Mercy Health Network 2016

Affiliated Hospitals (26)

Physician Clinics (207)

Owned Medical Centers / Hospitals (15, comprised of 8 urban and 7 community; plus 1 JV Surgical Hospital)
Clinical Specialties That Have Used Telemedicine Since 1994

- Burn
- Cardiology
- Dermatology
- Emergency
- Endocrinology
- ENT
- Gastroenterology
- General Surgery
- Infectious Disease
- Neonatology
- Nephrology
- Neurology
- Obstetrics
- Oncology
- Orthopedics
- Pain Management
- Palliative Care
- Pathology
- Pharmacy
- Plastic Surgery
- Psychiatry
- Pulmonology
- Radiology
- Thoracic Surgery
- Vascular Surgery
- Neurosurgery
Telemedicine/Telehealth

1. Telemedicine Definition
2. History
3. Reimbursement
4. Legislation and Policy
5. Services and Models
6. Technology
7. Barriers
8. Incentives for Growth
“Telemedicine”

means the use of synchronous, two-way conferencing, remote patient monitoring, and asynchronous health images or other health transmissions by a health care provider to deliver health care services at a site other than the site where the provider is located relating to the health care diagnosis or treatment of a patient.

Definition: American Telemedicine Association

“Telehealth”

A tool for enhancing health care, public health, and health education delivery and support, using electronic communication and information.

Definition: National Telehealth Resource Centers
Telemedicine Modes

Interactive video and audio equipment allows the provider to see and hear the patient, ask questions and use many additional tools, much like a face-to-face visit.

Store and Forward telemedicine shares medical images and data that may be read or viewed later.
MRTC History

• Originated in 1994 between Mercy Medical Center-Des Moines and Mercy Medical Center-North Iowa

• Grant funded through Centers for Medicare and Medicaid Services (CMS) and Office of Rural Health Policy (ORHP, OAT)

• Additional grant from Substance Abuse and Mental Health Services Administration (SAMHSA)

• Now self-funded through member contributions

1. MRTC funded by HCFA (CMS) in 1994 – 3 year demonstration project
2. Demonstration projects in IA, WV, NC, GA
3. Limited services based on consultations
4. Mental health exclusions
5. Medicare project waiver approved in 1996
7. Medicare telemedicine payment effective 1/1999
8. Adding services for payment tied to Physician Fee Schedule annual updates 2002
Telemedicine Reimbursement Rules Started With Early Missteps

1. Medicare Project Waiver (1996)
   - Tele-consultation model
   - Specialist, patient and primary care provider must be present
   - Limited services (no mental health or emergency)

   - Add two physician payments
   - Add site and telecommunication fees

   - Health Professional Shortage Area (HPSA) rules
   - Fee splitting (specialist pays primary care provider)
   - Limited services (no mental health or emergency)
## Telemedicine Reimbursement Limits From 1996 - 2001

### CPT-4 Code Coverage for Telemedicine by Provider Plan

<table>
<thead>
<tr>
<th>Category</th>
<th>CPT-4 Code Numbers</th>
<th>Medicaid ¹</th>
<th>Medicare ² Waiver</th>
<th>Medicare ³ HPSA Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation and Management</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office/Outpatient (established)</td>
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<tr>
<td>Inpatient – Initial Care</td>
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<td>√</td>
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</tr>
<tr>
<td>Subsequent Hospital Care</td>
<td>99231-99233</td>
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<td></td>
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</tr>
<tr>
<td>Consultations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office</td>
<td>99241-99245</td>
<td>√</td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>Inpatient - Initial</td>
<td>99251-99255</td>
<td>√</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient - Follow-up</td>
<td>99261-99263</td>
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<td>√</td>
<td></td>
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<tr>
<td>Confirmatory Consultations</td>
<td>99271-99275</td>
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<td></td>
<td>√</td>
</tr>
</tbody>
</table>


2. Medicare Waiver – As implemented under Medicare waiver for telemedicine project No. 95-P-90425/7-02 effective October 1, 1996 – September 30, 1999 and telemedicine project No. 95-P-90425/7-03 effective June 1, 1998 – September 30, 2001

3. Medicare Proposed – Proposed rules as found in 42 CFR Parts 410 and 414 [HCFA-1906-P] scheduled to be effective January 1, 1999
## Medicare Slowly Adds Services (2001)

<table>
<thead>
<tr>
<th>Category</th>
<th>CPT- 4 Code Numbers</th>
<th>Medicare ¹ Waiver</th>
<th>Medicare ² Rule</th>
<th>Medicare ³ Rule</th>
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<tbody>
<tr>
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<td>Office/Outpatient – New Patient</td>
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<td>QQG11-QQG15</td>
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<td>99211-99215 GT</td>
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<tr>
<td>Inpatient – Initial Care</td>
<td>99221-99223</td>
<td>QQG21-QQG23</td>
<td></td>
<td>99221-99223 GT</td>
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<tr>
<td>Subsequent Hospital Care</td>
<td>99231-99233</td>
<td>QQG31-QQG33</td>
<td></td>
<td>99231-99233 GT</td>
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<tr>
<td>Consultations</td>
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<tr>
<td>Office</td>
<td>99241-99245</td>
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<td>99241-99245 GT</td>
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<td>QQG51-QQG55</td>
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<tr>
<td>Inpatient - Follow-up</td>
<td>99261-99263</td>
<td>QQG61-QQG63</td>
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<td>99261-99263 GT</td>
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<tr>
<td>Confirmatory Consultations</td>
<td>99271-99275</td>
<td></td>
<td>99271-99275 GT</td>
<td>99271-99275 GT</td>
</tr>
<tr>
<td>Psychiatry</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Psychiatric Therapeutic Procedures – Office/Outpatient</td>
<td>90804-90809</td>
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<td></td>
<td>90804-90809 GT</td>
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<tr>
<td>Psychiatric Therapeutic Procedures – Other</td>
<td>90862</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Medicare Waiver – As implemented under Medicare waiver for telemedicine project No. 95-P-90425/7-02 effective October 1, 1996 – September 30, 1999 and telemedicine project No. 95-P-90425/7-03 effective June 1, 1998 – September 30, 2001


3. Medicare Rules “H.R.5661 Sec. 223 Revision of Medicare Reimbursement for Telehealth Services” effective October 1, 2001
Medicare Telehealth Services 2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network
Official Information Health Care Professionals Can Trust

RURAL HEALTH SERIES

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

This publication provides the following information on calendar year (CY) 2016 Medicare telehealth services:
- Originating sites;
- Distal site practitioners;
- Telehealth services;
- Billing and payment for professional services furnished via telehealth;
- Billing and payment for the originating site facility fee;
- Resources; and
- 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. Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in:
- A rural Health Professional Shortage Area (HPSA) located either outside of a Metropolitan Statistical Area (MSA) or in a rural census tract;
- A county outside of a MSA.

ICN 901705 December 2015

<table>
<thead>
<tr>
<th>CY 2016 Medicare Telehealth Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service</td>
</tr>
<tr>
<td>--------------------------------------</td>
</tr>
<tr>
<td>Telehealth consultations, emergency department or initial inpatient</td>
</tr>
<tr>
<td>Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNPs</td>
</tr>
<tr>
<td>Office or other outpatient visits</td>
</tr>
<tr>
<td>Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days</td>
</tr>
<tr>
<td>Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days</td>
</tr>
<tr>
<td>Individual and group kidney disease education services</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 of treatment period to ensure effective injection training</td>
</tr>
<tr>
<td>Individual and group health and behavior assessment and intervention</td>
</tr>
<tr>
<td>Individual psychotherapy</td>
</tr>
<tr>
<td>Telehealth Psychiologic Management</td>
</tr>
<tr>
<td>Psychiatric diagnostic interview examination</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents (effective for services furnished on and after January 1, 2016)</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents (effective for services furnished on and after January 1, 2010)</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents (effective for services furnished on and after January 1, 2010)</td>
</tr>
<tr>
<td>Individual and group medical nutrition therapy</td>
</tr>
<tr>
<td>Neurobehavioral status examination</td>
</tr>
<tr>
<td>Smoking cessation services</td>
</tr>
<tr>
<td>Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services</td>
</tr>
<tr>
<td>Annual alcohol misuse screening, 15 minutes</td>
</tr>
<tr>
<td>Brief face-to-face counseling for alcohol misuse, 15 minutes</td>
</tr>
</tbody>
</table>
Original Technology

Dual Monitor Room System

Home Grown Telemedicine Cart

MIDWEST RURAL
TELEMEDICINE CONSORTIUM
A service of Mercy Health Network

Mercy
HEALTH NETWORK
Sponsored by Catholic Health Initiatives—Denver, CO and Trinity Health—Novi, MI
Mercy Help Center

- Desktop and Laptop Video Units in the Crisis Center

- Portable Capability in the Emergency Department
Teleradiology
Broadband, Bandwidth and MRTC

1. Iowa Communications Network (ICN) primary telecommunications carrier since 1995

2. Partnered with Iowa Hospital Association and others in an FCC pilot project “Iowa Rural Health Telecommunications Program” (IRHTP) in 2007
Iowa Rural Health Telecommunications Program (2008)
Iowa Rural Health Telecommunications Program (IRHTP) was one of 69 programs across the U.S. funded by the Federal Communications Commission (FCC).

Fiber to the door

ICN provides fiber backbone

Capable of delivering 1Gbps to each endpoint

86 hospital partners, 2 radiology groups, Iowa Hospital Association
Benefits of Iowa Rural Health Telecommunications Program
Connections in Imaging

• Decreased image transmission times = quicker results to referring physicians and ease of physician to physician consultation

• Ease of access to increased bandwidth for new services = eg, addition of digital mammography or cardiac services
Telemedicine Barriers

1. Provider availability
2. Reimbursement
3. Regulatory and Policy
   - Licensure
   - Eligible provider limitations
   - Eligible facilities limitations
   - Inconsistency (All states are different)
4. Cost to deploy
5. Connectivity
6. Awareness and misperceptions
What is changing to address these barriers?

- 29 states have telehealth parity laws enacted
- Federal and state laws introduced
- Licensure change efforts
- Telehealth service vendors
- Lower equipment costs
- Expanded access to broadband
- Media interest, information, education, Telehealth Resource Centers
States with Parity Laws for Private Insurance Coverage of Telemedicine (2016)

- Telemedicine Parity Law
- Partial Parity Law
- Proposed Parity Bill
- No Parity Legislative Activity


*Coverage applies to certain health services.
Compact aims to ease licensing for telemedicine

A new pathway is being proposed that would make it easier for doctors licensed in one state to practice in others, according to an article in the New York Times.

Draft legislation—in the form of a model compact—has been introduced by officials representing state medical boards around the U.S., and is backed by the Federation of State Medical Boards (FSMB), argues an article in the New York Times.

This would allow doctors to see patients nationwide, according to the FSMB. Currently, they must apply to practice in each state they want to see patients in, a requirement that can take months or even years.

“Medical licensing barriers are a significant barrier to delivering care to underserved communities,” said Dr. Thomas Farley, the FSMB’s executive director.

“However, the federal model compact would allow a doctor in one state to be licensed in another state with no additional steps,” he added.

The compact, if passed, would require doctors to complete an electronic application and undergo a background check. The compact would also require doctors to complete a minimum of 50 hours of continuing education every two years.

“The compact would be a significant step forward in improving access to care for patients in underserved communities,” said Farley. “It would also help medical schools and residency programs attract more doctors.”
Telemicine

For purposes of Medicaid, telemedicine seeks to improve a patient’s health by permitting two-way, real-time communication between the patient and the physician or other practitioners. Real-time communication means that includes, at a minimum, audio, and possibly video, and the physician or other practitioner delivering care (hereafter referred to as “Telepresenters”) may be located at a distant site or a telehealth hub. It is a method of providing services that allows for telecommunication between the patient and the Telepresenter. This definition is based on Medicare regulations (42 CFR 410.1276). Telemedicine is generally recognized as a substitute for face-to-face visits by the patient, and for the purposes of this rulemaking, telemedicine is considered a form of telehealth.

Telemicine Terms

Distant or Hub site: The location where the Telepresenter delivering care is located. The site may be a distant site or a telehealth hub.

Originating or Spoke site: The location where the patient being furnished services is located. Telepresenters may be located at the same site or a different site.

Asynchronous or “store and forward” telehealth: Transferring data such as an image that is sent (stored) and then reviewed by the Telepresenter at a later time. Asynchronous telehealth is not considered telemedicine.

Medical Codes: State Medicaid agencies assign the appropriate codes to telehealth services.

Telemicine includes services that are furnished by Telepresenters who are located at a distant site or a telehealth hub. It includes services delivered by the Telepresenter via telecommunications. Telepresenters may treat the patient in a manner comparable to treatment for a comparable condition, which is delivered in person by a licensed physician. Services include but are not limited to these services:

- Consultation
- Diagnosis
- Evaluation
- Management
- Referral

House bill seeks to phase in Medicare coverage of telemedicine, remote patient monitoring

By: Jonah Comstock | Jul 23, 2014

Tags: Medicare Telehealth Parity Act of 2014 | remote patient monitoring | Rep. Glenn Thompson | Rep. Mike Thompson | Medicare telemedicine | Medicare legislation | Representatives Mike Thompson (D-Calif.) and Glenn Thompson (R-Penn.) are set to announce a new telehealth bill soon. Like some of Mike Thompson’s previous telehealth efforts, the bill seeks to amend the Title XVIII of the Social Security Act, the law that has long limited government-reimbursed telemedicine to rural areas and specific use cases.

As Jonathan Linkous, CEO of the American Telemedicine Association (ATA), has told MobilHealthNews in the past, when the Social Security Act was passed telehealth was in its infancy and legislators, worried about abuse or that telemedicine wouldn’t be cost-effective, limited Medicare and Medicaid coverage to very particular cases. Only patients in rural areas could be reimbursed for any telehealth service that required patient-physician interaction, for instance. Those laws of address restrictions have become...
The Telehealth Resource Centers (TRCs) have a mission to serve as a focal point for advancing the effective use of telehealth and support access to telehealth services in rural and underserved communities.

Telehealth Resource Centers (TRCs) are funded by the U.S. Department of Health and Human Services’ Health Resources and Services Administration (HRSA) Office for the Advancement of Telehealth, which is part of the Office of Rural Health Policy. Nationally, there are a total of 14 TRCs: 2 National Resource Centers and 12 Regional Resource Centers.
Incentives for Growth

1. Provider availability
2. Reimbursement
3. Regulatory and Policy
   - Licensure (Credentialing)
   - Eligible provider limitations
   - Eligible facilities limitations
   - States mandate coverage
4. Cost to deploy
5. Connectivity
6. Awareness (Public, Patient, Employer)
Summary – Telehealth is Poised for Growth

• Regulations are changing
• Telehealth can be used to ease workforce shortages and maintain workforce education
• Technology has improved to allow faster speeds, better workflow and greater access
• Awareness has been heightened
Fred Eastman
Telehealth Technology Manager
Mercy Health Network TeleHealth
1755 59th Pl
West Des Moines, IA 50266
515-358-8325
feastman@mercydesmoines.org
Helpful Links

http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Telehealth/whatarethereimbursement.html

http://cchpca.org/state-laws-and-reimbursement-policies

http://ctel.org/expertise/reimbursement/

http://www.telehealthresourcecenter.org/reimbursement

http://www.americantelemed.org/home
Moving Large Data Emphasizes the Importance of Bandwidth

Email without attachment: 2-20 KB
Skype: 10 minute call = 5MB
Netflix: standard movie = 700MB
Standard to HD Videoconferencing: 128 KB - 4MB

Imaging:
Chest x-ray 20MB
Average CT = 100MB
Digital Mammogram = 150MB
CT Angiogram = 500MB
Cardiac Echo (US) = up to 1GB
FCC Bandwidth Recommendations (2010)

<table>
<thead>
<tr>
<th>Facility</th>
<th>Mbps</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Physician</td>
<td>4</td>
</tr>
<tr>
<td>Small Practice</td>
<td>10</td>
</tr>
<tr>
<td>Large Clinic</td>
<td>25</td>
</tr>
<tr>
<td>Hospital</td>
<td>100</td>
</tr>
<tr>
<td>Medical Center</td>
<td>1000</td>
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</table>
Telehealth represents a transformation in healthcare delivery and is being driven by the increase in value-based care and patient access.

Panelists will discuss how changes in payment models and the availability of new technologies making remote care easier, will impact payers, vendors, and regulators to better integrate telehealth into the care continuum.