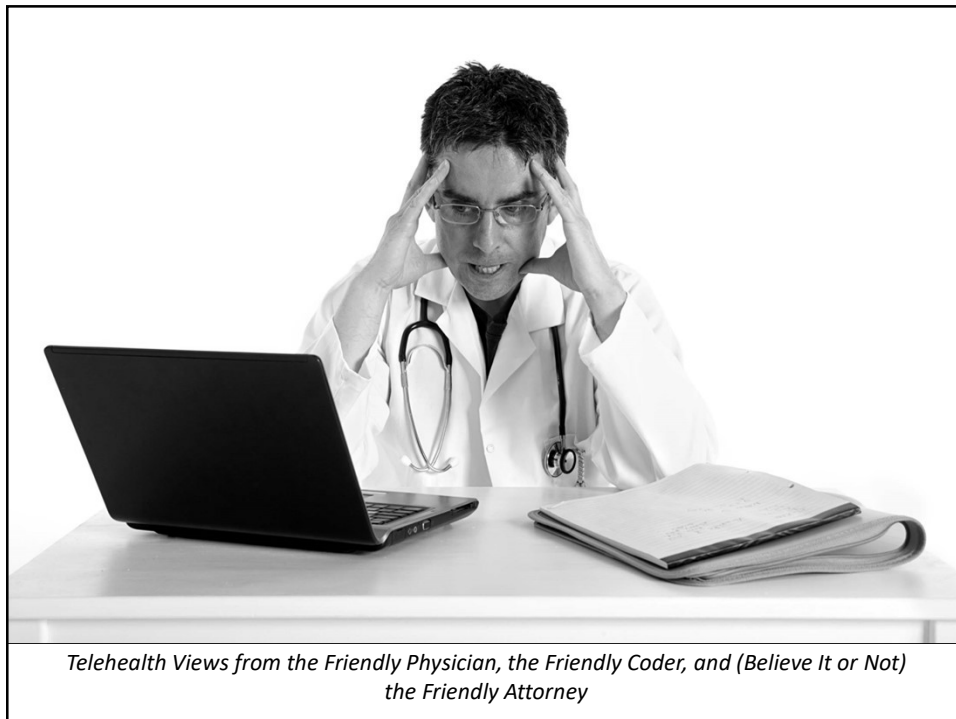




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the Friendly Attorney*

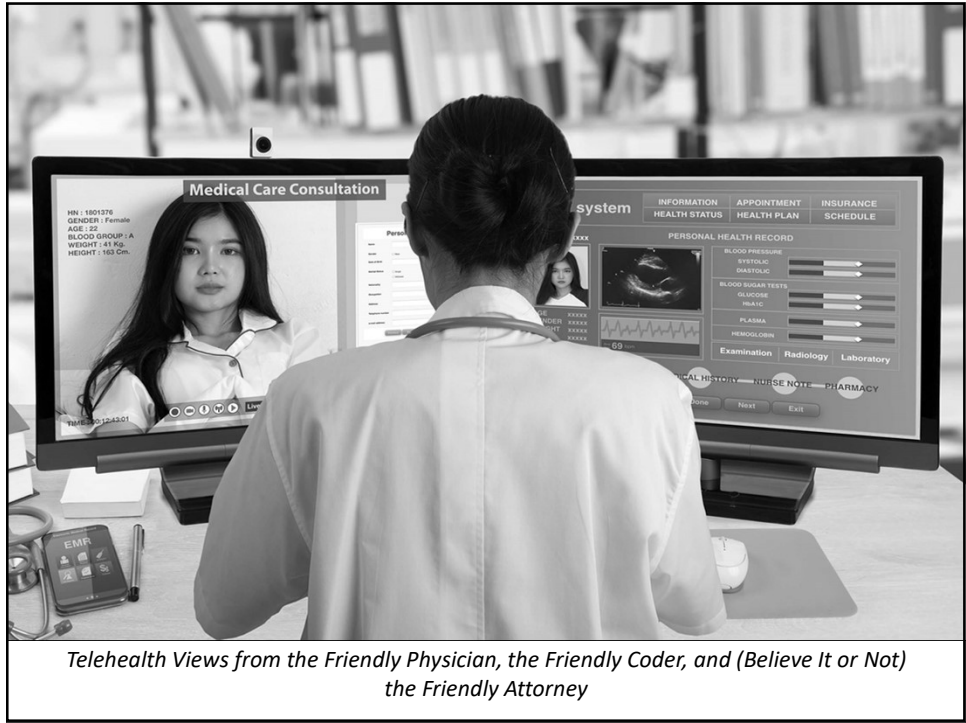
Chris Morrison, MD; CEO, Mgroup Healthcare Strategies, LLC
Mike Igel, Esquire; Johnson, Pope, Bokor, Ruppel & Burns, LLP
Maggie Mac; CPC, CEMC, CDEO, CHC, President, MM-MPC, Inc

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So What's The Issue?

- Historically, states legislatures and medical societies have sought to design laws to protect their state's licensed physicians. This led to...
- Corporate practice of medicine doctrine (typically, of the state in which the *patient* is located)
 - Non-licensed individuals cannot (i) own medical practices or (ii) sell prescription drugs to the general public (requires pharmacy license)

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What Is the Corporate Practice of Medicine Doctrine?

- Stems from the notion that an unlicensed person (or a legal entity) cannot practice a licensed profession (e.g. medicine)
 - Haven't gone to medical school
 - Haven't taken the Hippocratic Oath, etc.
- Presumption is that the unlicensed "person" must be motivated by profit, and not by caring for people
- Physicians still wanted asset protection and other benefits of entity ownership, so the corporate practice of medicine doctrine was born
- Most states have some form of corporate practice of medicine doctrine

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What Is the Corporate Practice of Medicine Doctrine?

- A business entity may not lawfully practice medicine
- A business entity may not employ a physician(s) to practice medicine for it
- A business entity entering into such an arrangement may be engaged in the unlawful practice of medicine, and the entity and the physician may be held liable for operating an unlicensed medical facility
- Most states have some form of exemption permitting entities that are wholly (e.g. 100%) owned by a physician licensed in that state

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Practical Issues

- CPOM statutes were enacted without consideration for the provision of health care across state lines
- As usual, the technology and ingenuity advances far faster than the legislation
- The purpose of telehealth is to make access to care easier...How can one health care business provide care on a nationwide basis?
- Which state's laws will apply to my business?
 - Generally, any state in which a patient resides

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I'm Off To A Great STOP... How Do I Move Forward?

- The “Friendly Physician Model”
- Most telehealth companies may appear to be one entity
- In reality, they are webs of business entities, bound together by various contracts to provide efficient and seamless care

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“Friendly Physician” Model... Your One, True Friend

- “Friendly physician” entity
 - Owned by one or more physicians licensed in the state where patient resides
 - Contracts with all medical providers licensed to practice medicine in the state
 - Physicians/entity maintain control over medical decisions and marketing
 - Remember: Need to form a friendly physician entity in each state where care is provided

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“Friendly Physician” Model... Your One, True Friend

- “Management entity”
 - Enters into contracts with each “friendly physician” entity
 - Needs to obtain permission to do business in each state
 - Owns all technology, intellectual property, and platform which hosts the medical consult
 - Maintains control over financial and management affairs

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Everyone Loves Contracts! Agreements For Relationship Between “Friendly Physician” Entity and “Management Entity”

- Entity organizational documents
- Administrative/Management Services Agreement
 - Management fee extracts funds from “friendly physician” entity
- Employment Agreement between “friendly physician” and “friendly physician” entity
- Line of Credit Agreement between the entities
- Security Agreement between the entities
- Ownership Interest Transfer Agreement between “friendly physician” and “friendly physician” entity
- IP Licensing Agreement between entities
- Etc.

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Another Option: Provide Telehealth Management Services to Existing Medical Practices

- Through a series of contracts, offer third-party management company services to existing medical practices and other health care providers
- You manage the “telehealth division” of the practice entity
- Services are similar to those offered by “management entity”
- No CPOM issues
- Less risk for liability claims against your entity
- Customers come and go
- No relationships with payors
 - Is that a bad thing?
- Do not include marketing services if you’re going to charge a percentage!

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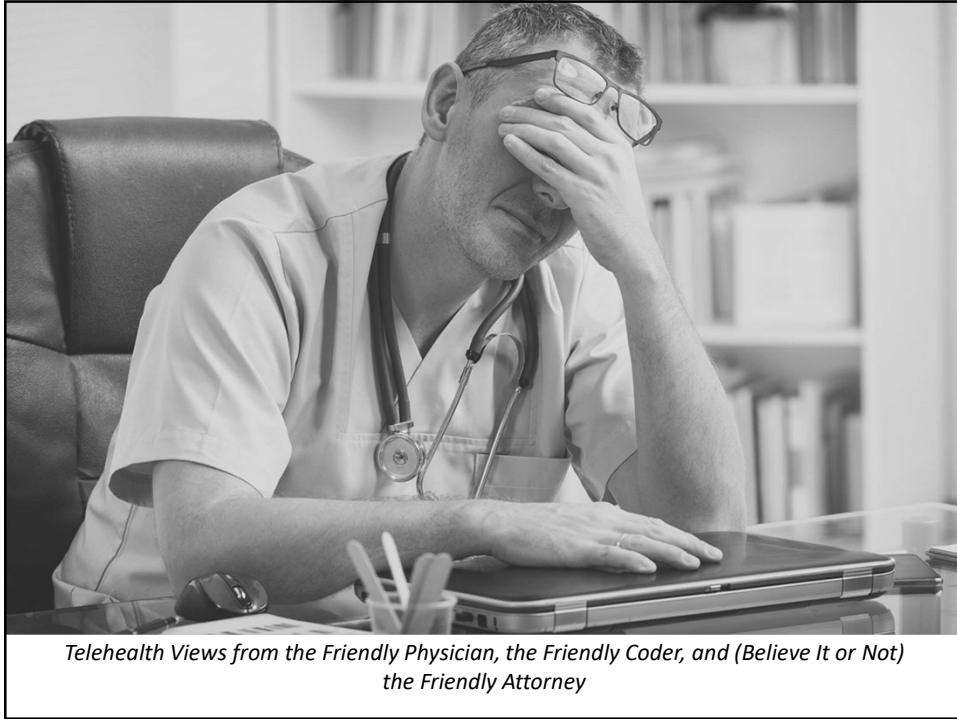
13

As If This Wasn’t Enough to Swallow!

- State and federal fraud and abuse laws
- HIPAA
- Informed consent
- Medical records
- Reimbursement
- Prescribing
- Establishment of practitioner-patient relationship

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Telehealth Coding

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Delivery Requirements for Telehealth Services

Medicare Telehealth Benefit
Social Security Act, Section 1834(m) – CY 2019

- Must be furnished by interactive, real-time communication technology; not a phone call, email or text message
- Asynchronous (store-and-forward) telehealth is only allowed in Alaska and Hawaii as federal demonstration projects (requires modifier GQ)

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Informed Consent

- State specific rules regarding Telehealth services
 - Verbal Consent
 - Written Consent
 - Notice of Privacy Practices

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Example: California

- In 2015, AB 809 revised the informed consent requirements relating to the delivery of health care via telehealth by permitting consent to be made verbally or in writing, and by deleting the requirement that the health care provider who obtains the consent be at the originating site where the patient is physically located. This bill requires the health care provider to document the consent.
- Physicians using telehealth technologies to provide care to patients located in California must be licensed in California. Physicians are held to the same standard of care, and retain the same responsibilities of providing informed consent, ensuring the privacy of medical information, and any other duties associated with practicing medicine regardless of whether they are practicing via telehealth or face-to-face, in-person visits.

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Example: Texas

- Texas law provides that a physician who provides or facilitates the use of telemedicine medical services “shall ensure that the informed consent of the patient, or another appropriate individual authorized to make health care treatment decisions for the patient, is obtained before telemedicine medical services . . . are provided.”
- Notices of privacy practices are an important part of complying with federal and state privacy and security requirements. Physicians should provide a notice of privacy practices in accordance with federal privacy requirements and must make a good-faith effort to obtain the patient’s written or electronic acknowledgement of the notice (which can be obtained through email).

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Example: Texas

- Additionally, physicians must provide notice of the method by which patients may file a complaint with TMB. This notice may be provided on the physician's website or with informed consent materials.²¹ TMB rules indicate that this notice must be provided before the telemedicine medical service is provided, and may be by a prominently displayed link on the physician's website, in a provider app, by a recording, or in a bill for services.²² The notice must be in at least a 10-point, easily readable font, and must contain exactly the text that TMB rules provide for such a notice.

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CPT/HCPCS Codes – Telehealth - Medicare

- List of 2020 Medicare approved telehealth codes:
<https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>
- 101 codes (3 added for 2020)

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CY 2020			
Code	Short Descriptor		
90785	Psytx complex interactive		
90791	Psych diagnostic evaluation		
90792	Psych diag eval w/med srvc		
90832	Psytx pt&/family 30 minutes		
90833	Psytx pt&/fam w/e&m 30 min		
90834	Psytx pt&/family 45 minutes		
90836	Psytx pt&/fam w/e&m 45 min		
90837	Psytx pt&/family 60 minutes		
90838	Psytx pt&/fam w/e&m 60 min		
90839	Psytx crisis initial 60 min		
90840	Psytx crisis ea addl 30 min		
90845	Psychoanalysis		
90846	Family psytx w/o patient		
90847	Family psytx w/patient		
90951	Esrd serv 4 visits p mo <2yr	90963	Esrd home pt serv p mo <2yrs
90952	Esrd serv 2-3 vsts p mo <2yr	90964	Esrd home pt serv p mo 2-11
90954	Esrd serv 4 vsts p mo 2-11	90965	Esrd home pt serv p mo 12-19
90955	Esrd srv 2-3 vsts p mo 2-11	90966	Esrd home pt serv p mo 20+
90957	Esrd srv 4 vsts p mo 12-19	90967	Esrd home pt serv p day <2
90958	Esrd srv 2-3 vsts p mo 12-19	90968	Esrd home pt serv p day 2-11
90960	Esrd serv 4 visits p mo 20+	90969	Esrd home pt serv p day 12-19
90961	Esrd srv 2-3 vsts p mo 20+	90970	Esrd home pt serv p day 20+
		96116	Neurobehavioral status exam
		96150	Assess hlth/behav init
		96151	Assess hlth/behav subseq
		96152	Intervene hlth/behav indiv
		96153	Intervene hlth/behav group
		96154	Interv hlth/behav fam w/pt
		96160	Pt-focused hlth risk asmt
		96161	Caregiver health risk asmt
		97802	Medical nutrition indiv in
		97803	Med nutrition indiv subseq
		97804	Medical nutrition group
		99201	Office/outpatient visit new
		99202	Office/outpatient visit new
		99203	Office/outpatient visit new
		99204	Office/outpatient visit new
		99205	Office/outpatient visit new
		99211	Office/outpatient visit est
		99212	Office/outpatient visit est
		99213	Office/outpatient visit est
		99214	Office/outpatient visit est
		99215	Office/outpatient visit est

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99231	Subsequent hospital care	G0406	Inpt/tele follow up 15
99232	Subsequent hospital care	G0407	Inpt/tele follow up 25
99233	Subsequent hospital care	G0408	Inpt/tele follow up 35
99307	Nursing fac care subseq	G0420	Ed svc ckd ind per session
99308	Nursing fac care subseq	G0421	Ed svc ckd grp per session
99309	Nursing fac care subseq	G0425	Inpt/ed teleconsult30
99310	Nursing fac care subseq	G0426	Inpt/ed teleconsult50
99354	Prolonged service office	G0427	Inpt/ed teleconsult70
99355	Prolonged service office	G0436	Tobacco-use counsel 3-10 min
99356	Prolonged service inpatient	G0437	Tobacco-use counsel>10min
99357	Prolonged service inpatient	G0438	Ppps, initial visit
99406	Behav chng smoking 3-10 min	G0439	Ppps, subseq visit
99407	Behav chng smoking > 10 min	G0442	Annual alcohol screen 15 min
99495	Trans care mgmt 14 day disch	G0443	Brief alcohol misuse counsel
99496	Trans care mgmt 7 day disch	G0444	Depression screen annual
99497	Advncd care plan 30 min	G0445	High inten beh couns std 30m
99498	Advncd are plan addl 30 min	G0446	Intens behave ther cardio dx
G0108	Diab manage trn per indiv	G0447	Behavior counsel obesity 15m
G0109	Diab manage trn ind/group	G0459	Telehealth inpt pharm mgmt
G0270	Mnt subs tx for change dx	G0506	Comp asses care plan ccm svc
G0296	Visit to determ ldct elig	G0508	Crit care telehea consult 60
G0396	Alcohol/subs interv 15-30mn	G0509	Crit care telehea consult 50
G0397	Alcohol/subs interv >30 min	G0513	Prolong prev svcs, first 30m
		G0514	Prolong prev svcs, addl 30m
		G2086	Off base opioid tx first month – 70 minutes
		G2087	Off base opioid tx, sub month – 60 minutes
		G2088	Off opioid tx month add 30 beyond the first 120 minutes

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Who Can Perform

- Physicians
- Nurse Practitioners
- Physician Assistants
- Nurse-midwives
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Clinical psychologists and Clinical social workers (except CPT codes 90792, 90833, 90836 and 90838)
- Registered dietitians or nutrition professional

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“Pocket Notes”

- A physician, NP, PA or CNS must furnish at least one ESRD ‘hands-on’ visit per month to examine the patient’s vascular access site. This cannot be performed via telehealth.
- Effective January 1, 2010 – G0406, G0407 and G0408 are valid for telehealth services provided to patients in a SNF (previously only allowed for patients in an inpatient hospital).
- Frequency of telehealth services for 99231, 99232 and 99233 is once every three days
- Frequency of telehealth services for 99307, 99308, 99309 and 99310 is once every thirty days

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From the Federal Register – 11/15/19

- No new requests from the public for additions to the CY 2020 Medicare Telehealth list
- The proposed codes (3 new HCPCS G codes) are added for treatment of opioid use disorders
- Requests to add/delete accepted through February 10
 - For example: to be considered during PFS rulemaking for CY 2022, request to add services must be submitted and received by February 10, 2021

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Add or Delete Telehealth Services

- **Requests to add or delete services should be mailed or e-mailed to:**

Division of Practitioner Services
Mail Stop: C4-03-06
Centers for Medicare and Medicaid Services
7500 Security Boulevard Baltimore, Maryland 21244-1850
Attention: Telehealth Review Process

CMS Telehealth_Review_Process@cms.hhs.gov

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Originating sites

- Physician and practitioner offices
- Hospitals
- Critical Access Hospitals
- Rural Health Clinics
- Federally Qualified Health Centers
- Hospital-based or CAH-based Renal Dialysis Centers
- Skilled Nursing Facilities
- Community Mental Health Centers
- Renal Dialysis Facilities
- Home of beneficiaries with ESRD getting home dialysis
- Mobile Stroke Units

Located in a county outside a Metropolitan Statistical Area (MSA) or in a Rural Health Professional Shortage Area (HPSA)
Check Medicare Telehealth HPSA Qualification Analyzer
<https://data.hrsa.gov/tools/medicare/telehealth>
Check Census Bureau for each
MSA <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk>

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Added sites

- Beginning January 1, 2019, the Bipartisan Budget Act of 2018 removed the originating site geographic conditions and added eligible originating sites to diagnose, evaluate, or treat symptoms of an acute stroke.
 - Change request (CR) 10883 establishes use of a new Healthcare Common Procedure Coding System (HCPCS) **modifier, G0 (G Zero)**, to be appended on claims for telehealth services that are furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke
- Beginning July 1, 2019, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act removes the originating site geographic conditions and adds an individual's home as a permissible originating telehealth services site for treatment of a substance use disorder or a co-occurring mental health disorder.

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E/M Services

- Documentation should include the informed consent was obtained
- Same documentation requirements for telehealth services
 - Chief Complaint, History, Exam, MDM, Signature and credentials of performing provider
 - CMS/AMA Documentation Guidelines – 1995
 - CMS/AMA Documentation Guidelines – 1997 (includes the specialty specific exams)
- Best practice suggests that documentation should also include a statement that the service was provided through telehealth, both the location of the patient and the provider and the names and roles of any other persons participating in the telehealth service.

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Counseling/Coordination of Care ~ Time

- Can be billed based on time for counseling/coordination of care (face-to-face time only) if more than 50% of total time
 - Document total time
 - Document time spent in counseling/coordination of care
 - Document specific details of content of the counseling/coordination of care
- Time spent NON face-to-face is **not included** in total time
Example: Review of patient forms, records prior to seeing patient

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More Pocket Notes

- Place of Service (POS) code = 02 Telehealth
- Time based services must include documentation of time in the progress notes
- Modifier appendage:
 - GT – now only required with services billed under Critical Access Hospital on institutional claims
 - GQ – only appended to services using asynchronous telecommunication system for services provided at a distant site under a Federal telemedicine demonstration project conducted in Alaska or Hawaii
 - GO – to be appended on claims for telehealth services that are for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke

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Case Example

A Medicare patient presents to a rural health clinic complaining of a headache, nausea and vomiting. A clinical staff employee at the originating site escorts the patient to a room where the patient can interact with the provider using audiovisual equipment. The provider performs the necessary history, and a clinical staff employee obtains the clinical information, such as vital signs, requested by the provider.

If the clinic has the appropriate equipment and personnel, diagnostic tests ordered by the provider are performed onsite. The provider renders the patient assessment and plan to be discussed with the patient. During this new patient encounter, the provider performs and documents a detailed history, an expanded problem-focused exam and moderate medical decision-making. Also included in the documentation is information stating that the service was provided through telehealth, the location of the patient and the provider, and the names of any other staff involved in the service.

For the distant site in this example, CPT code 99202 is billed with POS code 02 for the professional provider's service. The originating site should report HCPCS code Q3014 for the services provided.

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Reimbursement ~ Medicare

- Typically reimbursed the same as if the service was provided in-person
 - Subject to co-insurance and annual deductible

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Reimbursement ~ Private Payers

- Thirty states have laws that require private insurers to reimburse healthcare providers for services delivered through telemedicine. Ten more states also have pending or proposed laws to do the same. These laws generally prohibit private payers from taking into account the patient's location when making a reimbursement decision. This allows patients to conduct video visits from their home or office.
- Reimbursement for telemedicine will vary dependent upon a state's legislation. Some states specifically mandate private payers to reimburse the same amount for telemedicine as if the service was provided in-person. Many states leave this determination up to the payer.

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Originating Site

- Q3014 Telehealth originating site facility fee = \$26.65 for CY 2020

NOTE: If patient's home is originating site – the telehealth site facility fee is not paid

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Virtual Services

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Virtual Visit Codes

NOT subject to the limitations of 1834(m)
Meaning they can be used/billed without geographic restrictions

- Brief Communication Technology-Based Service (Virtual Check-In):
HCPCS Code G2012
- Remote Evaluation of Pre-Recorded Patient Information:
HCPCS Code G2010
- Interprofessional Internet Consultation:
(CPT Codes 99446, 99447, 99448, 99449, 99451, 99452)

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Brief Communication Technology-Based Service

Virtual Check-In): HCPCS Code G2012

- Previously these were bundled into the office visit E/M
- Address patient concerns and determine need for in-person encounter
- Can be a brief non-face-to-face check-in
- Must be provided by a Qualified Health Care Professional (QHCP) that can bill an E/M (ie., can't be an RN or PT)
- Must be provided to an established patient (per current CPT guidelines = seen by QHCP or the same specialty in the same group within 3 years)
- There must not have been a related E/M service billed within the previous 7 days or leading to an E/M or procedure within the next 24 hours or soonest available appointment
- Includes 5-10 minutes of medical discussion
- Must obtain verbal consent and document in the medical record

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Brief Communication Technology-Based Service

- There are no specific documentation requirements for billing the code G2012, meaning that you do not have to document an E/M type of service, but the communication must be medically reasonable and necessary
- There is no frequency limitation (can use as much as needed to assess need for in-person encounter), but will be monitored in CY2019 and the service must be medically necessary
- Can be audio-only, real-time telephone interaction in addition to synchronous A/V interactions – but must be between the patient and QHCP, not office clinical staff
- If the communication originates from a related E/M service billed within previous 7 days **by the same QHCP**, then it is bundled into the previously billed E/M
- The new G2012 is modeled after the CPT 99441 (Telephone Evaluation by QHCP)
- This service can be used as a treatment regimen for opioid and other substance abuse disorders
- Final Summary = page 35
- **G2012 (Virtual Check-in) = \$14.79 non-facility / \$13.42 facility (FL loc 99 rates)**

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Remote Evaluation of Pre-Recorded Patient Information

HCPCS Code G2010

- “Store-and-Forward” communication in 1834(m) where a physician uses video or images captured by the patient, also called “asynchronous transmission of health care information”
- Still only permitted in federal demonstration programs of Hawaii and Alaska
- Not considered a Medicare Telehealth Service and not subject to restrictions of 1834(m)
- Not separately billable if the video/images result in an in-person E/M office visit (or procedure) within next 24 hours or soonest available appointment, or originates from a related E/M service provided in the past 7 days by the same QHCP
- Can be a stand-alone service that is separately billable if there is no resulting E/M office visit and there is no related E/M office visit within the previous 7 days of the remote service

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Remote Evaluation of Pre-Recorded Patient Information

- Must be an established patient (meaning there has been a previous face-to-face encounter in-person or via telehealth – see new patient requirements below)
- Must be interpreted and have patient follow-up within 24 business hours (can be virtual)
- Follow-up can be via phone call, A/V communication, secure text message, email or patient portal communication and must be HIPAA compliant
- Different from G2012 because this evaluation results from a patient-generated image and is not real-time
- Must have either verbal, written or electronic beneficiary consent noted in the medical record for each billed G2010
- **G2010 (Asynchronous Evaluation) = \$12.47 non-facility / \$9.38 facility (FL loc 99 rates)**

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Interprofessional Internet Consultation:

CPT Codes 99446, 99447, 99448, 99449, 99451, 99452

- CMS is now adopting 99446, 99447, 99448, 99449, 99451 and 99452 for payment
- **99446:** Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or QHCP; 5-10 minutes of medical consultative discussion and review. **Rate = \$18.40 (FL loc 99 2019)**
- **99447:** Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or QHCP; 11-20 minutes of medical consultative discussion and review. **Rate = \$36.45 (FL loc 99 2019)**
- **99448:** Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or QHCP; 21-30 minutes of medical consultative discussion and review. **Rate = \$54.84 (FL loc 99 2019)**

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Interprofessional Internet Consultation:

- **99449:** Interprofessional telephone/internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or QHCP; 31 minutes or more of medical consultative discussion and review. **Rate = \$72.90 (FL loc 99 2019)**
- **99452:** Interprofessional telephone/internet/EHR referral service provided by a treating/requesting physician or QHCP, 30 minutes. **Rate = \$37.62 (FL loc 99 2019)**
- **99451:** Interprofessional telephone/internet/EHR assessment and management service provided by a consultative physician including a written report to the patient's treating/requesting physician or QHCP, 5 or more minutes of medical consultative time. **Rate = \$37.62 (FL loc 99 2019)**
- These are not considered Medicare Telehealth Services under 1834(m) because these services are inherently non-face-to-face
- Require the treating/requesting physician to obtain patient verbal consent for each service in advance of the service in the medical record
- Can only be billed by QHCP that can bill E/M services (not RN, PT, etc.)

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Commercial Insurance Coverage of Telehealth Services

- State-by-state statutes are being created to define requirements of health plans to cover services delivered via telehealth
- Some states (ie., FL and MI), merely clarify the contract between the insurer and provider be voluntary with mutually acceptable payment rates, meaning no mandatory coverage of telehealth is required
- Other states (CA) are developing statutes requiring "payment parity"
 - Same reimbursement for telehealth services as in-person
 - Reimbursement rates can still be negotiated under participation agreements
- In summary, approximately 36 states (plus D.C.) have laws requiring commercial health insurance to cover telehealth services
 - Of the 36 states, 11 have payment parity language similar to CA

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Newly Proposed OIG Fraud and Abuse Waivers

- OIG recently proposed revisions to the Anti-Kickback Statute (AKS) and Civil Monetary Penalties (CMP) Law
- Benefits companies offering telemedicine services, remote patient monitoring (RPM) , and Chronic Care Management (CCM) services
- Patients can receive free technology for patient engagement tools and support (smart watch, tracker, etc.)
- Tools cannot be used for patient marketing or recruitment
- OIG also proposing waivers of patient co-payments and deductibles for RPM and CCM services

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Consent for Communication Technology-Based Services (CTBS)

- CMS now allows practitioners to obtain a single consent from the patient covering multiple CTBS services or interprofessional consultation services
- Consent must be obtained at least once per year (no longer once per service)
- Consent must include the amount of the patient's financial responsibility (ie., co-pay)

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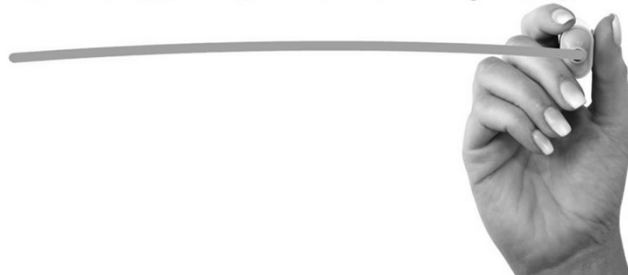
Summary

- Continued expansions in Medicare reimbursement
- Perceived decreases in administrative burden (consents and co-pays)
- Make enhancements to telehealth programs now to support:
 - Immediate cost savings of care
 - Growing opportunities for revenue generation
 - Improvement in patient quality
 - Improved patient satisfaction

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QUESTIONS



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Resources

Medicare Telehealth Services Fact Sheet

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcfsht.pdf>

Medicare Telehealth Regulations

http://www.ecfr.gov/cgi-bin/text-idx?SID=89f51d919ffc5b375f126c606b5b5cd3&node=se42.2.410_178&rgn=div8

Medicare Telehealth Payment Eligibility Analyzer

<http://datawarehouse.hrsa.gov/telehealthAdvisor/telehealthEligibility.aspx>

Medicare Telehealth Webpage

<http://www.cms.gov/Medicare/Medicare-General-information/telehealth/index.html>

Medicare Benefits Policy Manual Chapter 15 (sec. 270)

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>

Medicare Benefits Policy Manual Chapter 12 (sec. 190)

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf>

Medicaid Telemedicine Webpage

<https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html>

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