

## Washington State Telemedicine Collaborative Meeting

January 4, 2017

Multicare Tacoma General Hospital

- I. Review of 12.09.16 Minutes
- II. Review of Final Collaborative Report
- III. Q&A About Billing for Telehealth Services in 2017
- IV. Public Comment Period

**Attendees (In Person):** Sen. Randi Becker, Rep. Joe Schmick, Chris Cable (Group Health), Brodie Dychinco (Cambia Health Solutions), Sheila Green-Shook, Sheryl Huchala (Premera), Julie Stroud (Multicare), John Scott (UW)

**Attendees (Via Phone):** Joelle Fathi (Swedish), Denny Lordan (Providence), Scott Kennedy (Olympic Medical Center), Frances Gough (Molina), Cara Towle (UW), Julie Sylvester (Virginia Mason), Adam Romney, Sue Stern, Ian Goodhew (UW)

Meeting was called to order at 11:05am

- I. Review of 12.09.16 Minutes
  - a. Reviewed and no further changes suggested.
- II. Review of Final Collaborative Report
  - a. Dr. Scott went through the Table of Contents as a broad overview
  - b. Membership
    - i. credentials were verified as correct
      - i. We will cross reference with the website, to make sure updated and accurate.
  - c. Meeting times and Locations are listed
  - d. Info about Website
    - i. A Work in progress, is very basic
    - ii. We hope that the website would have more resources
      - i. How can it be more useful to the average person?
      - ii. Cara Towle had some thoughts on how to improve it?
        - i. Upcoming conferences related to telehealth
        - ii. Sample patient consent forms
        - iii. Contracts
        - iv. Templates
        - v. FAQ section
    - iii. It was suggested that we use Google analytics to look at # visitors and traffic
    - iv. We haven't promoted the website (Ian)
    - v. It is hard to find on the WISHA web page

- vi. We should figure out how we can promote our web page to get more traffic.
  - vii. **ACTION:** Denny will put together some resources for the website.
  - viii. Julie (Virginia Mason) has been putting together an FAQ and definitions. Things that keep people up to date. Billing changes, coding changes
    - i. **ACTION:** John and Julie (Virginia Mason) will come up with a FAQ for providers and share at the next mtg
    - ii. Sample question: What is telemedicine?
    - iii. Sample question: Can a provider get paid for telemedicine? What changed for 2016 and changes for 2017?
    - iv. **ACTION:** Sheila will draft a FAQ from patient perspective and share at next meeting
  - ix. Should we have a link to individual collaborative members to their telemedicine offerings
  - x. Might be dangerous is some people are on or some people aren't. Want to avoid appearance of promoting one program over another. But overall consensus was that this could be helpful.
  - xi. **ACTION:** Asking health systems to double check with their internal teams to make sure this is OK. We want this to be an all or nothing deal.
  - xii. Telehealth providers that are not local systems (like American Well or Doc on Demand, do we want to add doctors that are not a part of the collaborative?
  - xiii. Consensus was that since this is a WA state specific resource that only telehealth providers based in the state should be listed on the website.
  - xiv. **ACTION:** Denny will check with the Federal Resource Center to see if they have any guidelines
  - xv. Do the ATA have an approval process where they give a certification to Telehealth programs? Do they have a website that list those or have access to other people? Maybe provide that link then having a long list of telehealth programs.
  - xvi. From a legal perspective, Adam doesn't think this will be a problem. Not really a legal action that be thrown against the collaborative.
  - xvii. **ACTION:** Denny and Cara will look into the NRTRC and ATA website policies and report back.
- e. Telehealth Services Inventory
- i. We will send out again to update for all members
  - ii. Are all of these reimbursable?

- i. It varies, about half are not
  - ii. Anything Project ECHO is not reimbursable
  - iii. Should we have another list that describes which are reimbursable in 2017? 2018? Yes/No/Varies/Payer Dependent
  - iv. Wouldn't it vary by payer/payer dependent
  - v. This gives a glimpse of a quite a bit going on and much is not getting paid for.
  - vi. It's very similar to the types of questions we were asking on reimbursement. Maybe it's more scenario dependent. Are these categories in the similar type of space? Not a blanket yes or no.
  - vii. **ACTION:** Each group listed on the inventory was asked to add a column stating whether their service is reimbursable or not. If it varies, please put yes or no with an asterisk explaining what variables are.
- f. Definition of home
  - i. Reviewed language in the report
  - ii. Definition of Home: Home or any location determined appropriate by the individual receiving the service
  - iii. **ACTION:** Joelle will send us a references regarding RN
  - iv. Is there a policy about Dentists and Telemedicine?
  - v. **ACTION:** Dr. Scott will follow up with UW colleague in Dentistry school for information.
  - vi. Would it be worth it to include things like cars, tents, something to give people ideas
    - i. The hypothetical scenario of a patient participating in telemedicine visit from a car did come up, but it might not be safe in the case of moving car. But people might be homeless and the car is their home. "Home" is a broad term.
    - ii. We intended it to be inclusive.
- g. Innovative ways we can use Telemedicine (ECHO and ICTP highlighted)
- h. Fraud Prevention
  - i. We need to get more detailed on this in 2017
  - ii. We will look to Sheila Green-Shook and Adam Romney for expertise.
- i. Consent forms
  - i. Patents need to be consented prior to receiving care but there is no specific telemedicine consent form.
  - ii. A one size fits all consent form may not work for Telemedicine
  - iii. In certain cases, depending on the type of services, as a provider you may or may not want to add items to the consent forms. Think about your services and then draft a consent for that is closer to the MQAC guidelines
  - iv. Is the committee's discussion on consent forms a guideline or rule?
    - i. Guideline
  - v. This is something we would want on an FAQ for providers

- vi. Several systems have a verbal consent between provider and patient, that consent is documented in patient's chart
    - j. Disaster preparedness
- III. Q&A About Billing for Telehealth Services in 2017
  - a. Q1: If a specialist is providing a service/talking to a provider without a patient present, is it reimbursable?
  - b. A1: So long as it is NOT a form of store and forward, such an interaction between just two providers and NO patient present is not currently reimbursable under state laws.
  - c. Regence policy: Telehealth services are medically necessary and appropriate when the member is present (The member's identity is authenticated and eligibility is verified).
  - d. Premera Policy
    - i. This question addresses the "Interprofessional Telephone/Internet Consultation Codes (99446-99449)
    - ii. These are Medicare Status B codes and as such, PREMERA has a policy of "not" reimbursing any Medicare Status B Codes
    - iii. These are also "consultation codes" and as such, PREMERA also has a policy of "not" reimbursing consultations. The "Interprofessional Telephone/Internet Consultation" codes are part of this policy
  - e. Q2: How do we tell all the providers that you can or cannot bill for XYZ. Didn't think about where the patient would be.
  - f. A2: Medicare will not reimburse for consultation codes 99367
  - g. Q3: What is the new 95 modifier and how should we use?
    - i. A3: It is similar to the GT modifier and was created by the AMA primarily for commercial billing. For now, the safest code to use is the GT code, especially when billing Medicare. The 95 modifier has a more focused list of associated codes and procedure.
    - ii. Regence's policy states the following codes should be used for telehealth visits:
      - i. Physician codes:
        - i. 99441, Telephone assessment and management service; 5-10 minutes of medical discussion
        - ii. 99442, Telephone assessment and management service; 11-20 minutes of medical discussion
        - iii. 99443, Telephone assessment and management service; 21-30 minutes of medical discussion
        - iv. 99444, Online assessment and management services (using video, Internet)
      - ii. Non-physician codes:
        - i. 98966, Telephone assessment and management service provided by a qualified non-physician health care professional; 5-10 minutes of medical discussion

- ii. 98967, Telephone assessment and management service provided by a qualified non-physician health care professional; 11-20 minutes of medical discussion
      - iii. 98968, Telephone assessment and management service provided by a qualified non-physician; 21-30 minutes of medical discussion
      - iv. 98969, Online assessment and management services (using video, Internet)
    - iii. In addition, the following code will be used for telehealth psychotherapy services.
      - i. 90834-GT Psychotherapy, 45 minutes with patient and/or family member – synchronous telecommunication. The health plan will set a unique rate for the procedure code modifier combination.
    - iv. Only one (90834) of the 8 telehealth codes made it on the AMA list, where Modifier 95 can be used. Modifier GT can be appended to the rest of our telehealth codes.
  - iii. **PREMERA Policy:**
    - i. Modifier 95 was just created (effective with dates of service 01/01/2017 and after) by the American Medical Association (AMA) and added to the 2017 CPT Codebook published by the AMA.
    - ii. Its official title is: *“Synchronous Telemedicine Service Rendered via a real-time audio and video telecommunications system”*.
    - iii. The AMA created Appendix P-CPT Codes That May be Used for Synchronous Telemedicine Services” that contains the listing of codes that the AMA has designated may be used for reporting synchronous (real time) telemedicine services.
    - iv. This modifier is similar to the modifier *GT- Services via interactive audio and video telecommunication systems* which is required for Medicare beneficiaries rather than the use of modifier 95 on services rendered to a Medicare Beneficiary.
  - iv. **Group Health:** Group Health for telemedicine services – claims should be billed for appropriate CPT code and modifier GT or GQ. They are not accepting modifier 95. Telemedicine should NOT be billed with 99441-99444 or 98966-98969.
- h. Q4: How does this policy apply to other disciplines? If they are not an MD, they will bill a certain set of codes, if an MD then another set of codes?
- i. A4: There is no other codes for other qualifications of providers
- j. **PREMERA Policy:**
- i. When a member is in a “non-clinical” setting, there are different CPT codes to bill based on the credentials of the provider:
    - i. Telephone Assessment and Management services:
      - i. Physician rendered services codes: 99441, 99442, 99443

- ii. Qualified non-physician healthcare professional rendered services: 98966, 98967, 98968
  - ii. Online/Internet Communications:
    - i. Physician rendered services: 99444
    - ii. Qualifies non-physician rendered services: 98969
  - ii. When the member is in a “clinical” setting, such as sitting with their Primary Care provider who initiates a call to a “distant site” provider, whatever services are provided by that “distant site” provider are submitted with modifier 95 or GT.
- k. Q5: If a doctor who is seeing a patient via telephone vs in person, will they be paid the same (parity)?
- l. A5: It depends on individual payer, but most likely no. Comment from provider: As a provider, we feel that we should be paid same amount for the same amount of time spent with a patient, regardless of whether patient is seen in person or through televideo. We are not going to spend our time to be paid less for the same amount of work.
- m. From payer’s perspective, they follow normal use of Relative Value Units (RVU) when available and the Conversion Factors in reimbursement.
- n. PREMERA Policy: Providers will be paid whatever “allowed amount” is set up in their respective fee schedule agreements and contract terms. PREMERA’s policy describes clear criteria to be documented in the member’s record if a provider is communicating to a member via “telephone”.
- o. Q6: Is there parity language in either of the telehealth bills?
- p. A6: There is not language in either bill that mandates that there is parity reimbursement. In other words, it is legal for payers to pay \$75 for a 15 min in person office visit and \$50 for a 15 min telemedicine visit.
  - i. Comment: There is no facility fee from the specialist, which covers overhead and non-clinician staff. There was concern expressed that without reimbursement parity, access to specialty care in rural areas will not change significantly in rural areas.
  - ii. Need a center of excellence to teach people what will be covered and what won’t to keep people from being fraudulent
  - iii. Medicaid plans to follow the same Pay schedule, based on time. Same codes and same fee schedule as it is an in person visit, just need GT modifier.
  - iv. Group health: Please see above comment to Q3. One should use appropriate CPT code for service performed with GT or GQ modifier.
- q. Q7: Will store and forward telemedicine be covered? If so, how should it be billed?
  - i. Regence:
    - i. "Store and forward" technology means use of an asynchronous transmission of a covered member's medical information from an

originating site to the health care provider at a distant site which results in medical diagnosis and management of the covered member, and does not include the use of audio-only telephone, facsimile, or email.

- ii. Providers at the distant site must submit the appropriate HCPCS/Current Procedural Coding Terminology (CPT®) codes for the services rendered. Modifier GQ must be appended to all codes when the service is conducted via asynchronous (store and forward) telecommunication systems.

ii. **PREMERA:**

- i. **Definition Per Policy : Store and Forward (S&F):** S&F is a type of Telehealth/Telemedicine encounter or consult that uses still digital images of a patient for the purposes of rendering a medical opinion or diagnosis. Common types of S&F services include, but are not limited to radiology, pathology, dermatology, wound care or any other medical information that is to be used at a later time by a Physician or other non-physician practitioner. S&F also includes the Asynchronous transmission of clinical data from one site (e.g. patient's clinical setting) to another site (e.g. home health agency, hospital, etc.) S&F services do not include telephone calls, images transmitted via fax and text messages without visualization of the Patient.
- ii. The appropriate CPT/HCPCS code that represents the service that was forwarded to the "distant site" provider via asynchronous transmission would be billed with the modifier GQ to represent the service was transmitted as "store and forward".
- iii. Group Health: The bill states Store and forward is covered. Use appropriate CPT with GQ modifier.

1. **ACTION:** it would be helpful to have concrete examples of Store and Forward (**John Scott and Chris Cable**)

ii. **Molina:**

1. Frances would like the examples and will weigh in

r. **What is the Place of Service (02 code) and how do I use?**

- i. Different codes for doctors Office or home. It is now an 02 code
- ii. Medicare recently announced that they have created this code for Telehealth services.
- iii. Premera will accept 02 to acknowledge Telemedicine
- iv. No penalties
- v. If used by the distant site (provider consult)
- vi. Origin facility service is covered and different than 02
- vii. 11 code is for flesh in blood in person

- viii. Would they use the o2 services if the provider is at their own home
        - ix. Yes that is appropriate as it is their home office
        - x. **MD specialist don't need to be at their office in order to bill**
    - ii. Regence can accept the POS o2, but it is used for informational purposes only at this time.
    - iii. PREMERA Policy:
      - i. Place of Service (POS) code "o2" was created by CMS to identify that a service rendered to a Medicare beneficiary was rendered using "telehealth".
      - ii. PREMERA will accept POS code "o2" to identify a telehealth service was rendered
    - iv. Group Health – The distant site practitioner should bill with o2 place of service. Following Medicare guidelines.
  - s. Should there be a separate policy for telehealth vs Telemedicine?
    - i. Telemedicine
      - 1. Involves a provider, clinical service delivered
      - 2. CMS definition of telemedicine
      - 3. Doctor to Doctor
    - ii. Telehealth
      - 1. More expansive definition
      - 2. Public health
      - 3. Education
      - 4. Patient to doctor
    - iii. We need a common definition for Telehealth / Telemedicine
  - t. **ACTION:** Sheryl will send us the link to this appendix that has definitions
    - i. PREMERA Policy: Premera's Policy incorporates both terms in the same policy. A "common definition" that is accepted industry wide might be helpful but it must be acceptable on a national scale in order to avoid the potential for "conflicts".

#### IV. Public Comment Period

- a. Mary Kampfy (L&I)
  - i. L&I do not have special telemedicine codes. Expect the provider to bill whatever code they would typically bill
- b. Leslie Emerick
  - i. Would like definitions to be defined so they are up to date
- c. Matt Levi CHI (Franciscan)
  - i. Coding will be a topic for future conversations?
  - ii. Concern for a catch all code. Technically just two codes out of the 8.
  - iii. Level of reimbursement for the catch all codes



**ACTION:** Sen Becker will put together a list of definitions and some things in place so that we can get paid, definitions, parity, and center of excellence.

Next meeting will be at Olympia Feb 9<sup>th</sup> 3:30-5:30 or Feb 10<sup>th</sup> after 12pm.

Meeting adjourned 1:06pm