Telemedicine for Indiana CMHCs

Jonathan Neufeld, PhD, HSPP
Upper Midwest Telehealth Resource Center
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Outline

• Introduction to UMTRC
• Introduction to Telemedicine
• Telemedicine Law and Policy
• Reimbursement in Indiana
• Recent changes and Current Opportunities
• Clinical and Technical Considerations
telehealthresourcecenters.org

• Links to all TRCs
• National Webinar Series
• Reimbursement, Marketing, and Training Tools
UMTRC Services

- Presentations & Trainings
- Individual and Group Consultation
- Technical Assistance
- Connections with other programs
- Program Design and Evaluation
- Information on current legislative and policy developments
Definitions and Concepts

**Telehealth and Telemedicine**

- Sometimes used interchangeably
- Two types of distinctions -
  - Telemedicine = billable interactive clinical services
  - Telehealth =
    - Broader field of distance health activities (CME, etc.)
    - Clinical remote monitoring (usually at home)
Service vs. Delivery Mechanism

- TH is not a service, but a delivery mechanism for health care services
  - Most TH services duplicate in-person care
  - Some are made better or possible with TH
  - Reimbursement equal to “in-person” care
Three Basic “Types” or Domains

Hospitals & Specialties
• Specialists see and manage patients remotely

Integrated Care
• Mental health and other specialists work in primary care settings (e.g., PCMH’s, ACO’s)

Transitions & Monitoring
• Patients access care (or care accesses patients) where and when needed to avoid complications and higher levels of care
Federal Telemedicine Law & Policy

Professionals are regulated at the state level (doctors, nurses, counselors, etc.)

**Medicare:** Pays for certain outpatient professional services (CPT codes) for patients accessing care in rural counties and HPSAs in rural census tracts.

*No regs; only conditions of payment.

**Medicaid:** Telemedicine is “a cost-effective alternative to the more traditional face-to-face way of providing medical care…that states can choose to cover.”
<table>
<thead>
<tr>
<th>Service</th>
<th>Healthcare Common Procedure Coding System (HCPCS)/CPT Code</th>
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<tbody>
<tr>
<td>Telehealth consultations, emergency department or initial inpatient</td>
<td>HCPCS codes G0425 – G0427</td>
</tr>
<tr>
<td>Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs</td>
<td>HCPCS codes G0406 – G0408</td>
</tr>
<tr>
<td>Office or other outpatient visits</td>
<td>CPT codes 99201 – 99215</td>
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<tr>
<td>Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days</td>
<td>CPT codes 99231 – 99233</td>
</tr>
<tr>
<td>Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days</td>
<td>CPT codes 99307 – 99310</td>
</tr>
<tr>
<td>Individual and group kidney disease education services</td>
<td>HCPCS codes G0420 – G0421</td>
</tr>
<tr>
<td>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</td>
<td>HCPCS codes G0108 – G0109</td>
</tr>
<tr>
<td>Individual and group health and behavior assessment and intervention</td>
<td>CPT codes 96150 – 96154</td>
</tr>
<tr>
<td>Individual psychotherapy</td>
<td>CPT codes 90804 – 90809</td>
</tr>
<tr>
<td>Pharmacologic management</td>
<td>CPT code 90862</td>
</tr>
<tr>
<td>Psychiatric diagnostic interview examination</td>
<td>CPT code 90801</td>
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Update to HPSA Rural Designation

Effective January 1, 2014:

Otherwise eligible sites in health professional shortage areas (HPSAs) located in rural census tracts of MSA counties will be eligible originating sites. (RUCA codes 4-10, also 2-3 in counties over 400 sq. mi., <35/sq. mi. density)

Eligibility Lookup Tool
http://datawarehouse.hrsa.gov/telehealthAdvisor/telehealthEligibility.aspx
Indiana Telemedicine Law & Policy

Medical Board/Licensure

• Indiana medical license includes:

“Providing diagnostic or treatment services to a person in Indiana when the diagnostic or treatment services are transmitted through electronic communications; and are on a regular, routine, and non-episodic basis or under an oral or written agreement to regularly provide medical services.”
Prescribing

Except in institutional settings, on-call situations, cross-coverage situations, and [when supervising NPs],

a physician shall not prescribe, dispense, or otherwise provide, or cause to be provided, any legend drug that is not a controlled substance to a person who the physician has never personally physically examined and diagnosed unless the physician is providing care in consultation with another physician who has an ongoing professional relationship with the patient, and who has agreed to supervise the patient's use of the drug or drugs to be provided.
Medicaid Reimbursement (April 1, 2007)

• The member must be present and able to participate in the visit.

• The audio and visual quality of the transmission must meet the needs of the physician located at the hub site.

• When ongoing services are provided, the member should be seen by a physician for a traditional clinical evaluation at least once a year, unless otherwise stated in policy. In addition, the hub physician should coordinate with the patient’s primary care physician.
Indiana Telemedicine Law & Policy

Medicaid Reimbursable Codes

- Consultations – 99241 to 99245 and 99251 to 99255
- Office or other outpatient visit – 99201 to 99205 and 99211 to 99215
- Individual psychotherapy – 90832 to 90840
- Psychiatric diagnostic interview – 90791, 90792
- End stage renal disease services (ESRD) – G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318
- 90862 deprecated; replaced by E&M codes
Indiana Telemedicine Law & Policy

Documentation

1. Documentation must indicate the services were rendered via telemedicine.

2. Documentation must clearly indicate the location of the hub and spoke sites.

3. All other IHCP documentation guidelines for services rendered via telemedicine apply, for example chart notes and start and stop times. Documentation must be available for post-payment review.
Documentation

4. Providers must have written protocols for circumstances when the member must have a hands-on visit with the consulting provider. The member should always be given the choice between a traditional clinical encounter versus a telemedicine visit. Appropriate consent from the member must be obtained by the spoke site and maintained at the hub and spoke sites.
Indiana Telemedicine Law & Policy

“Telecommuting” as an Option

- Clinician is licensed in Indiana and employed or contracted with a licensed clinical entity and assigns billing rights to that entity
- Patient is seen by employed/contracted clinician on-site at the clinical facility
- Clinical service is billed by the facility
- Clinician may be located anywhere
- Medicaid views this as NOT telemedicine
  - No special rule or bulletin has been or will be issued
Indiana Telemedicine Law & Policy

EA 554 (July 1, 2013; Effective 10/1/2014)

- SPA 13-011 was submitted to CMS on 11/26/2013 and approved by CMS on 05/14/2014
- Removes the 20 mile radius restriction for telemedicine services provided by Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), Community Mental Health Centers (CMHCs), and critical access hospitals (CAHs)
- Additionally, this SPA provides reimbursement for telehealth services to home health agencies
HB 1258 (signed by Governor Pence on 3/24/2014)

Creates a telehealth pilot program which requires

1) The Medical Licensing Board of Indiana to establish a pilot program to provide telehealth services to patients in Indiana before August 1, 2014

2) Report to the Indiana General Assembly concerning the outcomes of the pilot program

3) Sets forth requirements of the pilot program

4) Established time frames for the expiration of the pilot program, the latest of which is July 1, 2016
Patient Satisfaction

Will patients accept care via telemedicine?


Patient satisfaction was examined in relation to patient age, gender, race, income, education, and insurance. **Overall patient satisfaction was found to be 98.3%**.


Results indicated that “most consumers found that a video link with a psychiatrist moderately or greatly helped them in managing their treatment, with 98% of the preferring to be offered videoconferencing in combination with local services.”


Results indicated that **satisfaction did not differ significantly between video and in-person consultations** for incarcerated patients.
Treatment Outcomes

Are treatment methods as effective?


Comparison of outcomes of patients admitted to two small rural hospitals. One hospital received neurological services by telehealth, the other in-person. There were no appreciable differences noted between the clinical outcomes and the length of stay between patients receiving services in-person and those who received services via telehealth.


This study enrolled 395 veterans with PHQ-9 scores >12 in collaborative care or usual care for 12 months. Patients in collaborative telepsychiatry program made significantly greater gains in symptoms and functioning than patients given usual care.

No “generic” form of telemedicine exists
Relationships Drive Effectiveness

Therapeutic Alliance Research

- The *therapeutic alliance*, defined broadly as the collaborative bond between therapist and patient, is widely considered to be an essential ingredient in the effectiveness of psychotherapy.

- Therapeutic alliance scores are significant predictors of clinical outcome for both psychotherapy and for active and placebo pharmacotherapy.

- Patient ratings are more predictive than doctor/therapist ratings.
Nothing “New” About It

- Get comfortable; be confident
- Know your craft
- Engage your patient
ATA Survey of Significant Research

Most Significant Studies by Specialty and Interest Group:

- Cost-effectiveness (8 studies)
- Quality of Care (12 studies)
- Patient Satisfaction (3 studies)
- Ocular Health (1 study)
- Tele-ICU Care (5 studies)
- Tele-dermatology (7 studies)
- Telemental Health (9 studies)
- Telerehabilitation (1 study)
- Human Factors in Telemedicine (7 studies)
- Telehealth Nursing (2 studies)
- Home Telehealth and Remote Monitoring (3 studies)
- Pediatric Telehealth (11 studies)
- Business and Finance (7 studies)

ATA Practice Guidelines

Prepared by teams of experts
Thoroughly referenced
Evidence based
Updated regularly

http://www.americantelemed.org/resources/standards/ata-standards-guidelines#.U57kkZRdWQk
ATA Telemedicine Gaps Analysis

State Telemedicine Gaps Analysis
Coverage & Reimbursement

Latoya Thomas
Gary Capistrant

September 2014
Technology Considerations

- High speed internet at both sites
  - 1 Mbps or more (nominal) for HD

- Endpoints – Two Major Classes
  - H.323 – Standalone system
    - Hardware based, often older and/or larger
    - Tandberg, Polycom, LifeSize, Sony, etc.
  - SIP – Client/server system
    - Software based (using a host computer)
    - Skype, Oovoo, Vsee, ClearSea, Zoom, etc.
    - Mobile apps
HIPAA Considerations

• Communications involving PHI (including live video) must be encrypted
• Any entity that stores PHI must sign a Business Associate Agreement (BAA)
• As long as live video is encrypted and not stored, BAA is not technically required

Some type of signed agreement to enforce this is likely to be helpful and is recommended
Peripherals

Exam Camera – Dermatology, wound evaluation

• Tremendous detail, resolution, lighting options
• Unnecessary for many applications

Stethoscope –

• Several very good models available
• Bluetooth (wireless) connections, excellent audio

ENT Scope –

• Multiple models available
• Modular, easy to use
Staff Training & Integration

Manipulation of peripherals

• Document training in equipment use

Professional Skills (within scope of licensure)

• Telemedicine (in general)
• Palpation, other specific techniques “under direct supervision” (up to licensed providers pending rule)

Key Strategies

1. Trust – Develop strong working relationships
2. Documentation
   – Policies & Procedures for TM (“same standard of care”)
   – Case/Progress Notes (start & stop times, locations, consent)
Review of Key Points

• TM is a delivery mechanism, not a service
• TM usually replicates in-person care
• TM provides multiple types of value
• TM value is embedded in larger movements in health care and is growing fast
• Reimbursement mirrors in-person care
• Technology considerations are important
• Business model considerations are critical
UMTRC Resources

IN Telemedicine Reimbursement Summary:

Update on MSA Counties and Eligibility:
Contact Information & Evaluation

Jonathan Neufeld, PhD
(574) 606-5038
jneufeld@indianarha.org

Becky Sanders
(812) 478-3919, ext. 232
bsanders@indianarha.org