



EDUCATIONAL RESOURCES

EVERYTHING YOU EVER WANTED TO KNOW ABOUT TELEHEALTH

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TELEHEALTH

- Definition

- The electronic transfer of medical information for the purpose of providing patient care. The use of technology to deliver health care, health information, or health education at a distance.

TELEHEALTH

- Telehealth can be divided into three general types of applications
 - Real-Time Communication
 - Real-time communication may include, but is not limited to, (i) a patient and a nurse practitioner consulting with a specialist through a video conference; (ii) a physician and a patient in an exam room communicating through an interpreter who is connected by phone or video conference; or (iii) a DME supplier's nurse or RT communication through a video conference with a homebound patient and/or his caregiver.
 - Store-and-Forward or Asynchronous
 - The transmission of digital images.
 - Remote Patient Monitoring
 - Involves collection of a patient's personal health and medical data via electronic communication technologies. Once collected, the data is transmitted to a health care provider at a different location, allowing the provider to track the patient's data.

TELEHEALTH

- The boundaries of telehealth are limited only by the technology available. New applications are being invented and tested every day.
- Bottom line - it's a tool to enhance the provision of quality care.



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TELEHEALTH ADVANTAGES

TELEHEALTH ADVANTAGES

- Increases access to physicians, providers and suppliers.
- Enhances the quality and coordination of care.
- Helps address the shortage of physicians, providers and suppliers in rural areas.
- Utilizes provider time more efficiently.
- Saves patient and provider travel.
- Saves patient and caregiver time.

TELEHEALTH ADVANTAGES

- Supports the local main street and health care community by keeping the patient at home.
- Medical education can be obtained locally.
- Enhances relationship between the patient/caregiver and the provider.

GROWING IN POPULARITY

- Hospitals are embracing the use of telehealth technologies.
 - In 2013, 52 percent of hospitals utilized telehealth, and
 - Another 10 percent were beginning the process of implementing telehealth services.
- Consumer interest, acceptance, and confidence in telehealth are growing.

GROWING IN POPULARITY

- Recent studies on the use of telehealth services have shown that:
 - 74% of U.S. consumers would use telehealth services;
 - 76% of patients prioritize access to care over the need for human interactions with their health care providers;
 - 70% of patients are comfortable communicating with their health care providers via text, e-mail or video in lieu of seeing them in person; and
 - 30% of patients already use computers or mobile devices to check for medical or diagnostic information.



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TELEHEALTH & THE COVID-19 PANDEMIC

TELEHEALTH & THE COVID-19 PANDEMIC

- Legislative and regulatory changes
- Important HIPAA changes
- Who can provide telehealth services
- What services can be provided
- What it means to you?

CORONAVIRUS PREPAREDNESS AND RESPONSE SUPPLEMENTAL APPROPRIATIONS ACT (3.6.2020)

- Congress authorized HHS to waive certain Medicare telehealth requirements.
- Expands coverage to patients outside of rural areas and patients in their homes.
- Expands coverage to new (not just established) patients.

CORONAVIRUS PREPAREDNESS AND RESPONSE SUPPLEMENTAL APPROPRIATIONS ACT (3.6.2020)

- Broader waiver authority—HHS can waive statutory coverage requirements for telehealth.
- Increased funding, e.g., for remote care technologies.
- Effective March 1, 2020, through the end of the PHE (public health emergency).

CMS RULES & DOCUMENTS ON TELEHEALTH EXPANSION DURING THE PHE

- Medicare pays for telehealth services at the same rate as in-office visits for all diagnoses, not just services related to COVID-19
- Physicians can reduce or waive Medicare beneficiary cost-sharing for telehealth visits, virtual visits, e-visits, and remote monitoring services
- CMS FAQ: COVID-19 FAQ on Medicare Fee-for-Service Billing
 - <https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf>
- CMS FAQ: Physicians and other Clinicians: CMS Flexibilities to Fight COVID-19
 - <https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf>

CMS STATE MEDICAID & CHIP TELEHEALTH TOOLKIT (COVID-19 VERSION)

- Each Medicaid program has its own policies
- CMS issued “Policy Considerations for States Expanding Use of Telehealth”
- To help Medicaid agencies have the necessary tools to respond to COVID-19 PHE; CMS will update over time
- Toolkit offers considerations for telehealth expansion and helps states identify which aspects of their statutory and regulatory infrastructure may impede the rapid deployment of telehealth capabilities
- States have great flexibility to cover services provided via telehealth—states need not submit a SPA if payments are made in the same manner as when delivered face-to-face
- Provides states with a checklist of policy questions to assess telehealth in their state, consideration to populations, services, providers, payment rates, technology, etc.

OCR* RELAXATION OF TECHNOLOGY REQUIREMENTS

- Historically, telehealth requirements limited access to telehealth to those with access to advanced technologies
- OCR relaxed HIPAA requirements for the use of technology to facilitate the relaxed CMS guidelines for telehealth, including standards of good faith for HIPAA requirements when using alternate technology
- This allows providers to utilize other mediums including Zoom, FaceTime, Webex, Skype, and other platforms that did not meet previous OCR requirements for telehealth

*Office of Civil Rights

OTHER IMPORTANT TELEHEALTH CHANGES

- The CARES Act permanently allows mid-level providers, including NPs and PAs, to prescribe DME for Medicaid patients
 - CMS has 6 months to implement
 - But CMS expanded the ability to prescribe to non-physician practitioners in its Interim Final Rule (CMS-1744-IFC) effective March 1, 2020
- Hospitals can bill for the telehealth services of its physicians even if that physician is at home while providing the service
- Many patient education and E&M services can now be conducted as audio-only and will be reimbursed at the same rates as if they had been provided in-office
- Many states and third-party payors have also expanded access to telehealth in significant ways
- A list of permitted telehealth codes can be found here:
 - <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>

APPLICATIONS TO PHYSICIAN PRACTICES

- Physician's can see both new and established patients for any normal E&M code and bill the same as if the patient were seen in the office.
- All tests required to be ordered to diagnose respiratory conditions can be ordered after these visits with the same medical necessity requirements as those applicable to in-office visits
 - For physician billing purposes, all clinical data and conditions as well as diagnoses supporting all tests ordered should be well documented
 - CMS is not enforcing the clinical conditions for coverage of DME respiratory items during the PHE, but the item must still be "reasonable and necessary" for the beneficiary
- These telehealth visits can be done by all providers in a physician's office, not just physicians, and all providers can prescribe the required DME
- CMS has temporarily waived Medicare and Medicaid's requirements requiring providers to be licensed in the state where they are providing services, but state licensing requirements still apply
- A great resource regarding CMS telehealth changes can be found here
 - <https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf>

SPECIAL CONSIDERATIONS

- There are no heightened documentation or billing requirements as they relate to Medicare compliance
- However, best practice may suggest heightened documentation as to why a telehealth visit was necessary as well as clear documentation of symptoms found to support the necessity of all ordered diagnostic tests
- Again, the above are not required, but there are inherent challenges associated with telehealth; and a little extra effort to document medical necessity may go a long way towards avoiding potential future issues
- Be sure that your billing staff remains up to date with policy changes pertaining to telehealth for Medicare, Medicaid, and your commercial payors

COVID-19 TELEHEALTH RESOURCES

- We have certainly reached a new frontier regarding the use of telehealth. When used appropriately, telehealth can be used to sustain your practice during this pandemic and as a driver of practice growth in the future.
 - <https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf>
 - <https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf>
 - <https://www.telehealth.hhs.gov/providers/policy-changes-during-the-covid-19-public-health-emergency/#hipaa-flexibility-during-the-covid-19-public-health-emergency>
 - <https://www.cms.gov/files/document/general-telemedicine-toolkit.pdf>
 - <https://www.cms.gov/files/document/faqs-telehealth-covid-19.pdf>
 - <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>



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NOT LIMITED TO PATIENTS IN THEIR HOMES

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- Referral Sources

- The supplier can set up video conferencing arrangements with referral sources.
 - Hospitals
 - Physician Offices
 - SNFs
 - Long-Term Care Facilities
 - Hospices
 - Therapy Clinics
 - Wound Care Clinics
 - Pharmacies

NOT LIMITED TO PATIENTS IN THEIR HOMES

- Referral Sources
 - The DME supplier can consult with a referral source employee regarding usage and maintenance of equipment.
 - The DME supplier can consult with the patient/caregiver regarding usage and maintenance of equipment.
- Caregivers
 - The DME supplier can use telehealth to communicate with a patient's caregiver.



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HEALTH PROFESSIONAL LICENSURE

HEALTH PROFESSIONAL LICENSURE

- The telehealth physician must be licensed in the state where the patient is located.
- At least 10 state medical boards issue special licenses or certificates that allow physicians to treat patients in another state via telehealth services.
- Other states permit a physician to provide services via telehealth in another state if certain conditions are met (such as agreeing not to open an office in that state).

HEALTH PROFESSIONAL LICENSURE

- Consultation Exception
 - Most state licensure requirements contain a consultation exception that permits an out-of-state physician, who is fully licensed in another state, to provide consultations to an in-state licensed physician without requiring the consulting physician to be licensed in the state.

HEALTH PROFESSIONAL LICENSURE

- Online Prescribing
 - A challenge with adopting telehealth pertains to prescriptions.
 - State approaches vary; therefore, state laws are inconsistent.
 - States regulate online prescribing to guard against fraud and abuse by physicians and patients.
 - Generally, unless an exception applies, state laws require that a physician first establish a valid physician-patient relationship before he/she may prescribe for the patient.

HEALTH PROFESSIONAL LICENSURE

- Most states require a physical examination before a prescription can be issued. The definition of physical exam varies from state to state.
- At least 20 states explicitly allow physical examinations or evaluations to be performed by electronic means or via telehealth technologies.
- 48 states and Washington, D.C. provide reimbursement for some form of live video for Medicaid fee-for-service.
- 13 state Medicaid programs reimburse for store and forward.

HEALTH PROFESSIONAL LICENSURE

- 22 state Medicaid programs provide reimbursement for remote patient monitoring.
- Nine state Medicaid programs reimburse for all three, although certain limitations apply.
- In Maryland, if a physician-patient relationship does not include prior in-person, face-to-face interaction with a patient, the physician shall incorporate real-time auditory communications or real-time visual and auditory communications to allow a free exchange of information between the patient and the physician performing the patient evaluation.

HEALTH PROFESSIONAL LICENSURE

- States that allow physical examinations to occur by electronic means or via telehealth technologies tend to be more progressive overall regarding their approach to regulating the practice of telehealth.
- Other states broadly interpret the requirement and offer flexibility in determining how a physical examination or evaluation is performed when trying to establish a physician-patient relationship before the physician may prescribe online.
- Many states prohibit prescribing based solely on information about a patient that the physician has gathered from an online questionnaire.

HEALTH PROFESSIONAL LICENSURE

- Some states have taken steps to regulate online prescribing through state pharmacy laws, which generally address issues related to when prescriptions are considered “valid.”
 - These states’ laws place importance on the validity of the associated physician-patient relationship (including the physical examination/evaluation) that must be in place before a pharmacist will be allowed to dispense.
 - In the District of Columbia, for example, a pharmacist cannot “dispense a prescription if the pharmacist knows that the prescription was issued without a valid patient-practitioner relationship.”

HEALTH PROFESSIONAL LICENSURE

- Under Colorado law, a pharmacist cannot dispense a prescription drug if the pharmacist knows or should have known that the order for such drug was issued on the basis of an internet-based questionnaire, an internet-based consultation or a telephonic consultation, all without a valid pre-existing patient practitioner relationship.



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PAYMENT FOR TELEHEALTH

PAYMENT FOR TELEHEALTH

- Medicare

- Prior to the PHE, limited payment:
 - Medicare coverage for telehealth services was authorized in 2000 as part of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA).
 - BIPA specified that Medicare covers telehealth only for beneficiaries receiving services in a facility in a rural area, defined as a facility located in a rural health professional shortage area or a county that is not included in a Metropolitan Statistical Area (MSA).
 - 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.
 - As a condition of payment, the care must be provided by using an interactive audio and video telecommunications system that permits real-time communication between the caregiver at the distant site, and the beneficiary at the originating site.

PAYMENT FOR TELEHEALTH

- Originating Site:
 - An originating site is the location of an eligible Medicare beneficiary at the time the service furnished via a telecommunications system occurs and must be located in
 - A rural Health Professional Shortage Area (HPSA) located either outside of a Metropolitan Statistical Area (MSA); or
 - In a rural census tract; or
 - County outside of an MSA.
- The originating sites authorized by law are:
 - The offices of physicians or practitioners
 - Hospitals
 - Critical Access Hospitals (CAHs)
 - Rural Health Clinics
 - Federally Qualified Health Centers
 - Hospital-based or CAH-based Renal Dialysis Centers (including satellites)
 - Note: Independent Renal Dialysis Facilities are not eligible originating sites
 - Skilled Nursing Facilities (SNFs) and
 - Community Mental Health Centers (CMHCs)

PAYMENT FOR TELEHEALTH

- Distant Site Practitioners

- Practitioners at the distant site who may furnish and receive payment for covered telehealth services (subject to state law) are:
 - Physicians
 - Nurse Practitioners (NPs)
 - Physician assistants (PAs)
 - Nurse-midwives;
 - Clinical nurse specialists (CNSs)
 - Certified registered nurse anesthetists;
 - Clinical psychologists (CPs) and
 - Clinical social workers (CSWs)

PAYMENT FOR TELEHEALTH

- For services that meet these criteria, hospitals are paid a facility fee of approximately \$25 for each claim to cover services provided to patients in an inpatient or hospital outpatient clinic setting.
 - Off-site hospital-owned sites also are considered “facilities” in the context of a facility fee.
 - Professional fees for provision of telehealth services are the same as those paid for an in-person encounter and are based on physician fee schedule.

PAYMENT FOR TELEHEALTH

- Medicaid
 - Many state Medicaid programs cover telehealth services to some extent, although the criteria for coverage vary widely from state to state
 - In at least 46 state Medicaid programs, both fee-for-service and Medicaid managed care have some form of coverage for telehealth services, such as for remote patient monitoring.

PAYMENT FOR TELEHEALTH

- Medicaid

- Live video is the most frequently covered telehealth service, while store and forward services are defined and reimbursed by only a handful of state Medicaid programs
- State Medicaid programs rarely cover e-mail, telephone and fax consultations, unless they are used in conjunction with some other type of communication
- At least 24 states pay providers either a transmission or a facility fee, or both
- A few states have adopted the Medicare policy that restricts coverage to only telehealth services that are provided in rural or underserved areas

PAYMENT FOR TELEHEALTH

- Third-Party Payors

- There has been significant expansion with many states passing laws requiring private payors to provide coverage for telehealth services
- At least 20 states and the District of Columbia have enacted “parity” laws, which generally require health insurers to cover and pay for services provided via telehealth the same way they would for services provided in-person



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PAYMENT FOR DME ARISING FROM TELEHEALTH ENCOUNTER

PAYMENT FOR DME ARISING FROM TELEHEALTH ENCOUNTER

- The DME MACs have made it clear that they will not pay for DME, in which the physician order arises from a telehealth encounter, unless the physician-patient encounter meets the requirements for Medicare to pay the physician for the telehealth encounter.
- It is irrelevant that the physician does not submit a claim to Medicare for payment for the telehealth encounter.



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ORTHOTICS AND TELEHEALTH

ORTHOTICS AND TELEHEALTH

- There has been a noticeable growth in the orthotics market.
- The reasons for this growth are: (i) orthotics were not covered by competitive bidding; (ii) Medicare has historically paid well for orthotics; and (iii) it is relatively easy for a DME supplier to ship orthotics (i.e., braces) all over the country.
- 20 years ago, we could not turn on television without seeing Wilford Brimley promoting diabetic testing supplies. Today, we cannot turn on television without seeing a back brace commercial.

ORTHOTICS AND TELEHEALTH

- The orthotics phenomenon has been driven by lead generation companies (“LGCs”) that can produce large “buckets” of leads.
- LGCs approach “standard” DME suppliers (oxygen concentrators, beds, etc.) and show them how they can make money selling braces throughout the U.S.

ORTHOTICS AND TELEHEALTH

- While it is relatively easy for a LGC to convince a prospective customer (usually a Medicare beneficiary) that he needs a brace, it is harder to motivate the prospective customer to drive to his physician's office to obtain an order.
- And so LGCs have hooked up with telehealth companies. Unfortunately, a number of these telehealth companies are suspect.
- A standard telehealth company receives its income from patients, patients' employers, and patients' insurance plans.

ORTHOTICS AND TELEHEALTH

- A suspect telehealth company receives its money (usually indirectly) from the DME suppliers selling the braces.
- Here is how a suspect telehealth arrangement works: (i) DME supplier pays the LGC; (ii) the LGC pays some of the money to the telehealth company; (iii) the telehealth company pays some of the money to the telehealth physician; and (iv) the telehealth physician writes the order for the brace ... with the order going to the DME supplier.
- In reality, the DME supplier is paying the telehealth physician who is writing the order.

ORTHOTICS AND TELEHEALTH

- This implicates the Medicare anti-kickback statute (“AKS”) which is a criminal statute and applies to all federal health care programs.
- The AKS says that a person/entity cannot pay anything to another person/entity in exchange for referring, or arranging for the referral of, a patient covered by a government health care program.

ORTHOTICS AND TELEHEALTH

- This is a very broad statute, and the DOJ has substantial latitude in determining whether or not to enforce it against a person/entity.
- Courts have enumerated the “one purpose” test.
- This states that if “one purpose” behind a payment is to reward a person/entity for a referral, then the AKS is violated notwithstanding that the “main purpose” behind the payment is to pay for legitimate services.

ORTHOTICS AND TELEHEALTH

- To the extent that a DME supplier directly or indirectly (e.g., through an intermediary) pays money to a telehealth physician, who in turn writes an order for braces that will be dispensed by the DME supplier and reimbursed by a federal health care program, the arrangement will likely be viewed as remuneration for a referral (or remuneration for “arranging for” a referral).



EDUCATIONAL RESOURCES

PAYMENT SUSPENSIONS AND PREPAYMENT REVIEWS



PAYMENT SUSPENSIONS AND PREPAYMENT REVIEWS

- DME suppliers, engaged in suspect telehealth arrangements, were targeted for prepayment reviews

PAYMENT SUSPENSIONS AND PREPAYMENT REVIEWS

- In addition, CMS contractors began suspending payments to DME suppliers that engaged in questionable telehealth arrangements.

OPERATION BRACE YOURSELF

- April 2019
- Charges against 24 defendants
- Over 130 Administrative Actions
- As of August 2019 suspended payments of \$74 million and revoked five suppliers from Medicare as a direct result of Operation Brace Yourself
- Efforts are continuing today



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QUESTIONS?

Call (855) 937-2242 | [achc.org](https://www.achc.org)



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THANK YOU

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