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Telehealth in Acute Care

Telehealth has a long history in the acute-care settings, specifically around conditions where a specialist is required to recommend interventions, and are needed to be available 24/7 (or other determined availability). In this module, we will explore these considerations, touch on contracted services, as well as delegated credentialing.

A small rural hospital may have an emergency room staffed 24/7, but that staffing might include two nurses, and a registration staff, with the attending physician being on call if needed. In this particular instance, if a patient presents with a stroke in the middle of the night, the physician must be called in, which can delay patient care. Additionally, if a patient needs to be transferred to a facility with a higher level of care, an ambulance/helicopter/airplane ride further increases the time until a patient can receive interventions.

A mid-sized hospital has an ICU, but only three intensivists on staff. These intensivists rotate as the attending physician on a schedule, but these shifts are 48-72 hours long. The intensivists are exhausted at the end of their shifts and wish that there was more coverage, but the hospital is unable to make a business case for hiring additional intensivists.

In each of these scenarios, acute telehealth may be a solution. In the first example, a tele-ER or tele-stroke contract may provide the small hospital staff with the expertise and on-demand doctors to increase response time to time-sensitive conditions like stroke or trauma, as well as improve patient outcomes.

In the second scenario, a tele-ICU contract may be implemented to cover the night shifts of this hospital so that the intensivists can rest, and be able to maintain and sustain the work that they have been hired to do. Physician burnout is a common element of these conversations, and many acute telehealth programs market themselves to increase the work/life balance of inpatient providers, as well as increasing the capacity of existing staff resources.

Contracted Services

Acute telehealth programs and services are being developed by different entities. For the intended audience of this document, this information is presented as considerations for contracting with an organization to provide services. Some large health systems have developed programs that can be leveraged by smaller facilities in their catchment areas. Other

acute telehealth programs are offered by for-profit telehealth corporations and provider groups as another offering in their telehealth portfolio.

Contracted services can be good options for smaller facilities whose instances of these type of acute conditions does not allow for the justification of a full staff of specialists. It is also significantly less expensive. Some common acute telehealth programs include:

- Tele-Stroke
- Tele-ICU
- Tele-ER
- Tele-Hospitalist
- Tele-Psychiatry

Depending on your facilities' location, needs, and existing relationships, you can reach out to partner facilities to engage in a conversation about telehealth needs.

Considerations

Determine whether or not your facility is an eligible originating site. In the examples given above, the facility eligibility requirement would be met, however you will need to verify that your facility meets CMS' rurality eligibility for telehealth services. For telestroke services, CMS has removed the rurality restrictions. This means telestroke service provided to non-rural originating sites can be billed to CMS.

The Center for Connected Health Policy has a comprehensive list of national coverage policies that are in effect during the public health emergency. These policies are current as of the publishing of this document, but they are not permanent. Keep this in mind when contracting for a contract and consider sustainability in a post-COVID regulatory environment.

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.

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Reimbursement

For the most part, the same Healthcare Common Procedure Coding System (HCPCS) codes are used to bill for acute or inpatient telehealth visits, though this should be verified with the list of telehealth-billable codes. Modifiers should be used, where appropriate, in order to provide enough details for the insurance carriers to make determinations of eligibility.

The Modifier G0 is used to identify telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.

Some private payors require a 95 modifier which indicates that covered benefits or services delivered via synchronous, interactive audio/visual telecommunications systems

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.

If you are contracting for acute telehealth services, a conversation about billing for services will be a part of the contracting process. It is common for companies to have a fee schedule for services rendered. Some companies will do the billing for you, and charge for that service as well, depending on the contractual arrangement.

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REFERENCES

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