Telehealth Overview

This guide was informed by the Northwest Regional Telehealth Resource Center's Quick-Start Guide. Much of this information is general, but specific topics do focus on Montana. Please keep this in mind- specifically for the reimbursement section.

Introduction

Twenty-twenty saw a huge increase in telehealth adoption, due to COVID-19 and then CMS' waivers that opened up billing eligibility for sites and services. This guide is meant to supplement the additional, specific information as it relates to different areas or types of telehealth services. It is the mission of the Montana Telehealth Alliance to advocate for and support the advancement of healthcare by the use of telehealth for the benefit of all Montanans, and this document has been designed with that in mind- specifically by helping to make telehealth accessible to all providers.

Implementing telehealth is a complex undertaking, one that requires input from many different areas of your organization: Compliance, legal, revenue cycle, billing and coding, clinical, and administration. It is our hope that this guide can provide some resources and assistance in building a robust telehealth program within your organization.

This document, and the others in this series, is intended for general education only. It is not clinical or legal advice.

Modalities

The Center for Connected Health Policy (CCHP) defines telehealth as a collection of means or methods for enhancing health care, public health and health education delivery and support using telecommunications technologies.

Telehealth encompasses a broad variety of technologies and tactics to deliver virtual medical, health, and education services. Telehealth is not a specific service, but a collection of means to enhance care and education delivery.

The CCHP has broken up telehealth modalities into five different buckets. Click on the headers to be directed to more information from CCHP:

- **Live Video (synchronous telehealth).** Live Video is two-way interaction between a person (patient, caregiver, or provider) and a provider using audiovisual telecommunications technology. This type of service is also referred to as “real-time” and may serve as a substitute for an in-person encounter when it is not available.

- **Store-and-forward (asynchronous).** Store-and-forward technologies allow for the electronic transmission of medical information, such as digital images, documents, and pre-recorded videos through secure email communication. As compared to a real-time visit, this service provides access to data after it has been collected, and involve communication tools such as secure email.

- **Remote Patient Monitoring.** Remote patient monitoring (RPM) uses digital technologies to collect medical and other forms of health data from individuals in one location and electronically transmit that information securely to health care providers in a different location for assessment and recommendations. Monitoring programs can collect a wide range of health data from the point of care, such as vital signs, weight, blood pressure, blood sugar, blood oxygen levels, heart rate, and electrocardiograms.

- **Mobile Health.** Mobile health or mHealth, a relatively new and rapidly evolving aspect of technology-enabled health care, is the provision of health care services and personal health data via mobile devices, such as cell phones, tablet computers, and PDAs. mHealth often includes use of a dedicated application software (apps), which are downloaded onto devices.

- **Remote Communication Technology-based.** In 2019 the Centers for Medicare and Medicaid Services (CMS) made the administrative decision to significantly expand their reimbursement for ‘remote communication technology-based services’ within the Medicare program. These are services that are not defined as telehealth within Medicare because they do not have an in-person equivalent, and therefore are not limited by the limitations and restrictions that apply to telehealth services.

Determining the Need

What is the need that you are trying to address, and what are the specific use-cases that you want to utilize telehealth for? This will help drive decisions for setting up and implementing telehealth. Many telehealth use-cases are contingent on clinician buy-in and it is important to get this from your practitioners early in the process.

Foundational questions:

- Will telehealth be extended to all patients, or only to certain clinical areas, certain conditions, or specific patient demographics?
- What types of visits will be done via telehealth? Scheduled or on-demand?
- Where will the patients be located? At other healthcare facilities, or in their homes? How will this impact technology requirements?
- Will all consecutive visits for each patient be eligible to be done via telehealth, or will they be alternated with in-person visits?
- What do you need your telehealth platform to do? Live video only, or are there other technical pieces of the workflow that need to be included as part of the software solution?

Technology

When developing a telehealth program, it is a good idea to identify a broader telehealth strategy for your organization before you enter into a contract with a vendor that may meet your needs at a point in time, but may be unable to grow with your use cases. Some vendors are specialized in the product(s) that they offer, and others can provide end-to-end solutions that include hardware, software, and peripheral devices.

HIPAA and telehealth platforms. Healthcare organizations selecting a telehealth platform should ensure that platforms are secure and encrypted, and that a HIPAA Business Associates Agreement (BAA) is in place to ensure HIPAA compliance.

During the COVID public health emergency, organizations will not be penalized for using video platforms that do not fully comply with HIPAA rules. Platforms such as Facetime and Skype are included in this category. These platforms became allowable in order to address the immediate need for access to health care when COVID restrictions were put into place in order to increase patient access during lockdown. However, these platforms are not recommended as a long-term telehealth solution.

Product types. It is important to distinguish between the software solution, and hardware products. Some software solutions are device-agnostic, and can be used on many different devices. Others may require proprietary hardware to run the software. More details on product types can be found in the ‘contracted services’ module.

Software. Video conferencing platforms are typically quick to implement. Many that are now in use for telehealth purposes were designed with video conferencing in mind. These products may be useful when needing a fast implementation, or when workflow needs are streamlined, or minimal. Video conferencing platforms may not always be secure, but this may be remedied with a BAA to make it HIPAA-compliant. These BAAs- and corresponding increased security- may increase the price point.

Telehealth-specific software products are more robust than the video conferencing platforms, and can include features such as virtual waiting rooms, the ability to share or complete documents (like consent forms) and the ability to handle payments. For additional integration costs, some of these products can be embedded into electronic health records.

Hardware. Hardware can be as simple as a webcam and headset at a desktop station, or as complex as a dedicated telehealth cart with 24/7 support and up-time, configured to your network. Consider your use case(s), timeline, budget, and flexibility of the product(s) when determining your hardware needs.

Vendors for software and hardware will typically provide training for superusers as part of the implementation process- this can be very useful for the success and utilization of the products by increasing confidence of the users.

Workflow

Prior to seeing patients via telehealth, think through the process. Who is responsible for scheduling and sending a link to the patient? Will the patient connect directly with the health care provider or will your staff register the patient first? Does your organization have the capacity to dedicate staff to the telehealth process, or is an additional process for all clinical staff? Do you want to mirror your in-person clinical practices as much as possible, or are some processes different or altered for telehealth visits? It is important to walk through the process, and to be consistent.

Pre-visit planning.

- What information is needed and how will that information be obtained?
- Is a test visit necessary or appropriate to check the connection?

Start of the visit.

- Introduce yourself.
- Verify the patient's identity.
- Check to see that both ends can see and hear each other.

- Consent the patient (and document), if appropriate.
- Communicate a back-up plan in the event the technology fails.

During the visit.

- Glance at the camera occasionally to mimic eye-contact.
- Over-narrate whatever you may be doing in addition to your conversation with the patient- if you are documenting during the visit, make sure that the patient knows this- they will be able to tell if your attention is elsewhere.
- Whoever is on screen should make sure that your face and shoulders are framed appropriately on the screen, and that light is on your face and not behind you. Orient your desk so that windows are not behind you in order to avoid being back-lit.

Following the visit.

- Document the following:
    - Patient's location
    - Provider's location
    - Total time spent on the visit
    - That the encounter was conducted via telehealth
    - That the patient consented to a telehealth visit (unless otherwise documented)
- Ensure that the patient is able to access their after visits summary- if not through an EHR, you may need to mail the AVS to the patient.

Evaluate and adjust the workflow as needed.

Legal and Regulatory Considerations

When beginning, revising, or evaluating a telehealth program, there are several legal and regulatory issues to consider, which are outlined in an overview by the Center for Connected Health Policy. Here are a few that deserve special mention given current circumstances.

Informed consent. Some states and payers require consent, and it is considered best practice to obtain the patient's consent when conducting care via telehealth. You should confirm with legal counsel to verify if telehealth consent is inclusive of your current consenting practices, or if you need to obtain additional consent. When informed consent is obtained during the telehealth visit, this needs to be documented in the patient record. For ideas to include in a consent form, see this article published by the Southwest Telehealth Resource Center

Licensure. Health care providers must be licensed in the state where the patient is located during a telehealth appointment. Some states have adopted waivers that expedite or exempt

providers from completing full licensure applications during the current public health emergency. The Federation of State Medical Boards are tracking adjustments by states during the public health emergency, as allowed by CMS waivers. The full current list can be obtained here. Some state licensing boards include Montana as part of their interstate licensure compact. Montana is part of the Interstate Medical Licensure Compact.

Provider Credentialing and Privileging. Providers must be credentialed at the facility where they will be providing telehealth services, as applicable. If a specialist from a health system plans on doing telehealth outreach to a critical access hospital or, they will need to be credentialed at that facility. Full credentialing can be a lengthy and resource-heavy process, but CMS and The Joint Commission have put out guidance on moving through this process in a less-burdensome way, which includes expedited credentialing, and credentialing by proxy. More information can be found at CCHP.

Medical Malpractice. Most malpractice insurers cover telehealth but you should confirm this with your organization's current coverage.

HIPAA. If providers are conducting telehealth visits from areas outside of the office, it is important to verify that their workspace is in a private area, free from any environmental risks that may comprise HIPAA.

For in-depth information on legal and regulatory issues at the national and state level, visit the Center for Connected Health Policy.

Reimbursement

Reimbursement of services delivered via telehealth varies between Medicare, Medicaid and private payers. Consider this a general overview and click on the links for more specific information.

Key terminology:

- Originating site – where the patient is located during the visit
- Distant site – where the provider is located during the visit

Medicare. Medicare fee-for-service reimburses the distant site provider for specific codes that are allowable for telehealth visits. The originating site is also able to bill for an originating site facility fee. Reimbursement for telehealth services has historically been limited to the following criteria:

- Originating sites must be in a rural area (with the exception of stroke services)

- Originating sites must be specific types of healthcare facilities
- Not all provider types are eligible to bill for distant site services
- Only certain HCPCS/CPT codes are eligible for reimbursement.

The MLN Booklet on Telehealth Services provides a detailed guide on Medicare Fee-for-Service reimbursement. This booklet is updated on an annual basis, and is informed by the Medicare Professional Fee Schedule that is updated and approved annually. Medicare Advantage plans follow Medicare Fee-for-Service guidelines but have more flexibility in what they cover.

With the declaration of COVID-19 as a public health emergency, the Centers for Medicare & Medicare Services (CMS) have expanded telehealth benefits to allow patients outside of rural areas and patients in their homes to receive telehealth services. Details are outlined in a CMS Fact Sheet and CMS FAQs.

In 2019, CMS added services utilizing Communication Technology Based Services which were not considered telehealth, so not subject to telehealth's limitations. CMS created codes for FQHCs and RHCs to bill for Virtual Check-ins, which are short visits by phone or video. Details are outlined in the link above.

Montana Medicaid. Because medicaid is administered independently by every state, variances on coverage between states exist. Montana Medicaid will reimburse originating sites for the Q3014 code, with the exception of when the originating site is the patient's home. Montana Medicaid recognizes the patient's home as an eligible originating site. Additionally, any enrolled Montana Medicaid provider can be a distant site, if telemedicine is appropriate within their license and scope of practice. For more information from Montana DPHHS, follow the link here. Additionally, the Center for Connected Health Policy (CCHP) has a searchable database, which outlines each state's Medicaid fee-for-service policies in detail with links to source documents and is updated every six months.

Private payers. Montana has a parity law (MCA 33-22-138) in which private payers are required to provide coverage for services delivered through telemedicine if the services are otherwise covered by the policy, certificate, contract, or agreement. Coverage must be equivalent to the coverage for services that are provided in person by a health care provider or health care facility. Payment parity is not explicitly called out in the law, and self-funded plans are exempt from the parity law. The only way to know a private payer's policies on telehealth reimbursement is to verify through the payer, either via a phone call or sometimes as published on their websites. Given the current public health emergency, more payers are making their policies public. A report on state telehealth laws and reimbursement policies as of fall 2020 has been compiled by CCHP.

Please note that some payers reimburse for telehealth but only when the visit is conducted using their own telehealth platform (these are typically for mild, acute, and on-demand visits, and limited to the health care providers associated with that platform). When checking on a payer's reimbursement policy, verify that the patient's health care providers are eligible for telehealth reimbursement. It is also important to learn which HCPCS/CPT codes the payer will reimburse.

Billing and coding for telehealth visits. For the most part, telehealth visits are billed using the same HCPCS or CPT code as if the care were delivered in person, although there are exceptions. All payers also require specific modifiers on the claim forms that are submitted for reimbursement to provide clear information on how that visit was conducted- in this case, via telehealth.

Typically, either a "GT" or "95" modifier is required. In some instances the use of place of service (POS) code, 02, should be used. Each payer and scenario has different requirements. The Center for Connected Health Policy has a very helpful Billing Guide, that is by no means exhaustive of different billing scenarios, but provides an excellent overview.

FQHCs and RHCs. For the duration of the public health emergency, CMS is allowing FQHCs and RHCs to bill as a distant site. Historically, FQHCs and RHCs were limited by Medicare to function as originating sites, and were not able to be reimbursed as a distant site provider. Montana Medicaid and some private payers will reimburse FQHCs and RHCs when serving as the distant site provider.

REFERENCES

Billing for Telehealth Encounters: An Introductory Guide on Fee-For-Service. (2020, January). https://www.cchpca.org/sites/default/files/2020-01/Billing%20Guide%20for%20Telehealth%20Encounters_FINAL.pdf

Center for Connected Health Policy. https://www.cchpca.org/

Communication Technology Based Services and Payment for Rural Health Clinic (RHCs) and Federally Qualified Health Centers (FQHCs). (2019, January 23). Retrieved from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10843.pdf

COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing. (2021, January 17). Retrieved from https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

Krupinski, E. A. (2017, February 1). Telemedicine & Informed Consent: How Informed are You? https://southwesttrc.org/blog/2017/telemedicine-informed-consent-how-informed-are-you

Medicare Learning Network Telehealth Services Booklet. (2020, March). Retrieved from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf

Medicare Telemedicine Health Care Provider Fact Sheet. (2020, March 17). Retrieved from https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Montana Code Annotated 2019. Retrieved from https://leg.mt.gov/bills/mca/title_0330/chapter_0220/part_0010/section_0380/0330-0220-0010-0380.html

Montana Healthcare Programs Notice: Frequently Asked Questions on Telemedicine/Telehealth. (2020, March 19). Retrieved from https://dphhs.mt.gov/Portals/85/dsd/documents/CMB/providermanuals/FAQTelemedicinetelehealth.pdf

Northwest Regional Telehealth Resource Center. https://nrtrc.org/

Interstate Medical Licensure Compact. https://www.imlcc.org/

Quick Start Guide to Telehealth During the Current Public Health Emergency. (2020, March). Retrieved from https://nrtrc.org/education/downloads/Telehealth-Quick-Start-Guide.pdf

U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19. (2021, March 2). Retrieved from https://www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf