Telehealth Conundrums

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Overview

Introductions

General Framework for Telehealth Regulation

Presentations on Specific Issue Areas
  ○ Documentation & Billing
  ○ Medicare/Medicaid/Payers
  ○ Chronic Care/Collaborative Care/New Models
  ○ FQHC/RHC issues

Break

Extended Q&A
Introduction

Catrena Smith, CCS, CPCO, CHTS-PW

Catrena Smith is Audit & Education Manager with KIWI-TEK, LLC. She brings over 19 years’ experience in the health information management industry. She has served in various roles from Health Information Management Technician to Subject Matter Expert (SME). She speaks at a numerous conferences, seminars, and workshops annually. She is a former AAPC Local Chapter President, currently serves as an AHIMA and AAPC student mentor, and is an active FHIMA Volunteer. Catrena currently serves as a SME for the Florida Health Information Management Association and prides herself in helping to advance the health information management profession.
Don Graf is a nationally recognized subject matter expert on telehealth. He has passionately supported telehealth expansion and reimbursement reform initiatives in Arizona and on the national stage for over twenty years. Don served on the AMA Telehealth Coding Task Force, the NQF, Telehealth Quality Framework Committee and was recently inducted into the ATA College of Fellows. He is a member of the Arizona Telemedicine Council, the New Mexico Telehealth Alliance and served as the National Telehealth Director for United Healthcare. Don currently provides telehealth consulting for provider, health system and payer community clients across the country.
Dr. Manny Castro is Medical Director for Behavioral Health Integration and Chief of the Department of Psychiatry at Atrium Health. Dr. Castro is a board certified psychiatrists who works in Charlotte, North Carolina. He is affiliated with Carolinas HealthCare System, Behavioral Health Charlotte, Carolinas HealthCare System University, and Carolinas Medical Center Pineville. He has 20 years of experience in creating innovative ways to provide real-time access to psychiatric care.
Nathaniel Lacktman, Esq.

Nathaniel (Nate) Lacktman is a partner and health care lawyer with Foley & Lardner LLP, and Chair of the firm’s national Telemedicine & Digital Health Industry Team. He advises health care providers and technology companies on business arrangements, compliance, and corporate matters, with particular attention to telehealth, digital health, and health innovation. Working with hospitals, health systems, providers, and start-ups to build telemedicine arrangements across the United States and internationally, his practice emphasizes strategic counseling, creative business modeling, and fresh approaches to realize clients' ambitious and innovative goals.
A Framework for Understanding Telehealth Regulation
Telemedicine is Many Things

➢ Primary care and specialty services/encounters
  ○ E.g., telestroke, telepsychiatry, tele-whatever...
  ○ Usually live video
➢ Provider-to-provider consultation
➢ Asynchronous communication and medical monitoring
  ○ Issues of identifying/establishing patients, defining services
➢ Direct-to-consumer services (primary/urgent)
  ○ Contracting directly with payers, a whole different “model”
➢ mHealth, consumer-facing apps
Overlapping Layers of Telemedicine Policy

➢ Professionals and corporations are regulated at the state level
  ○ Physicians, Physicians Assistants, Nurse Practitioners, Nurses, Counselors, etc.
  ○ Tele-services companies, medical groups, insurance companies, etc.

➢ Medicare
  ○ Federal “definitions” of telemedicine, and some significant restrictions
  ○ No regulations *per se*; only conditions of payment (and concepts, definitions)

➢ States & Medicaid
  ○ Medicaid varies by state; managed plans (MCOs) are regulated at state level
  ○ States can dabble in other areas of regulation: licensing boards, insurance, coverages

➢ Private Payers
  ○ Coverages can vary by company and plan
  ○ Compliant with state law (we hope), but limited transparency otherwise
Getting Paid <> Getting it Right

● Sometimes you don’t know which rules apply.
● Often you can get paid even if your bill is wrong.
● Often you can get denied even if your bill is correct.
● Sometimes you get conflicting interpretations from “experts.”
● Some situations are simply “undefined” in statute. What then?
Specific Issue Areas
Coding and Documentation
Importance of Documentation

- Continuity of care
- Payment considerations
- Provider’s memory
Documentation Considerations

- Consent for telehealth services
- Clear identification as telehealth
- Distant and originating sites
- Patient demographics
- Supporting documentation
- Telehealth statement
- Authentication
Sample Telehealth Statement

This visit was conducted with the use of an interactive audio and video telecommunication system that permits real-time communication between the patient and this provider.
Medicare & Interjurisdictional Issues
Medicare Coverage and Enrollment

- Medicare Changes to Telehealth Services
- New Virtual Care (non-F2F) Services
- Interjurisdictional Enrollment, Reassignment, and Claims Submission
New Medicare Telehealth Services

- ESRD Services
- Telestroke
- Mobile Stroke Units
  - See also Emergency Triage, Treat, and Transport (ET3) Model
- Substance Use Disorder
- Medicare Advantage expansion
New Medicare Virtual Codes for 2019

- Virtual Check-In (HCPCS G2012)
- Remote Evaluation of Pre-Recorded Data (HCPCS G2010)
- Interprofessional Consultations (99446, 99447, 99448, 99449) 2 new (99451, 99452)
Medicare Interjurisdictional Enrollment, Reassignment, and Claims Submission

1. Enrollment
2. Reassignment
3. Claims Submission (prof. fee and orig site fee)
Medicaid Policies and Environment
Reimbursement Conundrums

- Is patients home as originating site allowed
- Can remote patient monitoring be reimbursed
- Where is asynchronous or store and forward allowed
- Can FQHC bill for professional and or facility fees
- What specialties are allowed and where
- Is an established relationship required for billing
Source of Truth

- American Telemedicine Association GAP Reports
- Center for Connected Health Policy
- State Statue
- State Medicaid Policy
- Local/Regional Licensing Boards
Telehealth Policy Favorability Landscape
Color coded favorable, unfavorable and no reference by essential telehealth elements

- **FAVORABLE:**
  Most/all top four essential elements allowed

- **UNFAVORABLE:**
  Most/all essential elements not allowed

- **NO REFERENCE:**
  Most/all four essential elements not referred to in policy
Collaborative Care and Reimbursement
Impact/ Collaborative Care Model

2 year Randomized Control Trial:
1801 Adults with Depression

12 months:
50% reduction of depressive symptoms
45% IMPACT model
19% usual care participants

4 years
$3,300 in savings in health care spend per patient

Repeated in 80 Randomized Trials
Atrium Health Model
Virtual Behavioral Health Integration (vBHI)

The Collaborative Care Model

The Team

**Behavioral Health Professional**
- LCSW/ LPC/ Psych RN

**Health Coach**
- Bachelor level with two years’ experience
- Obtain Health Coach Certification within 1 year of hire date

**Provider**
- Adult Psychiatrist
- Child and Adolescent Psychiatrist
- Nurse Practitioner

**Pharmacy**
- Board Certified Psychiatric Pharmacist (BCPP)
The vBHI Process

- BH Patient
- PCP Office
  - Administers PHQ-9
  - PCP Appointment
- Elevated PHQ-9 Scores Captured in BH Patient Registry
- In office virtual visit (if desired)
- Post Appointment Call Back Protocol
- Virtual BH Support Team

PCP consults BH Provider for curbside chart review
vBHI Clinical Outcomes

**Depression**
- 60.2% of patients receiving BHI services demonstrated 50% reduction in PHQ-9 score

**Anxiety**
- 65.9% of patients receiving BHI services demonstrated 50% reduction in GAD-7 score

**Remission**
- 44.1% of patients receiving BHI services achieved remission

**Suicidal Ideations**
- 88.0% of patients receiving BHI services endorsed absence of suicidal ideations upon completion of Health Coaching
Collaborative Care Codes

- Medicare pays for behavioral health integration (BHI) services.
  - Any behavioral health condition being addressed by the treating provider, including substance use disorders.
  - Covers virtual Behavioral Health Integration care
  - Billed by the treating provider, the Primary Care Physician
  - Incorporate the services of all three members of the collaborative care team:
    - Treating Provider
    - BH Team
    - Psychiatric Consultant
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<th>CoCM</th>
<th>Description/Requirements</th>
<th>Teammates Required</th>
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| 99492 | • First **70** minutes in the calendar month.  
• Outreach and Engagement of patients.  
• Initial assessment, validated scales and a treatment plan.  
• Psychiatric consultant review and recommendations if needed.  
• Entering patients in a registry with weekly caseload review.  
• Provide brief interventions (SMART goals, problem solving, coping skills). | BH Team (BHP/HC)  
Psychiatric Consultant  
Treating Provider |
| 99493 | • First **60** minutes in a subsequent month.  
• Weekly caseload review with psychiatric consultant with recommendations if needed.  
• Collaboration and coordination with treating provider.  
• Provide brief interventions.  
• Monitor patient outcomes.  
• Relapse prevention and preparation for discharge from active treatment. | BH Team (BHP/HC)  
Psychiatric Consultant  
Treating Provider |
| 99494 | • Each additional **30** minutes in a calendar month.  
• Same activities listed above. | BH Team (BHP/HC)  
Psychiatric Consultant  
Treating Provider |
| 99484 | • At least **20** minutes per calendar month.  
• Initial assessment or follow-up monitoring + use of applicable validated rating scales.  
• Behavioral health care planning, including revision for patients who are not progressing or whose status changes.  
• Coordination of Care (psychotherapy, pharmacotherapy, counseling, psychiatric consultation)  
• Continuity of care with a designated member of the care team. | BH Team (BHP/HC) |
Other Topics (Optional)
Who “owns” the patient (Whose patient is it?)

“Standard” Arrangement (Medicare)

Patient location matters

“Contracting” “Assignment” “Telecommuting”

Provider location (usually) doesn’t matter
Collaborative Care Management

- Chart review
- Discussion with PCM
- Recommendations to PCP

- Behavioral Activation
- Motivational Interviewing
- Feedback to PCP
- Reporting and Monitoring to PSY
- Additional Therapy Services
BREAK

Please enter your questions using the conference app...
Questions & Discussion
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