L H Gerardi, R Shih, J Allegra, L Sannipoli and D Lutz. Telemedicine in the emergency department: a randomized controlled trial. *J Telemed Telecare* 1999; 5:18-22

⁵Reynolds HN, Rogove H, Bander J, McCambridge M, Cowboy E, Niemeier M. A working lexicon for the tele-intensive care unit: we need to define tele-intensive care unit to grow and understand it. *Telemed J E Health*. 2011;17(10):773-83.

hundreds of scientific studies, the guidelines were developed in conjunction with the nation's leading authorities in providing intensive care and have gone through an extensive comment period including public comments.⁶ The guidelines have been endorsed by the American Society of Critical Care Nurses and the Society of Critical Care Medicine.

A study by Kumar et al⁷, provided the current landscape for critical care in American hospitals and held that there is a shortage of intensivists in the United States, and the demand for them is only going to increase with the aging population.⁸ As of 2010, less than 15 percent of intensive care units (ICUs) are able to provide intensivist care.⁹ There are 6,000 ICUs but only 5,500 board-certified intensivists.¹⁰ Studies have shown that hospitals with a dedicated intensivist on staff had a significant reduction in ICU mortality and average length of stay (LOS).^{11 12} The complexity of today's ICU services entails the need for sharing health information through off-site ICU centers.¹³ TeleICU is the use of health information exchanged from a hospital critical care unit to another site via electronic communications.¹⁴ TeleICU intensivists provide real-time services to multiple care centers regardless of their locations. TeleICU uses an off-site command center in which a critical care team (intensivists and critical care nurses) is connected with patients in distant ICUs through real-time audio, visual, and electronic means. Similar to a bedside team, offsite teleICU intensivists require full access to patient data. TeleICU is capable of providing real-time monitoring of patient instability or any abnormality in laboratory results, ordering diagnostic tests, making diagnoses and ordering treatment, and implementing interventions through the control of life-support devices. As a result, teleICU provides the expertise of intensivists at the time of a patient crisis, which in turn improves the quality of critical care and clinical outcomes given to and experienced by Medicare beneficiaries.

In terms of outcomes, the study found a 10 percent reduction in ICU length of stay, creating the ability to care for one new ICU patient per day, which could result in a positive \$2.5 million net present value.¹⁵

Most studies reviewed used LOS and mortality to determine cost savings. For example, according to Rosenfeld et al., ICU costs decreased between 25 percent and 31 percent during the

⁶ American Telemedicine Association. 2014. Practice guidelines for tele-ICU practice. www.americantelemed.org

⁷ Kumar S, Merchant S, Ryenolds R. 2014. Tele-ICU: efficacy and cost-effectiveness of remotely managing critical care. *Perspectives*, On-line Research Journals. <http://perspectives.ahima.org/tele-icu-efficacy-and-cost-effectiveness-of-remotely-managing-critical-care/#.VKDL4l4A3s>

⁸ Mullen-Fortino, M., J. DiMartino, L. Entrikin, S. Muliner, C. W. Hanson, and J. M. Kahn. "Bedside Nurses' .

⁹ Goran, S. "A Second Set of Eyes: An Introduction to Tele-ICU." *Critical Care Nurse* 30, no. 4 (2010): 46–54.

¹⁰ Ries, M. "Tele-ICU: A New Paradigm in Critical Care." *International Anesthesiology Clinics* 47, no. 1 (2009): 153–70.

¹¹ Celi, L. A., E. Hassan, C. Marquardt, M. Breslow, and B. Rosenfeld. "The eICU: It's Not Just Telemedicine." *Critical Care Medicine* 29, no 8 (2001): N183–N189.

¹² Morrison, J. L., Q. Cai, N. Davis, Y. Yan, M. L. Berbaum, M. Ries, and G. Solomon. "Clinical and Economic Outcomes of the Electronic Intensive Care Unit: Results from Two Community Hospitals." *Critical Care Medicine* 38, no. 1 (2010): 2–8.

¹³ Halpern, N. A., S. M. Pastores, and R. J. Greenstein. "Critical Care Medicine in the United States 1985–2000: An Analysis of Bed Numbers, Use, and Costs." *Critical Care Medicine* 32, no. 6 (2004): 1254–59.

¹⁴ Grundy, B. L., P. K. Jones, and A. Lovitt. "Telemedicine in Critical Care: Problems in Design, Implementation, and Assessment." *Critical Care Medicine* 10, no. 7 (1982): 471–75.

¹⁵ Breslow, M. J., B. A. Rosenfeld, M. Doerfler, G. Burke, G. Yates, D. J. Stone, P. Tomaszewicz, R. Hochman, and D. W. Plocher. "Effect of a Multiple-Site Intensive Care Unit Telemedicine Program on Clinical and Economic Outcomes: An Alternative Paradigm for Intensivist Staffing."

intervention period, and hospital costs decreased by 12 percent to 19 percent.¹⁶ Breslow et al. hired an independent consulting firm to determine the financial outcome of a teleICU program.¹⁷ The researchers determined the cost of care per day of service and also included equipment costs, staff costs, and other costs associated with having a teleICU system. The report showed a 24.6 percent decrease in variable costs per patient. The decrease was attributed to a shorter LOS in the ICU and improved clinical outcomes.^{18,19} Early work by the Veterans Administration also showed that teleICU reduces mortality while the patient is in the ICU.²⁰

CMS currently defines a critical illness or injury as an illness or injury that acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition. Critical care services are defined as a physician's direct delivery of medical care for a critically ill or critically injured patient. Critical care services involves decision making of high complexity to assess, manipulate, and support vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition. Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure.

CMS adds that in order to qualify as critical care for Medicare patients, "the failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant or life threatening deterioration in the patient's condition. The services must be medically necessary and require the full attention of the physician or allied provider. CMS goes on to state that the duration of critical care services to be reported is the time the physician spent evaluating, providing care and managing the critically ill or injured patient's care. That time must be spent at the immediate bedside or elsewhere on the floor or unit so long as the physician is immediately available to the patient.²¹ For any given period of time spent providing critical care services, the physician must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time.

ATA holds that when a physician is providing teleICU services to a patient in the ICU, he or she meets all requirements of CMS for full attention to the patient, immediate availability to the patient, and to provide only medically necessary care. The use of teleICU is now standard of care, with thousands of beds in the United States being monitored through teleICU, and with national standards in place for the use of teleICU. ATA requests that CMS approve the use of critical care codes 99291, 99292, and any other comparable codes to the list approved for Medicare telehealth.

¹⁶ Rosenfeld, B. A., T. Dorman, M. J. Breslow, P. Pronovost, M. Jenckes, N. Zhang, et al. "Intensive Care Unit Telemedicine: Alternate Paradigm for Providing Continuous Intensivist Care." *Critical Care Medicine* 28, no. 12 (2000): 3925–31.

¹⁷ Breslow, M. J., B. A. Rosenfeld, M. Doerfler, G. Burke, G. Yates, D. J. Stone, P. Tomaszewicz, R. Hochman, and D. W. Plocher. "Effect of a Multiple-Site Intensive Care Unit Telemedicine Program on Clinical and Economic Outcomes: An Alternative Paradigm for Intensivist Staffing."

¹⁸ Celi, L. A., E. Hassan, C. Marquardt, M. Breslow, and B. Rosenfeld. "The eICU: It's Not Just Telemedicine."

¹⁹ Rosenfeld, B. A., T. Dorman, M. J. Breslow, P. Pronovost, M. Jenckes, N. Zhang, et al. Intensive Care Unit Telemedicine: Alternate Paradigm for Providing Continuous Intensivist Care.

²⁰ Veterans Rural Health Resource Center-Central Region Winter 2011. Impact of Tele-ICU Coverage on Patient Outcomes Table 1. Characteristics of Studies Included in Meta-Analysis and Length of Stay of Tele-ICU Mortality. VA Issue Brief #6.

²¹ <http://www.acep.org/Physician-Resources/Practice-Resources/Administration/Financial-Issues/-/Reimbursement/Critical-Care-FAQ/>

2. Clarify existing Medicare language defining “physician services”

CMS has long covered Medicare services that can be provided by “direct visualization” that do not require live interactions with the patient. In the Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services,” “30 - Physician Services, CMS considers these “physician services,” not telehealth. The Manual lists examples such as assessing an MRI, EKG or tissue slides.

There are other now other physician services that should be covered similarly be covered, such as urgent dermatological problems and wound care. In the most recent notice of proposed rulemaking for the fee schedule, we were cited for not specifying relevant codes for telehealth coverage (79 FR 40359). Our request made last year and renewed this year, is that the Manual be changed to be explicitly inclusive about such as “physician services,” not as code-based telehealth with its other major restrictions.

Specifically, we request a modification in **boldface** of the Manual as such:

“A. General

...

“A service may be considered to be a physician’s service where the physician either examines the patient in person or is able to visualize some aspect of the patient’s condition without the interposition of a third person’s judgment. Direct visualization would be possible by means of x-rays, electrocardiogram and electroencephalogram tapes, tissue samples, etc.”

*For example, the interpretation by a physician of an actual electrocardiogram or electroencephalogram reading that has been transmitted via telephone (i.e., electronically rather than by means of a verbal description) is a covered service. **Similar services performed by a physician visualizing, following appropriate practice guidelines and standards of care, are also covered as physician services.***

3. Cover chronic care monitoring (code 99091) in conjunction with the new coverage for chronic care management (99490)

Although the new coverage for chronic care management accommodates physician and staff time for review of monitoring data (similar to the unreimbursed 99090 code) and the fee schedule sets an RVU for the service costs of remote patient monitoring (code 99091), Medicare maintains a disconnect between the two codes.

Bashshur et al. surveyed the literature about the value of monitoring, especially for congestive heart failure and chronic obstructive pulmonary disease, conditions important for the savings from Medicare readmissions reductions.²² The telemedicine intervention in chronic disease

²² Bashshur RL, Shannon GW, Smith BR, Alverson DC, Antoniotti N, Barsan WG, Bashshur N, Brown EM, Coye MJ, Doarn CR, Ferguson S, Grigsby J, Krupinski EA, Kvedar JC, Linkous J, Merrell RC, Nesbitt T, Poropatich R, Rheuban KS, Sanders JH, Watson AR, Weinstein RS, Yellowlees P. The empirical foundations of telemedicine interventions for chronic disease management. *Telemed J E Health*. 2014 Sep;20(9):769-800.

management involves patients in their own care, provides continuous monitoring by their healthcare providers, identifies early symptoms, and responds promptly to exacerbations in their illnesses. The researchers' review set out to establish the evidence from the available literature on the impact of telemedicine for the management of three chronic diseases: congestive heart failure, stroke, and chronic obstructive pulmonary disease. By design, the review focuses on a limited set of representative chronic diseases because of the current and increasing importance relative to the prevalence of these conditions, associated morbidity, mortality, and cost. Furthermore, the three diseases are amenable to timely interventions and secondary prevention through telemonitoring. The preponderance of evidence from studies using rigorous research methods points to beneficial results from telemonitoring in its various manifestations, albeit with a few exceptions. Generally, the benefits include reductions in use of service: hospital admissions/re-admissions, length of hospital stay, and emergency department visits typically declined. It is important that there often were reductions in mortality. Few studies reported neutral or mixed findings.

We request Medicare, at least, reimburse for the service of chronic care monitoring (99091) in conjunction and for the same time period as chronic care management (99490).

4. Set relative value units for--

- **98969, On-line Internet Assessment and Management – non-physician**
- **99444, On-line Internet Assessment and Management – physician**

There is wide agreement in health care on the web's potential to positively transform the industry, and many payers have launched successful e-business efforts, including web portals for consumers that offer decision support tools for everything from healthy lifestyles to cost comparisons for surgical procedures. Goals of medical web portals are improving patient's health, reducing delays in communicating pertinent and timely health status information. The goals ultimately lower health care costs, and positively influencing the physician-patient relationship at the point of service, a key to improving safety, reducing duplicative tests and services, and enhancing satisfaction with the health care system overall. Programs such as pay for performance espouse the same goals, and rising popularity indicates that payers are committed to informing and supporting providers who use web-portals in improving patient outcomes.

The use of on-line internet assessment and management through clinician web-portals is a potential vehicle to get more clinically oriented information to physicians, laying the groundwork for improved care management and greater efficacies across the health care system. New requirements for interaction with patients electronically through EHRs and web-portals also drive the uptake and utilization of clinician-based web portals. As an example, a patient portal typically provides secure e-mail, allowing the patient to make a quick query of the physician (and presumably receive a reasonably quick response) without the delay and inconvenience of attempting to catch the physician on the phone between visits or after hours. Many office visits are less than 15 minutes and typically do not require any examination, only history. Patient portals can also be used for scheduling, allowing patients to make requests for particular times and days. Finally, the newest and most sophisticated patient portals will allow patients to take a peek inside their patient record, giving them online (and secure) access to their medication list, recent labs, and other data that might be useful in self management, or if the patient is seeing another provider.

In the Seattle area, Group Health Cooperative, a large health plan, has been very successful in engaging its members in using its web-portal over the last decade, with more than 40 percent using a portal for secure e-mail messaging with providers. Hundreds of other practices, large and small have been successful in launching patient portals.

Meaningful use of an EHR refers to the criteria practices are required to meet to qualify for federal incentives for EHR implementation. Meaningful use will be an incremental requirement, with three progressively more challenging stages over the five or more years of the program. The end game of meaningful use is a reshaping of how medicine is practiced. Front and center to this game is a more proactive level of engagement with patients. With an aging population, and chronic diseases soaking up an ever-increasing swath of already inflated medical spending, improved physician-patient collaboration is a matter of fiscal necessity.

The spirit of the medical home and accountable-care initiatives is predicated on this more proactive approach. The patient portal, with its ability to send preventative care reminders electronically, provide patients with an online record and tools for self-management, or for use with other providers will be central to making this engagement practical and efficient.

The problem is that the current fee schedule has 0.00 as the relative value units for 98969 and 99444. We renew our request from last year to set appropriate RVUs for these codes so that Medicare beneficiaries can make use of such emerging services and that they be available to all beneficiaries (such as 96103 for psychological testing and 96120 for neuropsychological testing), not as telehealth with accompanying artificial restrictions.

Sincerely,

A handwritten signature in blue ink that reads "Jonathan D. Linkous". The signature is fluid and cursive, with the first name "Jonathan" being more prominent than the last name "Linkous".

Jonathan D. Linkous
Chief Executive Officer
American Telemedicine Association

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§17-1737-51 Sleep services. (a) Sleep services are services provided for the diagnosis and treatment of sleep disorders and shall:

- (1) Be performed by sleep laboratories or sleep disorder centers; and
- (2) Be provided to Medicaid eligible individuals only when ordered by a physician and authorized by the department on form DHS 1144.

(b) Medicaid payments shall only be made for sleep services furnished by sleep laboratories or sleep centers who are accredited by the American Sleep Disorders Association by January 1, 1997.

[Eff 11/25/96] (Auth: HRS §§346-14, 346-59)
(Imp: HRS §§346-14, 346-59; 42 C.F.R. §431.10)

§17-1737-51.1 Telehealth services. (a) Telehealth services is the use of communication equipment to link health care practitioners and patients in different locations. It may be used in place of a face-to-face, "hands on" encounter for consultation, office visits, individual psychotherapy and pharmacologic management. For purposes of this section, the term "patient" refers to individuals eligible for medical assistance.

(b) Telehealth services may be provided to patients only if they are presented from an originating site located in either a:

- (1) Rural Health Professional Shortage Area (HPSA) as defined by section 332(a)(1)(A) of the Public Health Service Act;
- (2) In a county outside of a Metropolitan Statistical Area, as defined by Section 1886(d)(2)(D) of the Social Security Act; or
- (3) From an entity that participates in a Federal telemedicine demonstration project that has been approved by the Secretary of Health and Human Services as of December 31, 2000.

(c) Interactive audio and video telecommunication systems must be used. Interactive telecommunications systems must be multi-media communications that, at a minimum, include audio and video equipment, permitting real-time consultation among the patient, consulting practitioner, and referring practitioner. Telephones, facsimile machines, and electronic mail systems do not meet the requirements of interactive telecommunications system. As a condition of payment

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the patient must be present and participating in the telehealth visit.

(d) An originating site is the location of a patient at the time the service being furnished via a telecommunications system occurs. Originating sites authorized to furnish telehealth services are listed below:

- (1) The office of a physician or practitioner;
- (2) A hospital;
- (3) A critical access hospital;
- (4) A rural health clinic; and
- (5) A federally qualified health center.

An exception to this provision is an entity participating in a Federal telehealth demonstration project that is approved by or is receiving funding from the Secretary of Health and Human Services as of December 31, 2000. An entity participating in a Federal telehealth demonstration project qualifies as an originating site regardless of geographic location.

(e) A distant site is the site at which the physician or practitioner delivering the service is located at the time the service is provided via a telecommunications system.

(f) Coverage of telehealth services is based on Medicare's criteria. Each provider must bill the appropriate CPT procedure code with the modifier code "TM" indicating the services were provided via telehealth. Only providers eligible to participate in the medical assistance program will be reimbursed for telehealth services. Reimbursements to an originating site and distant site are based on the Hawaii Medicaid fee schedule. [Eff 02/07/05] (Auth: HRS §346-59) (Imp: 42 C.F.R. §410.78; Pub. L. 105-33)

§17-1737-52 (Reserved).

SUBCHAPTER 6

EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT (EPSDT)

§17-1737-53 Early and periodic screening, diagnosis, and treatment (EPSDT). (a) EPSDT means early screening and diagnostic services to identify physical or mental defects in recipients; and, to

Attachment 7

§431:10A-116.3 Coverage for telehealth. (a) It is the intent of the legislature to recognize the application of telehealth as a reimbursable service by which an individual shall receive medical services from a health care provider without face-to-face contact with the provider.

(b) No accident and health or sickness insurance plan that is issued, amended, or renewed shall require face-to-face contact between a health care provider and a patient as a prerequisite for payment for services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services were provided. The coverage required in this section may be subject to all terms and conditions of the plan agreed upon among the enrollee or subscriber, the insurer, and the provider.

(c) Reimbursement for services provided through telehealth shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and patient. There shall be no reimbursement for a telehealth consultation between health care providers unless a health care provider-patient relationship exists between the patient and one of the health care providers involved in the telehealth interaction and the patient is accompanied by a treating health care provider at the time telehealth services are provided by the consulting health care provider; provided that when behavioral health services are provided, a second health care provider shall not be required to accompany the patient.

For the purposes of this section, "health care provider" means a provider of services, as defined in 42 U.S.C. 1395x(u), a provider of medical and other health services, as defined in 42 U.S.C. 1395x(s), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business, including but not limited to primary care providers, mental health providers, oral health providers, physicians and osteopathic physicians licensed under chapter 453, advanced practice registered nurses licensed under chapter 457, psychologists licensed under chapter 465, and dentists licensed under chapter 448.

(d) Notwithstanding chapter 453 or rules adopted pursuant thereto, in the event that a health care provider-patient relationship does not exist between the patient and the health care provider to be involved in a telehealth interaction between the patient and the health care provider, a telehealth mechanism may be used to establish a health care provider-patient relationship.

(e) For the purposes of this section, "telehealth" means the use of telecommunication services, as defined in section 269-1,

including but not limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information to parties separated by distance. Standard telephone contacts, facsimile transmissions, or e-mail text, in combination or by itself, does not constitute a telehealth service for the purposes of this chapter. [L 1998, c 278, §2; am L 2002, c 155, §56; am L 2006, c 219, §2; am L 2009, c 20, §3; am L 2014, c 159, §3]

Cross References

Practice of telehealth, see §453-1.3.