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Enhancing Communication in Primary Care

Innovation Hub
– PROSPECTUS –

INNOVATION HUB

– EXECUTIVE SUMMARY –

PRIMARY CARE will be increasingly asked to care for a distinct population of patients and begin to be held accountable for both clinical and financial outcomes. Accountable Care Organizations, block grant funding, demonstration and pre-paid contracts will be more common and other payment models that offer a comprehensive payment structure will become more prevalent from a variety of insurance products, employers, and payers. We expect primary care will begin to share both financial savings and financial risk for the care delivered across the health delivery system. The current primary care delivery model, incentivized to provide in-person, episodic, procedure based care, is ill-equipped to meet this new mandate.

Primary care must move strategically toward a care delivery model that focuses on relational, continuous, accessible, **team-based care**. This care must offer diagnosis and treatment across the spectrum of disease acuity and also offer proactive preventive care, self-management support, care coordination, chronic disease case management and focused behavioral modification support for complex outliers. Clearly, patients will require different levels of investment as they move through different life stages and health challenges. Moreover, as patients develop more complex health needs they will require a more comprehensive, system-wide approach that maximizes traditional healthcare delivery and provides additional case management and care coordination.

EFFECTIVE COMMUNICATION will be critical in this new model of care. Teams will need to move beyond communication that is asynchronous and limited to silos of care to a model that allows seamless communication and collaboration within and *across* primary care and health systems, as well as with community health partners. Further, as the complexity of disease and care coordination increases, teams will need to use a full spectrum of communication tools and strategies and be able to shift between different modalities at the point of care.

Society is rapidly developing **technology** to enable this type of communication. Instant messaging and instant access, social platforms, video communication, multi-person interaction, mobile technology, screen sharing, and encrypted platforms are inexpensive, out-of-the-box, and road-tested outside of the healthcare arena. It will be the adoption of this type of innovative technology that will be at the foundation of a transformation within primary care.

This Prospectus—**Enhancing Communication in Primary Care**—explores the use of different communication modalities within the primary care healthcare space. These modalities include: Instant Messaging, "presence" capability (the ability to know if a person is available), video calls, multi-person video meetings, off-site video collaboration, and shared collaboration platforms across health systems. It will provide:

- Examples of the applicable technologies
- Considerations in choosing a given technology
- Examples of potential use cases for a specific communication tool
- Best practices and lessons learned
- Training guides and tools for adoption
- Budget for adoption and ongoing costs
- Legal and security implications and resources
- Billing requirements and limitations

Enhancing Communication in Primary Care

"We're bringing technology that's ready to use, out of the box, and affordable, into the healthcare space and effectively using relationships and extending those relationships through collaboration and communication using technology."

Jason Cunningham, D.O., Medical Director, WCHC
http://www.youtube.com/watch?v=DrLCNpiA2uE
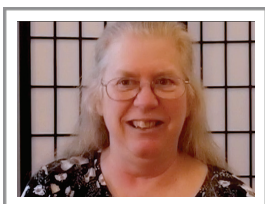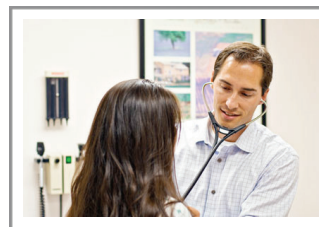
"I've never dealt with much technology before, but it was very simple and it made me feel more connected to my team here. You didn't want me to stay at home and just try and get well on my own. I felt like I had a team working with me. I think other health centers should do this, too; it makes the patient want to get better faster."
Terry Smith, PHC patient (after transition from hospital)

ABSTRACT

Purpose: To leverage communications technology to improve collaboration with the care delivery team and coordination of care across health systems

- Enhanced communication between staff using instant messaging and video conferencing
- Use of teleconferencing to improve care coordination and real-time collaboration between care team, specialty providers, care givers, community health partners, etc
- Improved case management using remote video conferencing to provide remote face-to-face encounter between RN/patient and provider or support staff/patient and provider
- Warm hand-off using video conferencing for internal referrals or with community partners
- Improved decision support using video conferencing with specialist, pharmacist, health plan, etc

Key Points:

- Ease of use and incorporation into existing staff work-flows is critical for adoption and success
- "Presence" – Functionality of knowing the availability of others is important to allow staff to connect real-time
- Face-to-face video connection adds significantly to care collaboration and transfer-of-trust
- Allowing staff, patients, and care partners the ability to communicate in a variety of ways (IM, video, phone, in-person, multi-person) is important within the Primary Care environment
- Communication platform needs to be device agnostic: staff and patients will naturally use a variety of devices within their existing work-flows and will need to adapt with a changing technology environment.
- Training and support need to be provided to staff to facilitate their comfort and competence in the operation of communication devices as well as on-camera technique

"The basic premise of fostering innovation is to have a group of staff … who are passionate about what they're doing. If you give them the time and the resources to make a difference … if you believe in them … then they feel they are empowered to be innovative… It's really respecting the genius that's inside everyone. [And] the impact of innovation on patients has increased. [They] feel the energy and enthusiasm of our staff. They really respond to that and they get better quicker. That's part of the magic."
Kathryn Powell, CEO, Petaluma Health Center
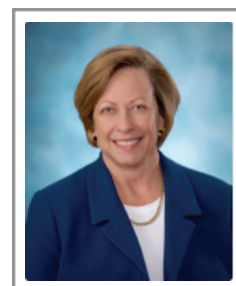
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INNOVATION HUB
– PROSPECTUS –

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Use Case VIDEO "WARM HAND-OFF"

Description – Provider (or other staff) virtually brings support staff into office visit with a patient to introduce them prior to a future visit or interaction.

Examples:
- Introduction to RN Care Manager to make an introduction and discuss goals for a future home visit
- Introduction to Behavioral Health Staff prior to future visit to demystify the visit and begin to set a common agenda for that visit
- Introduction to Dental Team to reduce patient's fear about future dental visit
- Other…

Communication functionality:
- Provider needs to know that the staff is available for a video call (Presence)
- Best practice to have the provider send quick IM to make sure the staff is not on the phone and is ready for a video call
- Video introduction is made
- Optional mobile – provider could be on a remote visit (home visit, homeless interaction, school clinic, etc.) and make a warm hand-off to Access Coordinator, RN, BH, etc.
- *Instant messaging, presence, video call, remote (optional)*

Hardware/ IT:
- Communication platform with IM, video, presence
- Webcam for support staff
- Headphones (with noise canceling feature, if in common space)
- Webcam (of device) at the point of care
- Internet capacity for video
- Remote device (if applicable) with communication platform, webcam, cellular with capacity to handle video traffic

Training *(Provider and support staff)*:
- Communication platform
- Video interaction training
- Care team-specific interaction training around use of IM, starting a video visit
- Training around when to use video versus in-person warm hand-off
- Huddle management to anticipate warm hand-off

HIPAA and Security:
- Verbal consent should be obtained before starting a video interaction
- Headphones and relatively secure environment are necessary both for the patient and the support staff receiving the warm hand-off

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Billing:

- No billing if the provider is initiating the visit

"At West County we use WebEx to connect the doctor and the patient with the nurse by video in the same visit. The patient can see me and we can connect as if I'm really there.

For example, we had one patient who was very depressed and not feeling well. The doctor had set a plan with her in the visit, checked labs, looked at medications, but knew that what she really needed was some contact between this office visit and the next. During the video call the patient was able to get a sense of 'who is this person who will be calling me in a couple of weeks to check on me?' and felt comfortable talking to me — so that's a <video warm hand-off.> Now when I contact the patient, I'm not a stranger to her, I have a familiarity with her, we have connected."

(Rachel Shalaby, RN, Sebastopol Health Center)

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Use Case Real-Time Office Collaboration

Description – Provider is in the office with a patient and wants to bring in staff to have a dynamic discussion, or collaboration

Examples:

- Provider has a complicated referral question to discuss with a referral staff
- Need to consult the Pharmacy Technician to discuss formulary alternatives and medications tried and failed
- Communication with a RN Care Manager to discuss complex social stressors identified in the office visit
- New information identified in the office visit is important to discuss with Access Coordinator regarding pending disability paperwork
- Real-time consult with dentist for high-risk dental need while patient is in the primary care clinic
- Medical consultation from Primary Care team for patient in the dental office
- Health Coach spends one hour with a patient and brings the provider in via video to add clinical insight & bill as a 99212

Communication functionality:

- Provider needs to know that the staff is available for a video call (Presence)
- Best practice to have the provider send quick IM to make sure the staff is not on the phone and is ready for a video call
- Video introduction is made
- Optional mobile – provider could be on a remote visit (home visit, homeless interaction, school clinic, etc.) and conduct a similar video collaboration
- *Instant messaging, presence, video call, remote (optional)*

Hardware/IT:

- Communication platform with IM, video, presence
- Webcam for support staff
- Headphones (with noise canceling feature, if in common space)
- Webcam (of device) at the point of care
- Internet capacity for video
- Remote device (if applicable) with communication platform, webcam, cellular with capacity to handle video traffic

Training *(Provider and support staff)*:

- Communication platform
- Video interaction training
- Care team-specific interaction training around use of IM, starting a video visit
- Billing training if the visit is initiated by a support staff and provider is brought in for clinical consult and billing
- Documentation in progress note for verbal consent and GT modifier code if visit is billed

HIPAA and Security:

- Verbal consent should be obtained before starting a video interaction

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- Headphones and relatively secure environment are necessary both for the patient and the staff receiving the video call

Billing:

- No additional billing if the provider is initiating the visit
- Provider can bill for the visit if the visit is conducted using video and the documentation supports a medically necessary visit, focused HPI, and problem-focused assessment and plan

"What makes this worthwhile to the patient is the face-to-face connection. Not all patients are familiar with me, so I think it's a really great opportunity to connect this way while they are in the exam room with their provider.

There was one patient that we had had a hard time trying to get a hold of … He's been homeless, no contact number, nowhere to reach him, no mail or email … He finally made an appointment and while he was in the exam room the provider contacted me on the webcam. [I got to meet] the patient this way and because my office is right next door, I told him, 'Walk over to my office and I'll get you the information you need.' I know it's a hardship for him trying to call in, getting busy signals, waiting on hold, and so it was a great connection for us. I'm very thankful we have this tool."

(Anabel Gonzalez, Referral & Authorization Specialist, Sebastopol Health Center)

Use Case MULTI-PERSON COLLABORATION

Description— Multi-person real-time video collaboration during an office visit

Examples:

- Patient, Medical Provider, RN Care Manager, and Social Worker conduct a collaborative video meeting to discuss identified complex social concerns
- Patient, Medical Provider, Specialist, and Pharmacy Tech discuss treatment options and need for complicated prior authorization for a needed medication that is not on the insurance formulary
- Patient, Medical Provider, off-site family discuss end-of-life wishes prior to establishing an Advance Directive

Communication functionality:

- Provider needs to know that the staff is available for a video call (Presence)
- Best practice to have the provider send quick IM to make sure the staff is not on the phone and is ready for a video call
- Video introduction is made
- Multi-person meeting is initiated
- *Instant messaging, presence, video call, remote (optional), multi-person meeting*

Hardware/IT:

- Communication platform with IM, video, presence
- Webcam for support staff
- Headphones (with noise canceling feature, if in common space)
- Webcam (of device) at the point of care
- Internet capacity for video
- Remote device (if applicable) with communication platform, web cam, cellular with capacity to handle video traffic
- Multi-person bridge for connection with some specialists depending on device used (Polycom multi-person bridge, Polycom M-100)

Training *(Provider and support staff):*

- Communication platform
- Video interaction training
- Care team-specific interaction training around use of IM, starting a video visit
- Billing training if a support staff initiates the visit and provider is brought in for clinical consult and billing
- Documentation in progress note for verbal consent and GT modifier code if visit is billed

HIPAA and Security:

- Verbal consent should be obtained before starting a video interaction
- Headphones and relatively secure environment are necessary both for the patient and the support staff receiving the video call

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Billing:

- No additional billing if the provider is initiating the visit

- Provider can bill for the visit if the visit is conducted using video and the documentation supports a medically necessary visit, focused HPI, and problem-focused assessment & plan

- Specialist and primary care provider can bill if the specialist is the consulting provider giving clinical advice and the primary care provider is the treating provider delivering the care (prescribing, ordering, scheduling, coordinating care) for the visit

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Use Case Off-Site Video Collaboration

Description: Staff is remote and connects to provider or other staff via remote video connection

Examples:

- RN Care Manager connects to a Medical Provider in the office while conducting a home visit for post-discharge hospital transition visit
- Support staff and patient are remote for an education visit and connect to the provider for clinical support and billing
- Outreach worker is meeting with a homeless client and has identified a clinical concern and brings in RN triage or Medical Provider via video for evaluation
- RN Care Manager visiting client during a homeless outreach visit or home health visit and brings in Access Coordinator to sign patient up for insurance or food stamps

Communication functionality:

- Remote staff needs to know that the office staff is available for a video call (Presence)
- Best practice to send quick IM to make sure the staff is not on the phone and is ready for a video call
- Video connection is made
- Mobile tablet (e.g., iPad) with cellular connectivity and adequate bandwidth
- Video meeting could be scheduled if IM or presence not available
- *Instant messaging (recommended), presence (recommended), video call, remote, multi-person meeting (optional)*

Hardware/IT:

- Communication platform with IM, video, presence (recommended)
- Webcam for provider and support staff depending on the use case
- Headphones (with noise canceling feature, if in common space)
- Internet capacity for video at the initiating site (remote) and receiving site (clinic)
- Remote device with webcam, cellular with capacity to handle video traffic, communication platform with IM and presence recommended

Training *(Provider and support staff):*

- Communication platform
- Video interaction training
- Use of the remote device
- Training for determining the internet speed at the remote site
- Billing training if a support staff initiates the visit and provider is brought in for clinical consult and billing
- Documentation in progress note for verbal consent and GT modifier code if visit is billed

HIPAA and Security:

- Verbal consent should be obtained before starting a video interaction

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- Headphones and relatively secure environment are necessary both for the remote site initiating the visit and the patient and provider or support staff receiving the video call

Billing:

- Provider can bill for the visit if the note is conducted using video and the documentation supports a medically necessary visit, focused HPI, and problem-focused assessment and plan

"We had a patient who, we found out, was admitted to the hospital with a relapse on methamphetamine… He's also diabetic. We found out they were going to discharge him with no after-care plan, so our team got together and decided that we had to help this patient before things got out of control. It was decided that the care team nurse and I needed to go on an urgent home visit.

I was so excited and empowered to be able to interact with the patient in this way, because the nurse was new to the team but the patient knew me and I could connect with him. I was able to facilitate the meeting between me, the nurse and the provider, who was at his office, by a video visit. It was very successful. I feel that if the intervention hadn't happened things could have gone down a very bad path."

(Sheena McDermond Toledo, Medical Assistant Supervisor, West County Health Centers)

Use Case HEALTH SYSTEM COLLABORATION

Description – Health system not connected with the primary care organization is given access to primary care team for improved communication and collaboration

Examples:

- Hospital staff (Discharge Planner, ER staff, Radiologist) given access to select primary care staff to improve communication for a patient admitted to the hospital
- Hospital transition sign out with hospital staff, primary care staff and patient, prior to discharge, to manage transition
- Geriatric Group Home given access to RN Care Manager to improve communication about primary care patients regarding scheduling, medication or clinical needs. IM can be escalated to a video call for clinical triage and medical provider can be brought in for consult or billing
- Hospice staff given access to primary care team to improve communication and coordination
- Health plan and primary care connected to improve communication and connect with clinical decision support for quick consult (pharmacist, care coordinator, access specialist)

Communication functionality:

- Both parties needs to know that the required staff are available for an IM or video call (Presence)
- IM or Video connection required
- *Instant messaging, presence, video call, multi-person meeting (optional)*

Hardware/ IT:

- Communication platform with IM, video, presence
- Webcam for both parties if video is needed
- Headphones (with noise canceling feature, if in common space)
- Internet capacity for video at the initiating site (remote) and receiving site (clinic)

Training *(Both entities - Provider and support staff):*

- Introduction and concept development for partnering organization
- Communication platform training for both parties
- Video interaction training
- Billing training, if applicable
- Documentation in progress note for verbal consent and GT modifier code if visit is billed
- Workflow developments across health systems for communication specifics

HIPAA and Security:

- Verbal consent should be obtained before starting a video warm hand-off
- Headphone and relatively secure environment are necessary both for the remote site initiating the visit and the patient and provider or support staff receiving the video call
- BAA and confidentiality agreement needed between entities

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Billing:

- Provider can bill for the visit if the visit is conducted using video and the documentation supports a medically necessary visit, focused HPI, and problem-focused assessment and plan

See also:

Hospital Pre-Discharge Virtual Patient Interview– Clinical Protocol (WCHC Example)
Hospital Pre-Discharge Virtual Patient Interview– Hospital RN Template
Hospital Pre-Discharge Virtual Patient Interview– Primary Care RN Template

HOSPITAL PRE-DISCHARGE VIRTUAL PATIENT INTERVIEW

Clinical Protocol: RN Care Management (example)

Protocol Summary – Goal: To facilitate successful hospital transition for patients by proactively meeting with patient and nurse for collaborative sign out prior to discharge focusing on medication changes, red flags, assessment of patient activation, discharge needs, and follow-up appointment.

Here is an example of how it has been done at West County Health Centers:

Setting up the meeting:

1. WCHC RN is notified of pending discharge by hospital discharge planner, WCHC social rounder, or hospital discharge nurse and sets up a rough time to have meeting.

2. At agreed upon time, the WCHC RN starts an "instant meeting" using the Cisco Jabber functionality.

3. The "meeting number" located at the upper left corner of the meeting when started is communicated to hospital medical surgery clerk by telephone.

4. Hospital clerk connects to the meeting using the iPad WebEx app by entering the meeting number.

5. Hospital RN and West County RN have initial RN-RN sign out as described below.

6. Hospital RN then brings iPad to the room to start the meeting with the patient/family/care giver.

7. *Note: family/care givers who are remote can join the meeting in a similar way if appropriate.*

Meeting content:

1. WCHC RN and hospital RN should have an initial conversation and sign-out of salient events and potential issues with successful discharge.

2. WCHC RN to make introductions if not already familiar with patient/care giver and introduce concept of meeting is to help facilitate a smooth transition home.

3. WCHC RN should ask hospital RN and patient to give a summary of what happened during the hospitalization, in front of the patient to make sure there is agreement from the patient as to the important events of the hospitalization.

4. Focus discussion on potential barriers to successful transition from perspective of hospital RN and patient/care giver.

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5. Review medication changes and ensure plan is made for getting needed medications prior to discharge.

6. Discuss needs for DME or other aids and plan for getting these items.

7. Review patient activation measure with hospital RN and discuss any insights from the experience of caring for the patient in the hospital that may be important to know.

8. Review red flag symptoms and get a sense of needed education or knowledge gaps or barriers.

9. Review needed follow up items including need for labs, PT/INR, x-rays.

10. Review follow-up appointments with non-WCHC: PT, wound care, specialty follow up.

11. Review follow-up appointment with WCHC and/or home transition visit.

HOSPITAL PRE-DISCHARGE VIRTUAL PATIENT INTERVIEW

Hospital RN Template

Working with the iPad:

- Enter the meeting number in the WebEx app – connect to audio using the internet.

- Start your video and enlarge the picture for a better visual experience.

- Position the iPad to have the best video experience for you (and the patient).

RN-RN Sign-out:

- **General Summary**:   Begin with a general summary of the reason for admission and hospital course.
    - Highlight new diagnoses, new allergies, procedures, complications that occurred during the hospitalization

- **Transition care**: Discuss important items for a successful discharge

    - Review discharge medications and highlight new or changed medications

    - Review follow up items such as pending labs, need for follow-up appointments, DME, wound care, etc.

    - Highlight your own concerns or identified barriers to success upon discharge.

    - Review the LACE tool to identify high risk for readmission.

- **Lessons learned or insights**: You have insights from your time with the patient that could be critical to successful transition or invaluable for a more comprehensive or holistic view of your patient – share with us!

- **Bring in others**: If appropriate bring in other members of your team that might have insight or wisdom to pass on.
    - Discharge planning, Social Work, Behavioral Health, Pharmacy, Hospitalist team, wound care, etc.

Patient-RN-RN Interview:

- **Introductions**: Introduce this interview and those involved in the meeting.

- **Set a shared agenda**: "We think this is a great opportunity to make sure we are all on the same page for making this transition home successful. Is it ok with you if we review what happened in the hospital, talk about important items that your WCHC nurse should know about when you go home and give you a chance to talk about concerns or potential barriers to being successful at home?"

- **Review Discharge items**:
    - Focus on medications, red flags symptoms, follow up needs, and follow up appointments.

(more)

- o   Offer a chance for the patient to teach back.

- **Patient preferences and concerns**: Give the patient a chance to identify concerns, talk about preferences for follow up and home visit (if needed), and help to lead the follow up plans. Lead the patient to focus on barriers, concerns, transportation support needs, etc. if needed.

- **Wrap up**: Close the meeting and ask if there are any other items that would be helpful.

HOSPITAL PRE-DISCHARGE VIRTUAL PATIENT INTERVIEW

Primary Care RN Template

Setting up the meeting:

- Talk to the Medical Surgery ward clerk to establish a good meeting time for your patient.

- Launch an instant meeting and give the ward clerk the meeting number.

- Turn on your camera, connect to audio and enlarge the picture for a better experience.

RN-RN Sign-out:

- **General Summary**: Introduce yourself and listen as the hospital RN gives a general summary of the reason for admission and hospital course.

    o Highlight new diagnoses, new allergies, procedures, complications that occurred during the hospitalization

- **Transition care**: Discuss important items for a successful discharge

    o Review discharge medications and highlight new or changed medications.

    o Review follow up items such as pending labs, need for follow-up appointments, DME, wound care, etc.

    o Highlight your own concerns that you have with your patients based on any history and focus on what items may be important as an outpatient.

    o Review the LACE tool to identify high risk for readmission.

- **Lessons learned or insights:** Engage around insights that the hospital RN may have and bring up any issues that know about that are important to discuss.

Patient-RN-RN Interview:

- **Introductions**: Receive the introduction from the Hospital RN.

- **Set a shared agenda**: The hospital RN will start with a shared agenda – help with this if needed. "That sounds like a great start – is it ok if we also talk about …?"

- **Review Discharge items**:

    o Focus on medications, red flags symptoms, follow up needs, and follow up appointments.

    o Offer a chance for the patient to teach back.

- **Patient preferences and concern**s: Give the patient a chance to identify concerns, talk about preferences for follow up and home visit (if needed), and help to lead the follow up plans. Lead the patient to focus on barriers, concerns, transportation support needs, etc. if needed.

- **Wrap up**: Close the meeting; ask if there are any other items that would be helpful.

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Use Cases LESSONS LEARNED

- Ease of use and incorporation into existing staff workflows is critical for adoption and success

- Face-to-face video connection adds significantly to care collaboration and transfer-of-trust

- Allowing staff, patients, and care partners the ability to communicate in a variety of ways (IM, video, phone, in-person, multi-person) is important within the complex Primary Care environment

- Communication platform needs to be device agnostic: staff and patients will naturally use a variety of devices within their existing work-flows and will need to adapt with a changing technology environment

- Presence is really helpful. Primary care is dynamic – need to know moment by moment who is available

- IM is a great tool for quick communication between staff. Giving the staff IM and presence is a huge win – Use that momentum to move toward video and multi-person video

- Video is a much more significant intrusion than phone or IM: Make sure the staff is available for a video before starting the visit (e.g., at the workstation, not on the phone)

- In certain situations where broadband reception is iffy, it's advisable to use different platforms for video and audio

- New IT projects will often generate early anxiety and at different levels for different staff. It is important to offer training at different starting levels and speeds

- Active follow-up with staff to ensure adoption and ongoing use is needed, which should include one-on-one mentorship for some staff

- Practice with staff without a patient is needed for most staff to become familiar with the system in a safe environment

- It is helpful to have a video to help staff and patients understand the concept, as this is a new type of interaction within primary care

- HIPAA is an important consideration and it should not be assumed that communication platforms have adequate security and privacy functionality

- Understand the connectivity implications of using video, both for the implementation of the new platform and the impact on other systems that may compete for bandwidth

- If remote video is used, test the bandwidth prior to starting a visit

- Inadequate bandwidth for a video visit will undermine the adoption and potential buy-in for other parts of the program roll-out

- AB415 allows for many types of visits using video technology but each payer determines the billing requirements. Further, a managed or state Medicaid payer may have requirements different from CMS

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CONSIDERATIONS FOR COMMUNICATIONS PLATFORMS

	WebEx Connect	WebEx alone	WellFX	Microsoft Lync	Oovoo	Go To Meeting	Skype	Face Time
Encryption (128-bit or greater)	✓	✓	✓	✓	✓	✓	✓	
Secure Instant Messaging	✓		✓	✓			✓	
Presence	✓		✓	✓		✓	✓	✓
Desktop Sharing	✓	✓	✓	✓	✓	✓	✓	
Video Recording Available	✓	✓	✓ Third quarter 2014	✓	✓	✓	✓	✓
Allows for HD Video Quality	✓	✓	✓	✓	✓	✓	✓	✓
Simultaneous Multi-Site Participation	✓	✓	✓	✓		✓	✓	
Enterprise License Available	✓		✓	✓		✓		
Clear documentation that the information transmitted in the meeting is not stored within platform	✓	✓	✓	✓				
Device agnostic	✓	✓	✓	✓		✓	✓	
Secure social networking platform for patients			✓					
Secure social networking platform for staff								
Single Sign-on	✓		✓ Third quarter 2014	✓			✓	

*Vendor features may have changed since this decision matrix was completed in Spring 2014.

Update May 2014: **Vocera** *is a secure voice and voice-messaging communication system, a viable alternative to other audio systems used in tandem with video.*

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HIT COST OVERVIEW

	Cost	Comments
WebEx Connect (Jabber for mobile devices)	$14,600/year ($10 per staff per month)	Enterprise edition for 120 employees (IM, video calls, presence, screen share)
WebEx	$24 per host per month (up to 8 hosts)	Needed for multi-person calls
WellFX	Free for health center staff communication	
Microsoft Lync	Between $4-$22 for enterprise license	Need Office 365 Plan
Web Cam: **Microsoft LifeCam Cinema**	$45	
Computer Speakers: **Logitech S120 Multimedia speakers**	$11	
Headphones: **Memorex**	$10	
Remote Tablet: iPad Air with cellular	$600	Other tablets would work (if using tablet as video connection in the exam room, need to consider EMR interface)

Contact Information

WebEx Connect
Contact for trial: **Jeff Jackson** jjackson@dpsciences.com **DPSciences** 209 SE Douglas, Lee's Summit, MO 64063 816-524-5555 extension 6427 816-524-2662 fax http://www.dpsciences.com/

WebEx Meeting license: WebEx License

WellFX
Contact for trail: **Jock Putney jp@well-fx.com** 1318 Redwood Way Suite 110 Petaluma, CA 94954
Phone: (888) 244-0107 http://www.well-fx.com/

Microsoft Lync: http://products.office.com/en-us/lync/
http://office.microsoft.com/en-us/business/compare-all-office-365-for-business-plans-FX104051403.aspx

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SECURITY AND HIPAA CONSIDERATIONS IN PRIMARY CARE

Bottom Line– **As healthcare providers we are required to take reasonable steps to ensure personal health information that we are privy to is secure for video, data, and database storage.**

THINGS TO CONSIDER:

- **Transport encryption** (most important for information that is not stored) – Should have reasonable encryption for all patient communication (56 byte likely fine; most are 128 byte or higher). If the transport encryption is in place, don't need to worry much about the link layer encryption (wireless, Ethernet, DSL, etc).

- **Database security** – if involving a third party, would need to ensure appropriate security measures, and workflows are in place. Who will have access to the records? Can staff record, oversee, or sell information that could contain patient information?

- **What is the security of your server** – If hosted elsewhere, is it co-located with other companies? Is it discoverable or can others log-into and read unencrypted? What are the interconnections between servers? What employees or contractors have access to the information?

- **Control over titles** – Will a meeting title be available to others?
  - *Example*: "Video conference with Dr. James and patient Betty Snow" in a title may be viewable in a company calendar or viewable beyond company or with shared partners.

- **E-mail and text** need to be unidentified or encrypted unless consent is documented for communicating health information across this medium.

- **Product specific considerations**:
  - Does the communication platform keep record of the interactions and what is done with that information?
    - *Example*: Skype has access to all their client records, calls, etc. WebEx does not have access to the sessions.
  - What other information is made available by using the product?
    - *Example*: Skype has buddy lists - Will your patient have you as a buddy or will you have a patient as a buddy, and who may see that information?
  - Are all forms of the communication encrypted - IM, Video calls, Chats, texts, etc?

- **Patient Consent** – After passage of California AB415 we are required to have at least a *verbal* consent to have video communication with a patient.

- **Staff Environment** - It is worth thinking about the environment in which the patient or healthcare staff is having the conversation.
  - Who else may be privy to private information?
    - *Example*: If a doctor is having the conversation in a shared workspace, what reasonable actions were taken to make sure the conversation was private (headphones, screen protection) and what level of informed consent was given to the patient?

- What level of informed consent or education do you want to give your patient who may
  - be having the call in a public environment or having a family member call in from a public setting?

- **Security policies of third party vendors** - When Personal Health Information is shared, we have the responsibility of considering and documenting what polices and procedures are in place around security of that information and whether or not Business Associate Agreements are required.
  - *Example*: Skype has access to all of their client records, calls, etc. whereas WebEx does not have access to the information in the sessions, etc.

- **Recording meetings** - Recording meetings or clinical sessions could offer significant benefit for care collaboration, patient recall, clinical documentation, etc, but have important legal ramifications. Where the data is stored and for how long; the security around access to the information; and discussion around informed patient consent need to be carefully considered. *We have not pursued recording sessions directly involving patients or their Personal Health Information at this time due to these legal concerns.*

- **Security and Privacy Rules under HITECH Act**: The Health Information Technology for Economic and Clinical Health (HITECH) Act that went into effect in September 2013 greatly tightens security and privacy rules. These new rulings restrict the use of mobile devices and particularly Bring Your Own Device (BYOD) that is becoming more commonplace. Recommendations include the implementation of a Mobile Device Management (MDM) system to help ensure compliance.

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BILLING FOR PRIMARY CARE TELEHEALTH SERVICES

Legality: Under California law AB415:

- All licensed health professionals can provide services using telehealth technology.

- Removes limits on the locations for telehealth. This allows for coverage of services delivered via telehealth, regardless of location.

- Eliminates the requirement to document a patient's barrier to receiving an in-person visit before a beneficiary could receive services via telehealth.

- Does not mandate the use of telehealth and leaves the billing specifications for each health plan to determine.

- *See AB415 fact sheet from the Center for Connected Health Policy*.

MediCal:

- Some managed MediCal plans, such as Partnership Health Plan, have created new billing policies allowing for reimbursement for synchronous and asynchronous telehealth services.

- For Partnership Health Plan, synchronous services can be provided and billed if the patient location is at a health facility, residential home, patient home, or other location.

- Most require a GT modifier code to be submitted with the claim.

- *See PHC Telehealth Policy*

CMS:

- FQHC/RHCs get paid an all-inclusive encounter rate (PPS rate). The PPS rate is the same whether the service is delivered through a traditional face-to-face encounter or using telehealth. FQHC/RHCs will bill Medi-Cal for these services using the same process as for other billable visits (e.g. code 01 for medical, code 03 for dental, code 18 for wrap, etc.). Modifiers to demonstrate telemedicine are not used currently.

- Under CMS guidelines, if the patient is not physically located within the four walls of the health center, the patient must be "homebound" and an FQHC representative must be present with the patient to bill for the services under telehealth. This is a departure from the guidelines under AB415 and billing requirements for some MediCal Managed care plans and limits the billing of the PPS rate for a visit. The definition of "homebound" is in the process of clarification.

- CMS does not allow a visit to be billed if the patient is home without a representative from the health center - even if the patient is homebound.

- *See Telehealth FQHC RHC FAQ*

Verbal Consent:

Each video visit requires the documentation of a verbal consent to conduct the visit using video technology and should be documented in the medical record. *Example of consent: Verbal consent obtained allowing for this visit to be conducted using telehealth video technology.*

(more)

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99212: A video visit can be billed as a 99212 with documentation of the following 2 or 3 components:

- Problem focused history
- Problem-focused examination (1 component of affected body area/organ system)
- Medical decision making that is straightforward
- Billing for time: requires an average visit of 10 minutes with at least 5 minutes or 50% of the time spent in counseling or coordinating care.

99213: A video visit can be billed as a 99213 with documentation of following 2 of 3 components:

- An expanded problem focused history with 1 element in ROS
- An expanded problem focused examination (1 component of affected body area/organ system, plus an additional 1-7 symptomatic-related body areas/organ systems)
- Medical decision making of low complexity.
- Billing for time: requires an average of visit of 15 minutes in which at least 7.5 minutes or 50% of your time was spent in counseling or coordinating care.

Modifier code:

A modifier code: "GT – *Via interactive audio and video telecommunication systems"* needs to be added to the billing.

BREAKING DOWN THE REQUIREMENTS

Coding 99212 vs. 99213[1] *(Need to* meet 2 of 3 of the following: History, Exam, Medical Decision Making)

	99212	*99213*
HISTORY	Problem-focused	Expanded problem-focused
	CC: yes	CC: yes
	HPI: brief (1-3 elements)	HPI: brief (1–3 elements)
	PFSH: none	PFSH: none
	ROS: none	ROS: 1 system
EXAM[2]	Problem-focused	Expanded problem-focused
	1 component of affected body area/organ system.	1 component of affected body area/organ system, plus an additional 1-7 symptomatic-related body areas/organ systems.
MEDICAL DECISION MAKING[3]	Straightforward	Low complexity
Diagnosis	Diagnosis/management options:	Diagnosis/management options:
	Minimal	Limited
	Need 1 point	Need 2 points
	Examples:	Examples:
	• One self-limited/minor problem (1 point). • One stable established problem (1 point).	• One self-limited/minor problem AND one stable established problem (2 points). • One established problem, worsening (2 points).
Data	Amount/complexity of data:	Amount/complexity of data:
	Minimal	Limited
	Need 1 point	Need 2 points
	Examples:	Examples:
	• Review and/or order lab, radiology or medical test (1 point).	• Review and/or order lab test (1 point). • Review and/or order radiology test (1 point).

		• Review and/or order medical test (1 point).
	• Discuss results with testing physician (1 point).	• Independently interpret specimen/imaging/tracing (2 points).
	• Obtain old records (1 point).	• Summarize review of old records/additional history (2 points).

Risk[4]	Level of risk: Minimal	Level of risk: Low
	Examples:	Examples:
Presenting problem	• One self-limited or minor problem, e.g., cold, insect bite, tinea corporis.	• Two or more self-limited or minor problems. • One stable chronic illness, e.g., controlled hypertension, diabetes mellitus, benign prostatic hyperplasia. • One acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain.
Diagnostic procedures	• Lab with venous puncture. • Chest X-ray. • ECG. • Urinalysis. • Ultrasound. • Wet prep.	• Physiologic tests not under stress, e.g., pulmonary function tests. • Non-CV imaging studies with contrast, e.g., barium enema. • Superficial needle biopsies. • Lab tests with arterial puncture. • Skin biopsies.
Management options	• Rest. • Gargles. • Elastic bandages. • Superficial dressings.	• OTC drugs. • Minor surgery with no identified risk factors. • Physical or occupational therapy. • IV fluids without additives.

[1] Two of the three key components (history, exam and medical decision making) must meet or exceed requirements for the code.

[2] Examples follow the 1995 Medicare documentation guidelines.

[3] Two of the three sections must meet or exceed requirements for the overall level of medical decision making.

[4] The highest risk level of the three sections determines the overall risk level.

DOCUMENTATION GUIDELINES FOR ESTABLISHED PATIENT VISITS

	99211	99212	99213	99214	99215
HISTORY					
CC	N/A	Required	Required	Required	Required
HPI	N/A	1-3 elements	1-3 elements	4+ elements (or 3+ chronic diseases)	4+ elements (or 3+ chronic diseases)
ROS	N/A	N/A	Pertinent	2-9 systems	10+ systems
PFSH	N/A	N/A	N/A	1 element	2 elements
EXAMINATION					
1997 documentation guidelines	N/A	1-5 elements	6-11 elements	12 or more elements	Comprehensive
1995 documentation guidelines	N/A	System of complaint	2-4 systems	5-7 systems	8+ systems
MEDICAL DECISION MAKING					
	N/A	Straightforward	Low	Moderate	High
TIME[1]					
	5 minutes	10 minutes	15 minutes	25 minutes	40 minutes

Note: Two of the three key components – history, exam and medical decision making – are required.

1. More than half of the total must involve counseling or coordination of care.

Video Interaction Surveys

See:

- **General Patient IT Satisfaction Survey**
- **General Staff IT Satisfaction Survey**
- **Provider Navigation Survey**

1. Please rate your overall satisfaction using video interaction.

○ Very Satisfactory

○ Satisfactory

○ Neutral

○ Unsatisfactory

○ Very Unsatisfactory

2. Please finish the statement--"Before today's visit, my attitude toward video interaction was..."

○ Very Positive

○ Positive

○ Neutral

○ Negative

○ Very Negative

3. Please finish the statement--"After today's visit, my attitude toward video interaction..."

○ Strongly Improved

○ Improved

○ Did Not Change

○ Worsened

○ Strongly Worsened

4. The use of video technology improved my care.

○ Strongly Agree

○ Agree

○ Neither Agree Nor Disagree

○ Disagree

○ Strongly Disagree

5. During today's video interaction, I was able to communicate well with my provider.

○ Strongly Agree

○ Agree

○ Neither Agree Nor Disagree

○ Disagree

○ Strongly Disagree

6. I have no concerns about privacy with the use of video after this experience.

○ Strongly Agree

○ Agree

○ Neither Agree nor Disagree

○ Disagree

○ Strongly Disagree

7. Additional comments:

General Staff IT Satisfaction Survey

1. Please rate your overall satisfaction using video interaction.

- ○ Very Satisfactory
- ○ Satisfactory
- ○ Neutral
- ○ Unsatisfactory
- ○ Very Unsatisfactory

2. The set-up process for using the video technology was relatively easy.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree Nor Disagree
- ○ Disagree
- ○ Strongly Disagree

3. Today's video interaction was an efficient use of my time.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree Nor Disagree
- ○ Disagree
- ○ Strongly Disagree

4. Today's video interaction added value to the care of the patient.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree nor Disagree
- ○ Disagree
- ○ Strongly Disagree

5. During today's video interaction, I was able to engage with the patient/family.

- ○ Strongly Agree
- ○ Agree
- ○ Neither Agree nor Disagree
- ○ Disagree
- ○ Strongly Disagree

6. Additional comments:

Provider Navigation Survey

1. Please rate your overall experience using video technology during today's Patient Navigator visit.

○ Very Satisfactory

○ Satisfactory

○ Neutral

○ Unsatisfactory

○ Very Unsatisfactory

2. The video camera worked well during this Patient Navigator visit

○ Strongly Agree

○ Agree

○ Neutral

○ Disagree

○ Strongly Disagree

3. The audio worked well during this Patient Navigator visit.

○ Strongly Agree

○ Agree

○ Neutral

○ Disagree

○ Strongly Disagree

4. During this visit, I was able to engage with the patient using video technology.

○ Strongly Agree

○ Agree

○ Neutral

○ Disagree

○ Strongly Disagree

5. It was easy to fit this Patient Navigator visit into my schedule.

○ Strongly Agree

○ Agree

○ Neutral

○ Disagree

○ Strongly Disagree

6. Additional comments:

LINKS TO TELEHEALTH RESOURCES

- **California Telemedicine and eHealth Center** – CTEC is the federally designated Telehealth Resource Center for California. CTEC's vision is to achieve the fully optimized use of telehealth and other technology enabled health care in order to: improve access to health care for all California citizens, improve clinical efficiency and access to health information and education and to reduce the cost of providing needed health care. Website includes comprehensive Reimbursement Guideline and other resources: www.caltrc.org

- **Center for Connected Health Policy** – Non-profit organization that conducts objective policy analysis and research, develops non-partisan policy recommendations, and operates telehealth demonstration projects: www.cchpca.org

- **California Telehealth Network** – high speed network resources: www.caltelehealth.org

- **UC Davis Center for Health and Technology** – provides telehealth specialty services, distance education on use of telehealth and variety of education courses: www.ucdmc.ucdavis.edu/cht/

- **Telehealth Consulting Services** – Telehealth planning to Implementation: Telemedicine.com

The Telehealth Advancement Act of 2011

The Telehealth Advancement Act of 2011 (AB 415), which became law Jan. 1, 2012, updates California telehealth law and removes policy barriers to telehealth use.

AB 415, authored by Assemblyman Dan Logue, R-Lake Wildwood, and sponsored by the California State Rural Health Association, updates legal definitions of telehealth, streamlines medical approval processes for the delivery of telehealth, and broadens the types of services that can be provided via telehealth.

AB 415 updates the definition of telehealth to reflect the broader range of services in use today.

AB 415 drew from CCHP's Telehealth Model Statute Report, which recommended modernizing state telemedicine and workforce laws, to encourage more robust adoption of telehealth technologies. CCHP provided non-partisan technical support to the author and sponsor of AB 415.

AB 415 modernizes California's landmark Telemedicine Development Act of 1996, to reflect advances in the field since the original law's passage. It updates the definition of telehealth, to reflect the broader range of services in use today, and allows all licensed health professionals in California to provide services via telehealth. Critically, it creates parity among clinical services, regardless of whether they are delivered in person or via telehealth.

AB 415 *does not mandate* the use of telehealth by public or private providers. Covered services and locations are still negotiated in contracts between health plans and providers, and established by regulation in public insurance programs, such as Medi-Cal, the state's Medicaid program. AB 415 does not change the scope of practice of any licensed health professional, or change interstate licensure laws.

What AB 415 Does

- **It replaces the outdated legal terminology of "telemedicine" with "telehealth."**
Telemedicine, under the old law's terminology, was defined as the practice of medicine via live video connections between patients and providers in separate locations, or via "data communications." As technological advances resulted in new telehealth treatment options, this legal definition eventually became obsolete—and a barrier to implementation of these new technologies.

In addition, while the old law referenced data communications, it did not explicitly include in its definitions the use of store & forward technologies, a prominent data communications delivery mechanism. While store & forward was allowed in a separate section of the old law, the lack of a clear and explicit presence in its definitions created difficulties for providers seeking reimbursement for these services.

Telehealth, the new legal term, refers to the technology-enabled delivery of services, rather than a specific medical practice. This allows for a far broader range of telehealth delivery than the old law, and does not limit future telehealth technologies, because of its encompassing, forward-looking definitions.

- **It removes limits on the physical locations where telehealth services may be provided.**
Under the old law, telemedicine appointments had to take place in licensed health care facilities, such as hospitals, clinics, doctors' offices, or skilled nursing facilities.

However, Medi-Cal restricted telemedicine delivery to four types of licensed facilities only: Critical Access Hospitals, provider or practitioner offices, rural health clinics, and Federally Qualified Health Centers.

Some private payors followed suit, and the perception took root that these were the only facilities where tele-medicine could occur.

AB 415 explicitly removes limits on the locations for telehealth. This allows for coverage of services delivered via telehealth, regardless of location, but does not mandate such coverage.

- **AB 415 eliminates the ban on services provided via email or telephone being included as telehealth.**
  AB 415's removal of this ban allows for substantial expansion of telehealth. AB 415 does not mandate the use of telephone or email in telehealth.

- **AB 415 expands the definition of health care provider, to include all state-licensed medical professionals.**
  Under the old law, only these medical professionals could provide services via telehealth:

  - Physicians
  - Surgeons
  - Dentists
  - Podiatrists
  - Clinical Psychologists
  - Marriage and Family Therapists
  - Ophthalmologists
  - Optometrists (in limited scope)
  - Professional clinical counselors
  - Clinical social workers

AB 415 expands this list to include all professionals licensed under California's healing arts statute, which allows for greatly expanded provider use of telehealth services. AB 415 does not mandate reimbursement for all licensed medical professionals.

- **AB 415 allows California hospitals to use new federal rules to more easily establish medical credentials of telehealth providers.**
  An amendment to AB 415 helped clear up confusion among California regulators, over a new federal rule to streamline the process for establishing medical credentials of telehealth providers.

The Centers for Medicare & Medicaid Services issued the new regulations, called "privileging by proxy," in July 2011. They allow hospitals and other entities engaged in tele-health to accept the credentialing paperwork of each facility's practitioners. These new regulations make for quicker approvals of practitioners, and eliminate duplicative, expensive, and often cumbersome credentialing processes.

AB 415 aligns California law with the new CMS regulations. The confusion among California regulators centered on whether existing state regulations were in conflict with the new rule, and whether the state's hospitals would still have to go through full credentialing processes for all telehealth practitioners.

- **AB 415 removes two Medi-Cal regulations viewed as restrictive to telehealth.**
  First, AB 415 eliminates a Medi-Cal rule requiring providers to document a barrier to an in-person visit before a beneficiary could receive services via telehealth, which was widely viewed by providers as a disincentive to its use.

  AB 415 streamlines medical approval processes for delivery of telehealth services, and broadens the types of services that can be provided via telehealth.

  Second, AB 415 removes a sunset date that would have eliminated Medi-Cal coverage of store & forward tele-dermatology, tele-opthalmalogy and tele-optometry.

- **AB 415 changes the requirement of an additional written patient consent specifically for telehealth to a verbal consent.**
  The old law required patients to sign a separate, tele-health-specific consent form for any type of service delivered via telehealth.

  Providers found that the written consent form stigmatized the use of telehealth, and created an unnecessary barrier to care.

  AB 415 replaces the written consent with a verbal consent. This establishes parity between services provided in person, and those provided via telehealth.

Information for Medicare Fee-For-Service Health Care Professionals

News Flash - Understanding the Remittance Advice: *A Guide for Medicare Providers, Physicians, Suppliers, and Billers* serves as a resource on how to read and understand a Remittance Advice (RA). Inside the guide, you will find useful information on topics such as the types of RAs, the purpose of the RA, and the types of codes that appear on the RA. The *RA Guide* is available as a downloadable document from the Medicare Learning Network Publications web page. To download and view, please go to **http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf** on the CMS website.

MLN Matters Number: MM5628 Revised	**Related Change Request (CR) #: 5628**
Related CR Release Date: June 29, 2007	**Effective Date: January 1, 2008**
Related CR Transmittal #: R1277CP and R74BP	**Implementation Date: January 7, 2008**

Addition to Medicare Telehealth Services

Note: **Note:** This article was updated on September 10, 2012, to reflect current Web addresses. Important new information regarding the use of CPT codes 99241-99245 and 99251-99255 is available at http://cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf on the CMS website. All other information remains the same.

Provider Types Affected

Physicians, practitioners and providers submitting claims to Medicare carriers, Fiscal Intermediaries (FIs), and/or Part A/B Medicare Administrative Contractors (A/B MACs) for telehealth services provided to Medicare beneficiaries

Provider Action Needed

STOP – Impact to You

This article is based on Change Request (CR) 5628 which adds the neurobehavioral status exam (as represented by HCPCS code 96116) to the list of Medicare telehealth services.

CAUTION – What You Need to Know

Effective January 1, 2008, the telehealth modifiers "GT" (via interactive audio and video telecommunications system) and modifier "GQ" (via asynchronous telecommunications system) are valid when billed with HCPCS code 96116.
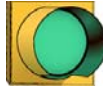
GO – What You Need to Do

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

The Centers for Medicare & Medicare Services (CMS) announced in CR 5628 that the neurobehavioral status exam (Healthcare Common Procedure Coding System (HCPCS) code 96116) has been added to the list of Medicare telehealth services (see the final rule for the calendar year (CY) 2008 physician fee schedule (CMS-1385-FC)). Previously, CMS determined that, if the eligibility criteria, and conditions of payment are satisfied, the use of a telecommunications system may substitute for a face-to-face, "hands on" encounter for consultation, office visits, individual psychotherapy, pharmacologic management, psychiatric diagnostic interview examination, end stage renal disease related services, and individual medical nutrition therapy. CR5628 added neurobehavioral status exam to the list of telehealth services (bolded). Medicare telehealth services are listed below.

- Consultations (CPT codes 99241 - 99275) - Effective October 1, 2001 – December 31, 2005;

- Consultations (CPT codes 99241 - 99255) - Effective January 1, 2006;

- Office or other outpatient visits (CPT codes 99201 - 99215);

- Individual psychotherapy (CPT codes 90804 - 90809);

- Pharmacologic management (CPT code 90862);

- Psychiatric diagnostic interview examination (CPT code 90801) – Effective March 1, 2003;

- End Stage Renal Disease (ESRD) related services (HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318) – Effective January 1, 2005;

- Individual Medical Nutrition Therapy (HCPCS codes G0270, 97802, and 97803) (Effective January 1, 2006); and

- **Neurobehavioral status exam (HCPCS code 96116) (Effective January 1, 2008).**

In addition, effective January 1, 2008, the following modifiers are valid when billed with HCPCS code 96116:

Modifier	Descriptor
GT	Via interactive audio and video telecommunications system
GQ	Via asynchronous telecommunications system

The expansion to the list of Medicare telehealth services does not change the eligibility criteria, conditions of payment, or payment or billing methodology applicable to Medicare telehealth services as set forth in the Medicare Benefit Policy Manual (Publication 100-02, Chapter 15, Section 270) and the Medicare Claims Processing Manual (Publication 100-04, Chapter 12, Section 190).

For example, originating sites must be located in either a non- Metropolitan Statistical Area (non-MSA) county or rural Health Professional Shortage Area (HPSA) and must be one of the following:

- Physician's or practitioner's office,

- Hospital,

- Critical access hospital (CAH),

- Rural health clinic, or

- Federally qualified health center.

Also, an interactive audio and video telecommunications system must be used permitting real-time communication between the distant site physician or practitioner and the Medicare beneficiary, and as a condition of payment, the patient must be present and participating in the telehealth visit. The only exception to the interactive telecommunications requirement is in the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii. In this circumstance, Medicare payment is permitted for telehealth services when asynchronous store and forward technology is used.

Effective January 1, 2008, CR 5628 instructs that:

- Your local part B Carriers and or A/B MACs will pay for HCPCS code 96116 according to the appropriate physician or practitioner fee schedule amount when submitted with a GT or GQ modifier, and

- Your local FIs and or A/B MACs will pay for HCPCS code 96116 when submitted with a GT or GQ modifier, by CAHs that have elected Method II payment on Type of Bill (TOB) 85x.

Additional Information

To view the official instructions issued to your carrier, FI, or A/B MAC, see the two transmittals for CR5628 at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1277CP.pdf** and **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R74BP.pdf** on the CMS website.

If you have any questions, please contact your carrier, FI, or A/B MAC, at their toll-free number, which may be found at **http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html** on the CMS website.

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WebEx Security and HIPAA Considerations

WebEx Communications Inc.

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WebEx Communications, Inc. Security Standards

HIPAA Considerations

As the global leader of online web communications services, WebEx™ has built a unique communications infrastructure based on information-switching technology. This proprietary technology enables true, interactive, communication sessions with levels of functionality, reliability, security, and scalability unmatched by any other organization in this industry.

Data security, an essential element of HIPAA regulations, remains an extremely high priority for WebEx and our customers. WebEx security standards ensure sensitive information is not stored anywhere in our network; the data is simply transmitted during the session. WebEx provides secured sessions, transmission, and session information allowing any healthcare organization to maintain HIPAA compliancy.

When talking about security there are two aspects to be considered, session management and data management. The purpose of this document is to give the reader an overview of WebEx's communication technology, and the optional features an organization can use to go beyond the scope of collaboration.

Please refer to the WebEx Security Overview white paper for details on WebEx unattended support sessions and data management. SMARTtech (WebEx's unattended remote support solution), AccessAnywhere, (WebEx's remote access solution), and Training Center Hands-on-Lab (WebEx's virtual lab solution) provides healthcare organizations with the required technical, physical and administrative safeguards required, ensuring HIPAA compliance is maintained when using WebEx.

WebEx Communication Technology

WebEx's technology does not require the upload or storage of customer information, including, but not limited to, patient information. When collaborating, no information is sent in clear text. In addition, WebEx offers full 128 bit encryption of all meeting data as an optional feature. In addition, controls exist to ensure only when information sharing is required, only authorized meeting attendees can view necessary documents. WebEx's proprietary communication technology delivers levels of functionality, reliability, security, and scalability impossible with the database-centric, store-and-retrieve architecture utilized by others.

In addition to WebEx's proprietary communication technology, WebEx has a number of specific session management security measures for the purposes of restricting attendance. Passwords can be required for all meetings, and strong password requirements can be configured by the customer and enforced at the site level. Meetings can be unlisted, and attendance can be restricted to participants with accounts on the meeting site. Once in a meeting, the attendee window displays all attendees, ensuring that the host is aware of all meeting participants. Should it be determined that an attendee does not belong, or must be removed from a meeting; the host can eject the attendee from the meeting. At any point during a meeting, the host can lock the meeting, ensuring that no additional participants can join.

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Additional Meeting Features

There are certain optional features a customer can employ, which have the potential for release of customer data beyond the scope of a collaboration session. Note that none of these features are required in order to use WebEx services, and all can be disabled at the site admin, and meeting host levels.

For customers who want a better understanding of these additional features, as well as the risks and mitigating factors associated with using them, the matrix below provides additional information. As stated previously, in addition to the mitigating factors listed below, all the features mentioned can be disabled on a per site basis.

Feature	Description	Risk	Mitigating Factors if feature is used
SMARTtech™	Allows a TSR to access a remote computer or server from any location in the world.	Remotely accessing computers or servers running an Access Anywhere agent.	Two-factor authentication. SSL encryption.
Access Anywhere	Allows a user to access a remote computer or server from any location in the world	Remotely accessing computers or servers running an Access Anywhere agent.	Two-factor authentication. SSL encryption.
Training Center Hands-On Lab	Allows virtual students and instructors to access a remote computer or server from any location in the world.	Remotely accessing computers or servers running a hands-on-lab agent	Two-factor authentication. SSL encryption.
File Transfer	Files can be transferred to and from the customer's system. The TSR can apply patches and updates during the session or get customer data files for further in-depth analysis.	Remotely accessing computers or servers running an Access Anywhere agent.	Two-factor authentication. SSL encryption.
My Folder	If you have a user account, you can create multiple folders to store your files, and specify folder-level access controls.	Storing a user's data files, contacts, which could be patient names, etc.	User name and password required to authenticate.Strong password requirements configurable by customer. SSL encryption (for information transfer).
Print	The host of the session has the ability to enable printing of presentations or documents for off-line review and analysis.	Allowing attendees to create printed copies of session content.	Ability to disable this feature in a meeting, to prohibit printing during the meeting.
Recording	Each session can be recorded for use in archival or training purposes.	Creating persistent records of session activities.	Ability to disable this feature from within a meeting to prohibit recordings
Remote Control	TSRs can take control of the customer's system or application, with the customer's permission, to fix the problem.	Accessing information and resources that are available to the remotely controlled machine.	Must be actively initiated by remote controlled computer. Can be disabled at any time by information owner. All actions visible to information owner. Information owner can restrict access to designated applications only.

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