Hawaii Telehealth Collaborative

to maximize the potential benefits of telehealth...

Reimbursement in Telehealth LUNCHEON

Agenda:

*Check in & Lunch Pick up

*Welcome

- Purpose & Introductions

*Celebrating our Successes

- November 2007 Symposium
- Legislative Session 2008: HCR 138

*Planning for the Future

- Grant Proposal & Task Force pending
- Discussion Question:

Given our success over the previous year and our suggested path for the next few years, any suggestions to modify the current priorities for this theme? What has happened, what needs more focus, what was forgotten, etc.

*Getting Involved

- How can you get involved?
- Who else should be involved?
- Types and levels of involvement

*Next Steps & Evaluation

Friday July 25, 2008 * 11:00 am to 1:00 pm
HMSA Center * 818 Keeaumoku Street

Parking will be validated

Information on the Telehealth Collaborative

http://www.hawaiitelehealth.net/

Background

Hawaii is a state that could potentially use telehealth to address the mal-distribution of medical resources and substantially increase access to specialty care. Telehealth projects in Hawaii have attempted to improve access and reduce cost, but the programs usually closed once the funding was exhausted. Projects tended to be relatively small and often did not fully mature due to provider resistance, support costs and integration into larger programs.

Intervention

An informal telehealth committee formed in the summer of 2007 to explore options to better collaborate on telehealth with the goal to improve care and increase the probability that clinical telehealth activities would be sustainable. The formation of this committee was initiated by Hawaii Medical Service Association (BCBS Hawaii), Hawaii's largest health plan and lead to funding for a one day symposium through the HMSA Foundation. Others involved in organizing the event were: University of Hawaii (Telehealth Research Institute, Telecommunications and Information Policy Group, and State Telehealth Access Network); Queen's Medical Center; Hawaii Pacific Health; Shriners Hospital; Hawaii Health Systems Corporation; Pacific Islands Chapter of the American Telemedicine Association; and Northwest Regional Telehealth Resource Center.

On November 15, 2007, a full-day symposium was convened with many of the key stakeholders involved in telehealth in Hawaii. The intent was not just to share knowledge, but to identify critical needs, explore common interests and mutual benefits, as well as to lay the foundation for a working community collaborative. The event was professionally facilitated to focus discussion on producing an actionable plan to better organize telehealth in Hawaii through a collaborative effort. This entity would seek to integrate activities, assist in seeking funding, and address issues related to policy, legislation, reimbursement, and sustainability through integrating telehealth into business strategies and clinical practices. This lunch is one outcome of this symposium.

Outcome

There was a clear mandate from the participants of the symposium that Hawaii needed better structured clinical coordination of telehealth activities to provide the scalability and sustainability of the services. This goal not only requires collaboration among the major stakeholders and rural end users, but also an organization and resources to mature the collaborative effort. The Telehealth committee has taken the summarized output from the symposium and is exploring funding opportunities to establish a clinical coordinator for telehealth in Hawaii.

Information on the Reimbursement & Funding at the Symposium

Highest Priority Actions

- Address medical malpractice (legislation or other resources)
- Medicaid and private insurers' consensus on the recognition of telehealth
- Developing measurable outcomes (i.e. travel costs vs. telehealth)

Key Results

- Malpractice is available to cover telehealth
- All payers reimburse telehealth adequately
- More programs have measurable outcomes
- Progress in closing gap between actual utilization and perceived utilization
- Measurements are in place and data is collected. Outcomes are measured.

Overview of Telemedicine Policies at HMSA

The summary below can be seen in full at the HMSA Provider Resource Center http://www.hmsa.com/portal/provider the specific page on Telemedicine can be seen here: http://www.hmsa.com/portal/provider/zav_pel.aa.TEL.500.htm

HMSA's plans recognize telemedicine (where an individual receives medical services from a healthcare provider without face-to-face contact) for benefit payment in accordance with Medicare guidelines for payment of this service.

Telemedicine is the practice of healthcare delivery, diagnosis, consultation, treatment, and transfer of medical data, using interactive audio, video, or data communications. Standard telephone calls, fax transmissions and email, in the absence of other integrated information and data, do not qualify for benefit payment under HMSA plans.

Covered Services: The following services will be covered under this benefit if the criteria are met:

- Consultations (99241-99275)
- Office visits (99201-99215)
- Individual psychotherapy (90804-90809)
- Pharmacologic management (90862)

HMSA also will cover "store and forward technology" in single or multimedia formats, when used as a substitute for an interactive telecommunications system.

Consultations: An interactive video consultation allows a practitioner to consult with a specialist when they are separated by distance. This type of consultation generally involves a local "presenting" or referring practitioner, who presents and examines the patient while communicating with a distant specialist concerning the patient's condition and course of treatment.

Claims and Coding: The consulting specialist may bill the appropriate consultation code as referenced above followed by modifier code GT (by interactive audio and visual communication systems). Plan benefits will be paid based on HMSA's maximum allowable charge (MAC) for the consultation.

Presenting practitioners may bill for the appropriate level office visit code if a medical examination is carried out at the time of the telemedicine consultation. No modifier code is required. Plan benefits will be paid based on HMSA's MAC for the office visit.

Procedural services: If procedural services are performed under the direction of the specialist/consultant, the physician who actually performs the service should bill using standard procedure codes. It is not necessary to use a -GT modifier. Benefits will be paid based on HMSA's MAC for the procedural service.

The specialist/consultant physician (who monitors the procedure and advises the attending physician via video) should bill for a consultation, not for the procedure. The consultation should be billed using modifier code GT. Plan benefits will be paid based on HMSA's MAC for the consultation.

Emergency room services: An emergency room physician may bill for a consultation if a physician in an outlying area requests a telemedicine consultation. The consultation should be billed using modifier code GT. Plan benefits will be paid based on HMSA's MAC for the consultation.

If the patient is eventually taken to the consulting physician's emergency room for treatment, the physician may only bill for the resulting emergency room visit. The physician should not bill both a telemedicine consultation and an emergency room visit for the same patient on the same date.

All previously established plan provisions, exclusions, payment guidelines and negotiated agreements apply to services delivered through telemedicine.

Latest revision: 03/15/2007

Overview of Telemedicine Policies from Medicare

Taken from Medicare B News Issue 242 January 4 2008 on the Noridian website:
https://www.noridianmedicare.com/shared/partb/bulletins/2008/242_jan/Addition_to_Medicare_Telehealth_Services.htm

Provider Action Needed: This article is based on Change Request (CR) 5628 which adds the neurobehavioral status exam (as represented by HCPCS code 96116) to the list of Medicare telehealth services.
Effective January 1, 2008, the telehealth modifiers "GT" (via interactive audio and video telecommunications system) and modifier "GQ" (via asynchronous telecommunications system) are valid when billed with HCPCS code 96116.

Background: The Centers for Medicare & Medicare Services (CMS) announced in CR 5628 that the neurobehavioral status exam (Healthcare Common Procedure Coding System (HCPCS) code 96116) has been added to the list of Medicare telehealth services (see the final rule for the calendar year (CY) 2008 physician fee schedule (CMS-1385-FC)).

Previously, CMS determined that, if the eligibility criteria, and conditions of payment are satisfied, the use of a telecommunications system may substitute for a face-to-face, "hands on" encounter for consultation, office visits, individual psychotherapy, pharmacologic management, psychiatric diagnostic interview examination, end stage renal disease related services, and individual medical nutrition therapy. CR5628 added neurobehavioral status exam to the list of telehealth services (bolded). Medicare telehealth services are listed below.

- Consultations (CPT codes 99241 - 99275) - Effective October 1, 2001 December 31, 2005;
- Consultations (CPT codes 99241 - 99255) - Effective January 1, 2006;
- Office or other outpatient visits (CPT codes 99201 - 99215);
- Individual psychotherapy (CPT codes 90804 - 90809);
- Pharmacologic management (CPT code 90862);
- Psychiatric diagnostic interview examination (CPT code 90801) Effective March 1, 2003;
- End Stage Renal Disease (ESRD) related services (HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318) Effective January 1, 2005;
- Individual Medical Nutrition Therapy (HCPCS codes G0270, 97802, and 97803) (Effective January 1, 2006); and
- Neurobehavioral status exam (HCPCS code 96116) (Effective January 1, 2008).

In addition, effective January 1, 2008, the following modifiers are valid when billed with HCPCS code 96116: GT via interactive audio and video telecommunications system and GQ via asynchronous telecommunications system.

Exceptions: An interactive audio and video telecommunications system must be used permitting real-time communication between the distant site physician or practitioner and the Medicare beneficiary, and as a condition of payment, the patient must be present and participating in the telehealth visit. The only exception to the interactive telecommunications requirement is in the case of Federal telemedicine demonstration programs conducted in Alaska or **Hawaii**. In this circumstance, Medicare payment is permitted for telehealth services when asynchronous store and forward technology is used.

Additional Information: To view the official instructions issued to your carrier, FI, or A/B MAC, see the two transmittals for CR5628 on the CMS website at
http://www.cms.hhs.gov/Transmittals/downloads/R1277CP.pdf and
http://www.cms.hhs.gov/transmittals/downloads/R74BP.pdf .

Posted on: 1/4/2008
Handed out at the Hawaii Telehealth Collaborative Lunch Meeting on Reimbursement, 7/25/08