Telehealth Reimbursement in the State of Indiana

June 14, 2017

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telehealthresourcecenters.org

- Links to all TRCs
- National Webinar Series
- Reimbursement, Marketing, and Training Tools
Getting Paid for Services Delivered via Telehealth in the state of Indiana
Payment Reform

- 1967
  - American Academy of Pediatrics introduced the term ‘medical home’
- 1980’s
  - National Long Term Care Demo Project
- 2009
  - CMS Roadmap for Implementing Value Driven Healthcare in the Traditional Medicare Fee-for-Service Program
- 2007 - 2010
  - Triple Aim Introduced
- 2011
  - Accountable Care Organizations
    - National Rural ACO
- CMS readmission measures
  - 2012 - acute myocardial infarction, heart failure, pneumonia
  - 2014 – chronic obstructive pulmonary disease, elective total hip arthroplasty, total knee arthroplasty
  - 2015 – coronary artery bypass graft
  - 2016 – update for pneumonia; aspiration pneumonia, sepsis patients coded with pneumonia present on admission (but not including severe sepsis)
- 2015 – Medicare
  - Chronic Care Management – 99490 - $40/month
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
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.”
Medicare Telehealth Reimbursement Requirements

1. Patient Outside of a MSA
2. Patient in Designated Originating site
3. Services within CPT Code Range
4. Services Delivered by Eligible Practitioners?
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

NOTE: HPSAs to be revised in 2017; expect release in July 2017 to become effective 1/1/2018
Telehealth Services

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

Learn about these calendar year (CY) 2017 Medicare telehealth services topics:

- Originating sites
- Distant site practitioners
- Telehealth services
- Billing and payment for professional services furnished via telehealth
- Billing and payment for the originating site facility fee
- Resources
- Lists of helpful websites and Regional Office Rural Health Coordinators

When “you” is used in this publication, we are referring to physicians or practitioners at the distant site.

Medicare pays for a limited number of Part B services furnished by a physician or practitioner to an eligible beneficiary via a telecommunications system. For eligible telehealth services, the use of a telecommunications system substitutes for an in-person encounter.
<table>
<thead>
<tr>
<th>Service</th>
<th>Healthcare Common Procedure Coding System (HCPCS)/CPT Code</th>
</tr>
</thead>
<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</td>
<td>HCPCS codes G0406–G0408</td>
</tr>
<tr>
<td>in hospitals or SNFs</td>
<td></td>
</tr>
<tr>
<td>Office or other outpatient visits</td>
<td>CPT codes 99201–99215</td>
</tr>
<tr>
<td>Subsequent hospital care services, with the limitation of 1 telehealth</td>
<td>CPT codes 99231–99233</td>
</tr>
<tr>
<td>visit every 3 days</td>
<td></td>
</tr>
<tr>
<td>Subsequent nursing facility care services, with the limitation of</td>
<td>CPT codes 99307–99310</td>
</tr>
<tr>
<td>1 telehealth visit every 30 days</td>
<td></td>
</tr>
<tr>
<td>Individual and group kidney disease education services</td>
<td>HCPCS codes G0420 and G0421</td>
</tr>
<tr>
<td>Individual and group diabetes self-management training services, with</td>
<td>HCPCS codes G0108 and G0109</td>
</tr>
<tr>
<td>a minimum of 1 hour of in-person instruction to be furnished in the</td>
<td></td>
</tr>
<tr>
<td>initial year training period to ensure effective injection training</td>
<td></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 90832–90834 and 90836–90838</td>
</tr>
<tr>
<td>Telehealth Pharmacologic Management</td>
<td>HCPCS code G0459</td>
</tr>
<tr>
<td>Psychiatric diagnostic interview examination</td>
<td>CPT codes 90791 and 90792</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services included in the</td>
<td>CPT codes 90951, 90952, 90954, 90955, 90957, 90958,</td>
</tr>
<tr>
<td>monthly capitation payment</td>
<td></td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for home dialysis</td>
<td>CPT code 90963</td>
</tr>
<tr>
<td>per full month, for patients younger than 2 years of age to include</td>
<td></td>
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<tr>
<td>monitoring for the adequacy of nutrition, assessment of growth and</td>
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</tr>
<tr>
<td>development, and counseling of parents (effective for services</td>
<td></td>
</tr>
<tr>
<td>furnished on and after January 1, 2016)</td>
<td></td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for home dialysis</td>
<td>CPT code 90964</td>
</tr>
<tr>
<td>per full month, for patients 2-11 years of age to include monitoring</td>
<td></td>
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<tr>
<td>for the adequacy of nutrition, assessment of growth and development,</td>
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<tr>
<td>and counseling of parents (effective for services furnished on and</td>
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<tr>
<td>after January 1, 2016)</td>
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<tr>
<td>End-Stage Renal Disease (ESRD)-related services for home dialysis</td>
<td>CPT code 90965</td>
</tr>
<tr>
<td>per full month, for patients 12-19 years of age to include monitoring</td>
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<tr>
<td>for the adequacy of nutrition, assessment of growth and development,</td>
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<tr>
<td>and counseling of parents (effective for services furnished on and</td>
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<tr>
<td>after January 1, 2016)</td>
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</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for home dialysis</td>
<td>CPT code 90966</td>
</tr>
<tr>
<td>per full month, for patients 20 years of age and older (effective for</td>
<td></td>
</tr>
<tr>
<td>services furnished on and after January 1, 2016)</td>
<td></td>
</tr>
<tr>
<td>Individual and group medical nutrition therapy</td>
<td>HCPCS code G0270 and CPT codes 97802–97804</td>
</tr>
<tr>
<td>Neurobehavioral status examination</td>
<td>CPT code 96116</td>
</tr>
<tr>
<td>Smoking cessation services</td>
<td>HCPCS codes G0436 and G0437 and CPT codes 99406 and 99407</td>
</tr>
<tr>
<td>Alcohol and/or substance (other than tobacco) abuse structured</td>
<td>HCPCS codes G0396 and G0397</td>
</tr>
<tr>
<td>assessment and intervention services</td>
<td></td>
</tr>
<tr>
<td>Annual alcohol misuse screening, 15 minutes</td>
<td>HCPCS code G0442</td>
</tr>
<tr>
<td>Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes</td>
<td>HCPCS code G0443</td>
</tr>
</tbody>
</table>
Many services can be billed multiple ways
Most basic are usually allowed
Many screening and prevention services allowed
2017 New Telehealth Codes

**90967-90970 End-Stage Renal Disease** related services for dialysis less than a full month of service, per day. The proposed fee schedule notes that there is a required clinical examination of the catheter access site which must be furnished face-to-face “hands on”.

- **90967** for patients younger that 2 years of age
- **90968** for patients ages 2-11
- **90969** for patients ages 12-19
- **90970** for patients ages 20 and older

**99497-99498 Advance Care Planning** including the explanation and discussion of advance directives such as standard forms, by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), or surrogate.

- **99497** first 30 minutes
- **99498** additional 30 minutes

**G0508-G0509 Telehealth Consultation**, critical care, physicians typically spend 60 minutes communicating with the patient and providers via telehealth.

- **G0508** initial 60 minutes
- **G0509** subsequent 50 minutes
2017 Place of Service

Effective 1/1/2017

(POS) 02 = Telehealth

Continue to use GT modifier

GT has not changed to 95 as proposed in July 2016
In the past, providers report the POS code of the originating site for telehealth services.

CMS has adopted a new telehealth specific POS code (02), that starting January 1, 2017, will be used by providers at the distant site to indicate that the service took place via telehealth.

CMS indicates that it is their hope the new POS code will help “track telehealth utilization and spending”.

CMS also indicated that since the new POS code would serve to identify telehealth services under 1834(m) of the Social Security Act, they believe that they should consider eliminating the required use of GT and GQ telehealth modifiers, and will revisit this question through future rulemaking.

They will use the facility PE RVUs to pay for the telehealth services reported by physicians or practitioners with the telehealth POS code. CMS does not anticipate that this will result in a significant change in the total payment for the majority of services on the telehealth list.

But they also state that they will consider the concerns and monitor telehealth utilization, and welcome information from stakeholders regarding any potential unintended consequences of the payment rate.

The POS code would not apply to originating sites billing the facility fee. Regulatory changes consistent with this include:

- Change to regulation Section 414.22(b)(5)(i)(A) addressing the PE RVUs – amends section to specify that the facility PE RVUs are paid for practitioner services furnished via telehealth under 410.78.
- Delete Section 414.32 that refers to the calculating of payment for certain services prior to 2002.

http://www.cchpca.org/sites/default/files/resources/CY%202017%20Final%20Fee%20Schedule%20Fact%20Sheet.pdf
2016 Telehealth Codes

End Stage Renal Disease (ESRD)

90963 (ESRD related services for home dialysis per full month for patients younger that 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents)

90964 (ESRD ages 2-11)

90965 (ESRD ages 12-19)

90966 (ESRD ages 20 and older)

Inpatient/Observation

99356 (Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; first hour (list separately in addition to code for inpatient evaluation and management services)

99357 (each additional 30 minutes)
2016 RHC Medicare Reimbursement

- 2016 Medicare changes for Rural Health Clinics (RHCs)
  - 1/1/2016 - paid for Chronic Care Management
  - Requires RHCs to start including HCPCS codes on the UB-04 form
  - Provides safe harbors from Stark and anti-kickback rules for RHCs to help recruit new providers
Chronic Care Management (CCM)

Introduced 1/1/2015 – 99490 - Chronic care management services furnished to patients with 2 or more chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation or decompensation, or functional decline

Effective 1/1/2017

99487 – 60 minutes of CCM

99489 – additional 30 minutes

Use of these codes will help drive the overall shift from inpatient to outpatient services that is required for successful population health management
# CCM-Services and Billing

<table>
<thead>
<tr>
<th>CCM Service-99490</th>
<th>CCM Service-99487/89</th>
<th>Authorized Billing Providers</th>
</tr>
</thead>
</table>
| • 20 minutes of clinical staff time per month, directed by physician or other qualified professional.  
  • Comprehensive care plan established, implemented, revised, or monitored.  
  • Create structured, clinical summary record, care plan – demographics, problems, allergies, medications | • 60 minutes of clinical staff time per month, directed by a qualified professional.  
  • Comprehensive care plan established, implemented, revised, or monitored.  
  • Each additional 30 minutes of care delivered, additional billing  
  • Create structured, clinical summary record, care plan—demographics, problems, allergies, medications | • Physicians  
  • Certified Nurse Midwives  
  • Clinical Nurse Specialists  
  • Nurse Practitioner  
  • Physician Assistant |

**National Average:** $40.82

**National Average Rates**

- 99487 - $92
- 99489 - $47
# CCM Eligibility

## Eligible Patients

- Multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Primary coverage - Medicare or other participating health plan

## Eligible Chronic Conditions - Examples

- Alzheimer’s disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- Autism Spectrum Disorder
- Cancer
- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Heart Failure
- Hypertension
- Ischemic Heart Disease
- Osteoporosis

[UMTRC.org](http://UMTRC.org)
### CCM-Care Plan

#### Requirements

- Patient-centered - based on physical, mental, cognitive, psychosocial, functional, and environmental (re)assessment, and an inventory of resources. Comprehensive plan for all health issues.

- Patient provided with written or electronic copy. Provision documented in the medical record.

- Care plan should be shareable with outside entities electronically (fax counts).

#### Typical Clinical Content

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Symptom management
- Planned interventions and individuals responsible for each
- Medication management
- Community/social services ordered
- A description of services outside the practice and how they will be directed/coordinated
- Schedule for periodic plan review, and revision as appropriate
Implications of 99490/99487/99489

• Not “telehealth codes” but will drive many telehealth services that meet its requirements

• Will be used to promote:
  • Primary Care Redesign
  • Expansion of ACOs
  • Commercial payer reimbursement for same services
  • MACRA/MIPS
Eligible Practitioners

- Physician
- Nurse Practitioner
- Physicians Assistant
- Clinical Nurse Specialist
- Certified Nursing Anesthetist
- Nurse Midwife
- Nutrition Therapist or Other Nutrition Professional
- Clinical Social Worker
- Clinical Psychologist
NO TWO STATES ARE ALIKE!

48 states (and DC) have a definition for telemedicine and/or telehealth.

2 states
New Jersey and Rhode Island have no definition for either.

As of April 2017
MEDICAID REIMBURSEMENT BY SERVICE MODALITY

**Live Video**
- 48 states and DC
- (Massachusetts and Rhode Island do not)

**Store and Forward**
- Only in 13 states

**Remote Patient Monitoring**
- 22 states

As of April 2017
PARITY IN PAYMENT WITH IN-PERSON

35 states and DC have telehealth private payer laws
Some go into effect at a later date.
This is the most common policy change at the state level!

Parity is difficult to determine:
- Parity in services covered vs. parity in payment
- Many states make their telehealth private payer laws “subject to the terms and conditions of the contract”

http://www.cchpca.org/sites/default/files/resources/50%20STATE%20PDF%20FILE%20APRIL%202017%20FINAL%20PASSWORD%20PROTECT.pdf

As of April 2017
Indiana Telemedicine Law & Policy
House Enrolled Act 1337

Effective 7/1/2017

- **Removes** the 20 mile distance limitation for Indiana Medicaid Telemedicine Reimbursement for *all providers*
  - Previously, only FQHCs, RHCs, CAHs, and CMHCs were exempt
- Adds podiatrist to the definition of "prescriber" for purposes of telemedicine services.
- Requires a telemedicine services prescriber to contact the patient's primary care provider if the telemedicine services prescriber has provided care to the patient at least two consecutive times through the use of telemedicine services.
Indiana Telemedicine Law & Policy
House Enrolled Act 1337 (cont’d)

Effective 7/1/2017

- Removes a limitation on prescribing controlled substances except for opioids through the use of telemedicine if:
  - (1) the prescriber maintains a controlled substance registration;
  - (2) the prescriber meets federal requirements concerning the prescribing of the controlled substance;
  - (3) the patient has been examined in person by a licensed Indiana health care provider that has established a treatment plan to assist the prescriber in the diagnosis of the patient;
  - (4) the prescriber has reviewed and approved the treatment plan and is prescribing for the patient pursuant to the treatment plan; and
  - (5) the prescriber complies with the requirements of the INSPECT program. Allows for the prescribing of an opioid using telemedicine services if the opioid being prescribed is a partial agonist being prescribed to treat or manage an opioid dependence.
Indiana Telemedicine Law & Policy
House Enrolled Act 1540

Effective 7/1/2017 – Pharmacies and Pharmacists

• Allows the state health commissioner or a designated public health authority who is a licensed prescriber to issue a statewide standing order, prescription, or protocol that allows a pharmacist to administer or dispense a smoking cessation product.

• Adds the following immunizations to the list of immunizations that pharmacists may administer if certain conditions are met: (1) Measles, mumps, and rubella. (2) Varicella. (3) Hepatitis A. (4) Hepatitis B. (5) Haemophilus influenzae type b (Hib). Allows a pharmacist to administer pneumonia immunizations to individuals who are at least 50 years of age.

• Requires a pharmacist to comply with the public health emergency consent requirements for immunizations administered during a public health emergency. Authorizes a pharmacist to administer immunizations under a standing order, prescription, or protocol of the state health commissioner.
Indiana Telemedicine Law & Policy
House Enrolled Act 1540 (cont’d)

Effective 7/1/2017 – Pharmacies and Pharmacists

• Defines "patient care", "remote dispensing facilities" and "telepharmacy" for purposes of the laws concerning remote dispensing facilities.

• Establishes a registration for pharmacy remote dispensing facilities and sets forth requirements for the registration.
  • NOTE: This allows for telepharmacy in the state of Indiana

• Requires that a health insurance policy and a health maintenance organization contract that provide coverage for prescription medications must provide for synchronized refill schedule coordination for prescription medications for chronic conditions.
Indiana Telemedicine Law & Policy
House Enrolled Act 1540 (cont’d)

**Effective 7/1/2017 – Pharmacies and Pharmacists**

- Provides that the taking of a controlled substance from:
  - (1) a pharmacist acting in an official capacity; or (2) a pharmacy; is robbery, a Level 4 felony.
- Provides that:
  - (1) the use of a deadly weapon; or (2) causing bodily injury to any person other than the defendant; during the robbery of: (A) a pharmacist acting in an official capacity; or (B) a pharmacy; is a Level 2 felony.
- Provides that causing serious bodily injury to any person other than the defendant during a robbery of:
  - (1) a pharmacist acting in an official capacity; or (2) a pharmacy; is a Level 1 felony.
Telemedicine in Indiana

- HB 1263 – Effective 7/1/2016
  - Provider/Patient relationship can be established during 1\textsuperscript{st} telemedicine visit if applicable standards of care are provided.
  - Prescriptions can be issued during the 1\textsuperscript{st} visit with restrictions – \textit{no controlled substances or abortion inducing drugs}

- HB 1269 – Effective 7/1/2015
  - Coverage Parity for Indiana

- Indiana Telehealth Pilot (HB 1258)
  - Establishment of Patient / Physician relationship via virtual visit, including prescriptions
  - \textit{Ended 7/1/2016 with new telemedicine prescribing law}
FQHC AND RHC Telehealth Reimbursement
Medicaid

Subject to the following criteria, reimbursement is available to FQHCs and RHCs when they are serving as either the hub site or the spoke site for telemedicine services:

• When serving as the hub site
• When serving as the spoke site
FQHC AND RHC Telehealth Reimbursement

Medicare

FQHCs and RHCs may serve **ONLY** as an originating site for telehealth services.

Medicare deductible must be applied when a FQHC bills for the telehealth originating site facility fee, since this is not considered a FQHC service.

**RHCs and FQHCs are not authorized to serve as a distant site for telehealth consultations**

Dual Eligibility

Bill Medicare for approved Telehealth CPT Codes

If denied, automatically goes to Medicaid

Medicaid uses a different CPT code for Telehealth services

If Medicaid also denies the services based on the fact that Medicare was not billed first

Resubmit the claim to Medicaid
Ultimate Goal: Increase Access to Care
Contact Information & Questions

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