



Telehealth Reimbursement Models Gallery Walk

Review the different telehealth reimbursement models posted around the room.

Add your questions to sticky notes. They will be answered later in the day.





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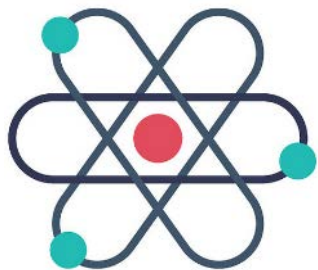
CALIFORNIA
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Sustainable Models of Telehealth in the Safety Net In-Person Workshop

November 5, 2018



Program Goals



Expand access to specialty telehealth services



Develop **sustainable telehealth programs** in the safety net



Understand **how to expand** and sustain telehealth programs



Share lessons with other safety net organizations

"Telehealth Trifecta" Team



Veenu
Aulakh



Alexis
Wielunski



Chris
Perrone



Jeanne
Russell



Kathy
Chorba



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Participating Sites and Health Plans



Today's Agenda



1. Models of Contracting & Reimbursement for Telehealth
2. Payer Discussions: Billing & Reimbursement Policy
3. Networking Lunch
4. Program Updates
5. Peer-to-Peer Problem Solving Sessions
6. Talking about Telehealth: Inspiring Change Through Storytelling
7. Wrap Up & Evaluation Survey

STAY UP TO DATE!

Sustainable Models of Telehealth Community Portal

OVERVIEW

TELEHEALTH RESOURCES

REPORTING

COMMUNITY

WELCOME, TELEHEALTH TEAMS!

This website is a support center for the use of **Sustainable Models of Telehealth in the Safety Net** participants. Program updates, report due dates, resources, newsletters and more will be posted to this website. This website is managed by Center for Care Innovations.

For more information about Sustainable Models of Telehealth in the Safety Net, please visit the [program page](#).

www.careinnovations.org/telehealth-portal/

Housekeeping, Breaks, and Timing



Restroom location



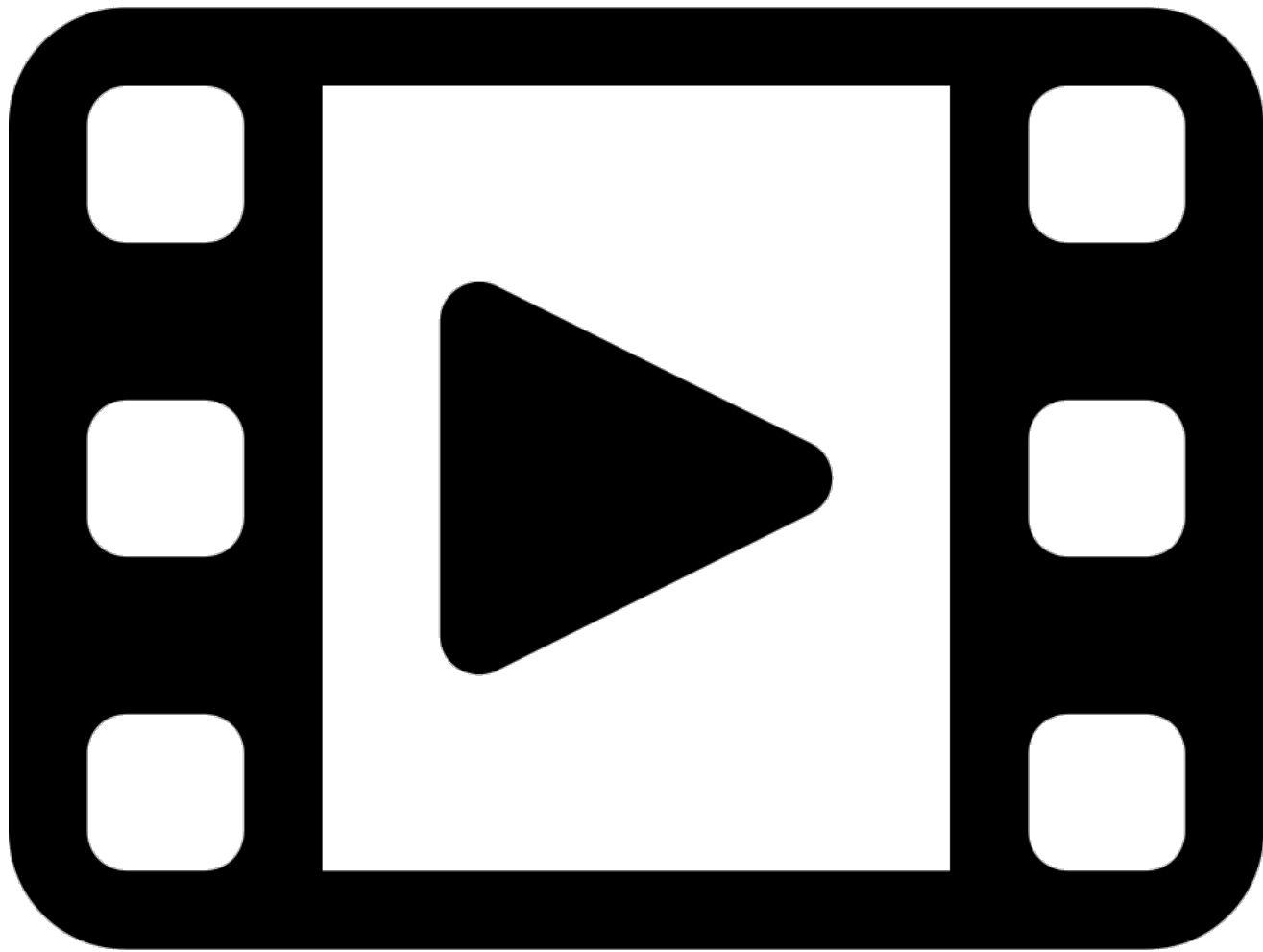
Lunch from 12:00 -
12:30



15 minute afternoon
break



Finish by 4pm



Models of Contracting and Reimbursement for Telehealth

YOUR RESOURCE FOR TELEHEALTH SUCCESS

**CALIFORNIA
TELEHEALTH
RESOURCE
CENTER**



TRC

An orange outline of the state of California is positioned behind the TRC logo. The logo consists of the letters 'TRC' in a blue, sans-serif font, enclosed within a blue circular graphic that has two curved lines extending from the top and bottom, resembling a stylized 'C' or a signal wave.



Telehealth Billing: What you need to know

Rebecca Picasso
CTRC Program Director
picassor@ochin.org



Medicare Telemedicine Billing for the FQHC/RHC



Reimbursement for Medicare telehealth has five criteria for payment of telehealth services:

1. The patient was seen from an "originating site" as defined by CMS.

An originating site is the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. Originating sites authorized by law are:

- a. Offices of a Physician or Practitioner
- b. Hospitals
- c. Critical Access Hospitals
- d. Community Mental Health Centers
- e. Skilled Nursing Facilities
- f. Community Mental Health Centers
- g. Rural Health Clinics
- h. Federally Qualified Health Centers
- i. Hospital-Based or CAH-Based Renal Dialysis Centers (including satellites)





Reimbursement for Medicare telehealth has five criteria for payment of telehealth services:

2. The originating site must be located in any of the following geographic areas:

A county outside of a Metropolitan Statistical Area (MSA)

-or-

A rural Health Professional Shortage Area (HPSA) located in a rural census tract

Determining Eligible Locations

You can access HRSA's Medicare Telehealth Payment Eligibility Analyzer to determine a potential originating site's eligibility for Medicare telehealth payment.

<https://data.hrsa.gov/tools/medicare/telehealth>



Reimbursement for Medicare telehealth has five criteria for payment of telehealth services:

3. The encounter was performed at the “distant site”, as defined by CMS. Eligible distant site practitioners are as follows:

- a. Physicians
- b. Physician assistants
- c. Nurse practitioners
- d. Clinical nurse specialists
- e. Registered dietitians or nutrition professionals
- f. Nurse midwives
- g. Certified registered nurse anesthetists
- h. Clinical psychologists*
- i. Clinical social workers*



*CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare.

RHCs and FQHCs cannot provide services as a distant site for Medicare reimbursement. This includes bringing the specialist in to the 4 walls virtually.

Reimbursement for Medicare telehealth has five criteria for payment of telehealth services:

4. The patient must be present and the encounter must involve interactive audio and video telecommunications that provides real-time communication between the practitioner and the Medicare beneficiary.

NOTE: Store and forward telehealth services are only permitted in federal demonstration programs currently conducted in Alaska and Hawaii. California Medicare sites are not eligible for reimbursement for store and forward telehealth services.

5. **Type of Service** provided must fall within the Medicare Eligible Services to:






Medicare Telemedicine Billing

Originating Site Fee

The originating site is eligible to receive a facility fee for providing services via telehealth. For 2018, the payment amount is "80% of the lesser of the actual charge or \$25.76".

Medicare provides specific instructions for different originating facility types:

For FQHC and RHCs: the originating site facility fee for Medicare telehealth services is not an FQHC or RHC service. When an FQHC or RHC serves as the originating site, the originating site facility fee must be paid separately from the center or clinic all-inclusive rate. (billed as a part B service to your MAC)



Medicare Telemedicine Billing

FQHC/RHC with a PPS or AIR rate



In order to be eligible to bill Medicare for the all inclusive rate, an FQHC or RHC must have a medical need for a provider to be in the room with the patient. The facility will then bill the appropriate level of office visit without the use of telehealth modifiers.

If a provider has no medical need to be in the room with the patient, an FQHC or RHC is only eligible to bill an originating site fee (Q3014).

Medicare Telemedicine Billing

Distant Site Clinical Services Fees

Reimbursement to the health professional delivering the clinical service is the same as the current fee schedule amount for the service provided without telemedicine.

- The location must be on the provider's enrollment file. For example, if the provider uses their home as an office location, the home must be listed on the enrollment file. A hotel, boat and car are not valid locations. The provider must be licensed and enrolled in the state the services are provided in. For example, if a beneficiary is in California and the provider is in Florida, the provider must be licensed and enrolled with the Medicare Administrative Contractor (MAC) for Florida.

As of Jan 1, 2018, the GT modifier is no longer required

Place of Service code 02 (Telehealth) is to be used for all telehealth visits.

A medical professional is not required to present the beneficiary to the physician or practitioner unless it is medically necessary. The decision of medical necessity is made by the physician or practitioner at the distant site.

You can find all of the eligible CPT codes on the Medicare Telehealth Services fact Sheet:

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



Proposed CMS Expansion of Telehealth 2019

Advancing Virtual Care

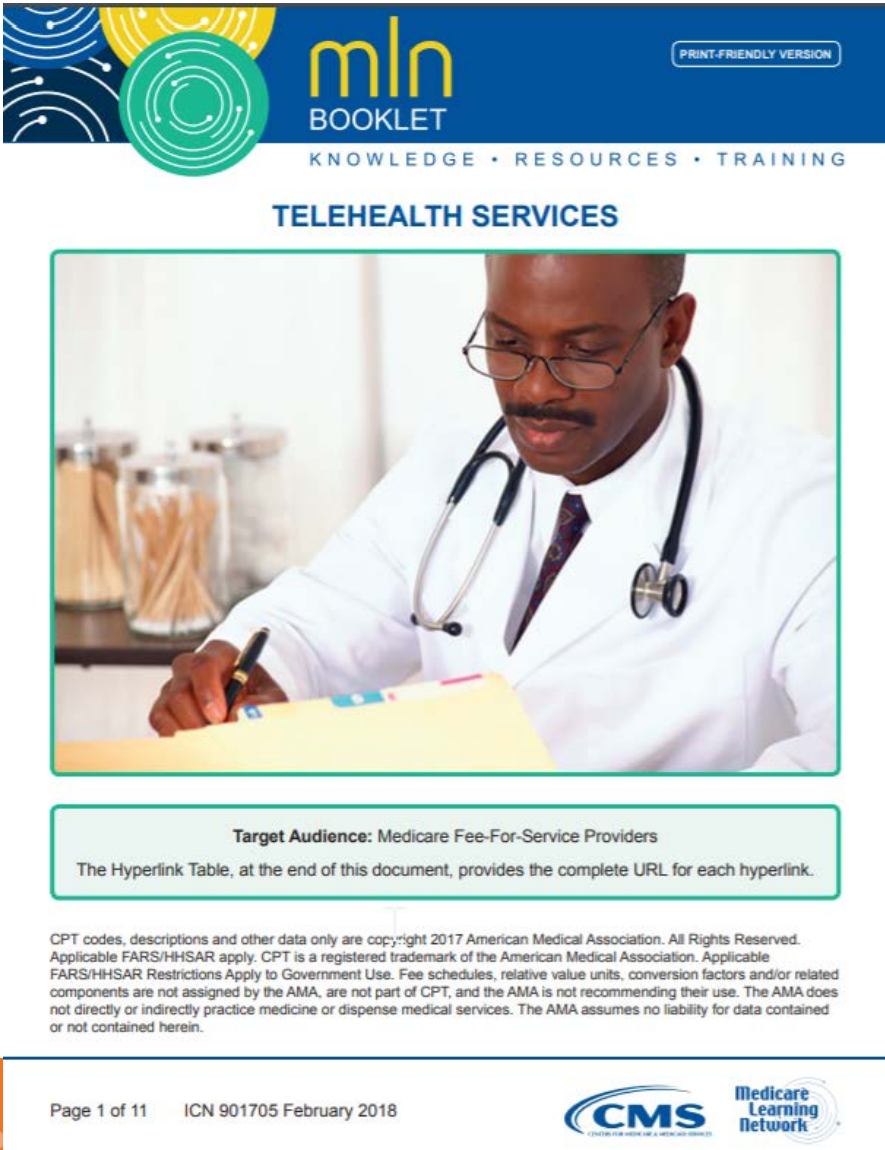
To support access to care using communication technology, CMS is proposing to:

- Pay clinicians for virtual check-ins – brief, non-face-to-face assessments via communication technology;
- Pay Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for communication technology-based services and remote evaluation services that are furnished by an RHC or FQHC practitioner when there is no associated billable visit;
- Pay clinicians for remote evaluation of patient-submitted photos or recorded video; and
- Expand Medicare telehealth services to include prolonged preventive services.

Learn more here: <https://www.cms.gov/newsroom/fact-sheets/proposed-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-3>



Telehealth Services Fact Sheet



mln
BOOKLET
KNOWLEDGE • RESOURCES • TRAINING

PRINT-FRIENDLY VERSION

TELEHEALTH SERVICES

Target Audience: Medicare Fee-For-Service Providers

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

CPT codes, descriptions and other data only are copyright 2017 American Medical Association. All Rights Reserved. Applicable FARS/HHSAR apply. CPT is a registered trademark of the American Medical Association. Applicable FARS/HHSAR Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Page 1 of 11 ICN 901705 February 2018

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network

- Published Annually
- 11 pages
- All allowable codes, providers, and locations
- Provides contact information for your regional CMS rep

Region IX – San Francisco
Neal Logue

neal.logue@cms.hhs.gov
Telephone: (415) 744-3551

California State Telehealth Billing Overview



Medi-Cal Fee-For-Service

So what exactly does Medi-Cal pay For?



- Pays for both sides of the consult
- Selected E&M services, psychiatric diagnostic interview examination, and selected psychiatric and therapeutic services.
- Store and forward & teleophthalmology.
- Interpretation and report of X-rays and electrocardiograms performed after telehealth transmission.
- Teledentistry
- Transmission costs (up to 90 minutes per patient, per day).
- Originating site facility fee



Medi-Cal Fee-For-Service

Originating Site


In general, an originating site is where the patient is located at the time health care services are provided via a telecommunications system, or where the asynchronous store and forward service originates.

For purposes of reimbursement for covered treatment or services provided through telehealth, the type of setting where services are provided for the patient or by the health care provider is not limited (W&I Code Section 14132.72(e))

Distant Site

In general, a distant site is where the health care provider is located while providing services via a telecommunication system

No restrictions on types or locations; however, requires licensure in State of California and adherence to licensure scope of practice. In addition, the distant (provider) site is only a billable visit if it meets all the requirements of the Medi-Cal program.





Medi-Cal Fee-For-Service

Modifiers

Only services rendered from the distant site are billed with modifiers. Claims for reimbursement should be submitted with the appropriate CPT code or HCPCS code for the professional services provided and one of the following Telemedicine modifiers:

- GT or 95 for interactive audio and video telecommunications system (live interactive) or
- GQ for Store and forward applications.


Originating Site Fee

The originating site is eligible to receive a facility fee for providing services via telehealth. For 2018, the site facility fee is \$22.94. Sites are instructed to use HCPCS code Q3014 when submitting facility fee claims. **Sites fee are limited to once per day, same recipient, same provider.**

Transmission Fee: Live Interactive

Medi-Cal allows payment of transmission costs associated with live interactive services. This fee can be paid to originating and distant sites. It is limited to a maximum of 90 minutes per day, same recipient, and same provider. One unit of service is equal to one minute of transmission cost.

Sites are instructed to use code T1014: telehealth transmission, per minute. For 2014 the transmission fee is \$0.24 per minute.






Medi-Cal Fee-For-Service

Store and Forward Dermatology and Ophthalmology Reimbursable Services

Services provided via store and forward telecommunications system must be billed with modifier GQ (service rendered by store-and-forward telecommunications system). Only the portion(s) rendered from the distant site (hub) are billed with modifier GQ.

Services provided at the originating site (face-to-face) with the patient during service that will be provided by store and forward transaction are billed according to standard Medi-Cal practices (without a GQ modifier).



Medi-Cal Fee-For-Service



A patient receiving teleophthalmology or teledermatology by store-and-forward shall be notified of the right to receive interactive communication with the distant specialist physician consulted through store-and-forward, upon request. If requested, communication with the distant specialist physician may occur either at the time of consultation or within 30 days of the patient's notification of the results of the consultation.

Private Payors, Managed Care, and IPA

Most follow Medi-Cal in that they pay for both ends of the consult.

Modifiers may be different (and in some cases, not existent)

Payers must have a telemedicine policy in place. That policy may be that they do not pay for telemedicine or that they only pay for certain services. Please check with payors to find out their reimbursement policies before providing and billing for telehealth services.

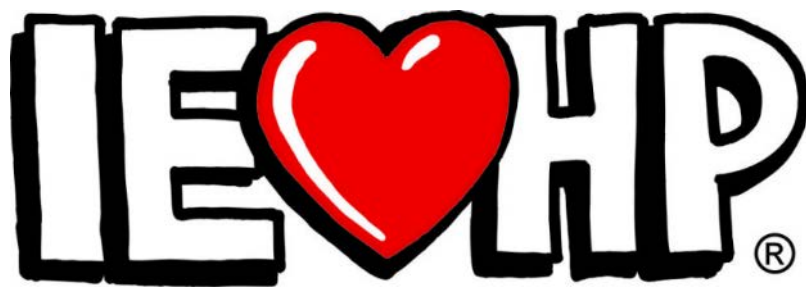
Most MCPs allow FQHCs/RHCs to bill both the Q3014 and the T1014.

Some MCPs will allow an FQHC/RHC to be a distant site

Managed Care Plans



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A Public Entity

Inland Empire Health Plan

PARTNERSHIP



HEALTHPLAN
of CALIFORNIA

Telehealth Models

There are three models of telehealth services available to CH&W members.

Traditional Synchronous Telehealth Services, connects the patient with a distant licensed provider through audio-video equipment on a real-time basis.

Synchronous Patient to Provider Telehealth Services, connects a single licensed provider (primary care or specialty provider) to a member using audio-visual equipment on a real-time basis. The member can be in a health facility, residential group home, private residence or other setting, provided the appropriate equipment is used.

Asynchronous Telehealth Services or store and forward services, connects a member with a distant licensed provider of ophthalmology, dermatology or certain optometry services using audio-video equipment, but not on a real-time basis. Generally an image or picture is taken and forwarded to the distant licensed provider to review at a later time.

California Health & Wellness



Reimbursement for Traditional Synchronous Telehealth Services



Billing Guidelines for Originating Site Providers:

Originating Site	
Service	CPT/HCPCS Code
Originating Site Facility	Q3014
Transmission Cost Fee:	T1014 (per minute for maximum of 90 minutes per day, same recipient, same provider)
Licensed Provider Fee (if present)	E&M codes 99201 - 99215 and other CPT codes for services distinct and in addition to those rendered by the Distant Site Provider

If a licensed provider is present at the telehealth originating site with the member present, medical necessity is established and documented in a progress note generated by the originating provider, the visit is reimbursable. The scope of the interaction with the originating site provider should be documented in the progress note that are distinct from those provided by the Distant Site and will be the basis of the E&M and other CPT code(s) billed. If an E&M code is included, the transmission cost fees may be billed by eligible sites. No modifier is needed at the originating site.

California Health & Wellness

Reimbursement for Synchronous Telehealth Services: Provider to Patient Telehealth Services

Telehealth Advancement Act of 2011 allows for telehealth services to be provided between a qualified provider and patient at a distant location. The location may be a health facility, residential home, patient's home or other location.



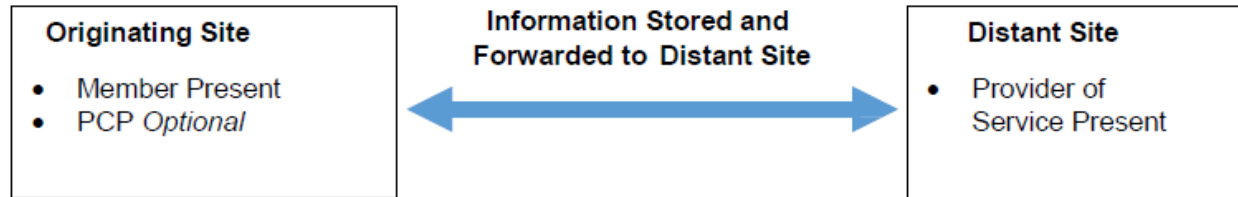
Billing Guidelines for the Distant Site

Distant Site	
Service	CPT/HCPCS Code
Transmission Cost Fee:	T1014 (per minute for maximum of 90 minutes per day, same recipient, same provider)
Licensed Provider Fees:	See Tables A and B below

A licensed provider who provides E&M services for a patient utilizing telehealth technology to access the provider's office may submit claims for this service using the E&M code, without the modifier. The contracted arrangements for primary care providers and specialty providers continue to apply. HCPCS Code T1014 Transmission Cost fee may also be billed by eligible sites

California Health & Wellness

Reimbursement for Asynchronous Telehealth Services (Store and Forward) for Teleophthalmology, Teleoptometry and Teledermatology Services



Billing Guidelines for Originating Site Providers

Originating Site	
Service	CPT/HCPCS Code
Site Facility Fee: (billable by eligible sites only when no provider at visit)	Q3014
Transmission Cost Fee: (billable by eligible sites)	T1014 (per minute for maximum of 90 minutes per day, same provider)
Licensed Provider Fees: (<i>if present</i>)	E&M codes 99201 - 99215 and other CPT codes for services distinct and in addition to those rendered by the Distant Site Provider

If a licensed provider is present at the telehealth originating site with the member present, medical necessity is established and documented in a progress note generated by the originating provider, the visit is reimbursable. The scope of the interaction with the originating provider should be documented in the progress note that are distinct from those provided by the Distant Site and will be the basis of the E&M and other CPT code(s) billed. If an E&M code is included, the transmission cost fees may be billed by eligible sites. No modifier is needed at the originating site.

Partnership HealthPlan

Telehealth Models



There are three models of telehealth services available to Partnership members.

Traditional Synchronous Telehealth Services connects the patient with a distant provider of health services through audio-video equipment on a real-time basis. This model is commonly used between specialty centers such as UCSF or UCD with outlying physician offices or community health centers.

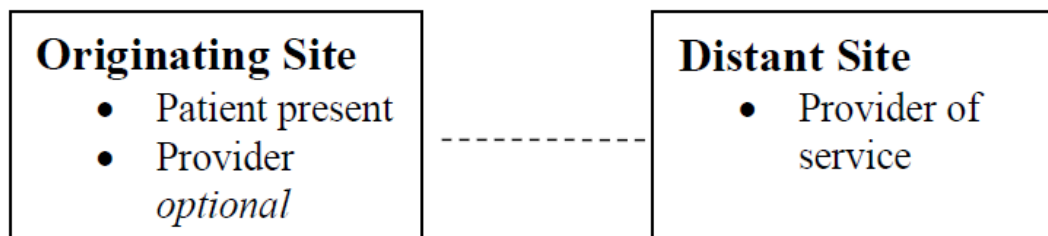
Synchronous Patient to Provider Telehealth Services connects a single provider (primary care or specialty provider) to a patient using audio-visual equipment on a real-time basis. The patient can be in a health facility, residential group home, private residence or other setting, provided the appropriate equipment is used.

Asynchronous Telehealth Services or the store and forward model connects a patient with a distant provider of ophthalmology, dermatology or certain optometry services using audio-video equipment, but not on a real-time basis. Generally an image or picture is taken and forwarded to the specialty provider to review at a later time. This also includes specialty services provided via eConsults, or electronic consultations, which consist of an electronic exchange of information through the eConsult platform and may include images or photos, labs, and other relevant patient information.

Partnership HealthPlan



H. Reimbursement for Traditional Synchronous Telehealth Services



Billing guidelines for Originating Site Providers:

Originating Site	
Service	Code
Site facility fee	Q3014
Transmission Cost	T1014 (per minute for maximum of 90 min. per patient)
Licensed provider fee (<i>if present</i>)	E&M codes 99201 - 99215 and other CPT codes for services distinct and in addition to those rendered by the Distant Site Provider.

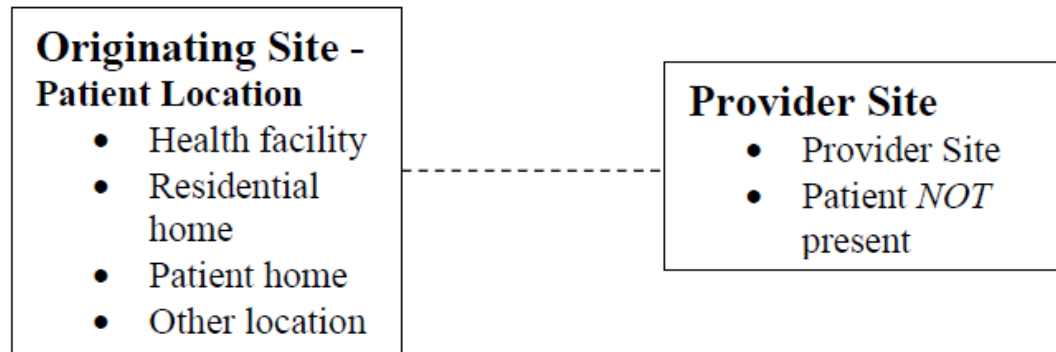
If a Licensed provider also is present at the telehealth Originating Site with the patient present and a progress note is generated by the originating provider, the visit is reimbursable. The scope of the interaction with the originating provider should be documented in the progress note that are distinct from those provided by the Distant Site and will be the basis of the E&M and other CPT code(s) billed. If an E&M code is included, the transmission cost fees may be billed. No modifier is needed at the Originating Site.

Partnership HealthPlan



J. Reimbursement for Synchronous: Provider to Patient Telehealth Services

Telehealth Advancement Act of 2011 allows for telehealth services to be provided between a qualified provider and patient at a distant location. The location may be a health facility, residential home, patient's home or other location.



Billing Guidelines for the Provider Site:

Provider Site	
Service	Code
Transmission Cost	T1014 (per minute for maximum of 90 min. per patient)
Licensed provider fee (<i>if present</i>)	E&M codes 99201 – 99215
Nutrition Counseling per PHC Guidelines (See Policy MCUP3052)	97802, 97803, 97804, 99539 – use GT modifier
Required Modifier	GT modifier required for all CPT-Codes except Transmission Cost codes

Partnership HealthPlan



Reimbursement for Asynchronous Telehealth Services (Store and Forward) for Teleophthamology, Teleoptometry, Teledermatology, and eConsult Program Services

Originating Site

- Patient present
- Provider
optional

Information stored and
forwarded to Distant Site

Distant Site

- Provider of
service

Billing guidelines for Originating Site Providers:

Originating Site	
Service	Code
Site facility fee	Q3014
Transmission Cost	T1014 (per minute for maximum of 90 min. per patient)
Licensed provider fee (<i>if present</i>)	E&M codes 99201 - 99215 and other CPT codes for services distinct and in addition to those rendered by the Distant Site Provider.

If a Licensed provider also is present at the telehealth Originating Site, with the patient present and a progress note generated by the originating provider, the visit is reimbursable as a visit. The scope of the interaction with the originating provider should be documented in the progress note, and will be the basis of the CPT code(s) used. If a CPT code is included, the originating site fee and the transmission cost fees may still be billed. No modifier is needed.

Special Billing Guidelines for Asynchronous Retinal Photography - Originating Site Providers:

If a provider uses asynchronous telehealth for diabetic eye exam screenings, through the use of a retinal camera located at the originating site, special billing guidelines apply, when the originating site is paying the specialist directly for reading the results of the retinal photographs. A licensed provider does not need to be present for retinal photography service to be reimbursable. If no provider is present at visit, bill using the following CPT codes:

Originating Store and Forward Site	
Service	CPT Codes
Retinal photography with interpretation for services provided by optometrists or ophthalmologists	92250 (Do not use modifier)
Site facility fee	Q3014
Transmission Cost	T1014 (per minute for maximum of 90 min. per patient)

If provider is present at visit, E&M codes can also be billed as usual. The scope of the interaction with the originating provider should be documented in the progress note. The originating site fee and the transmission cost fees may still be billed. No modifier is needed.



Inland Empire HealthPlan



IEHPs telehealth policy is currently being drafted, however, it is not ready to share at this time.

Medi-Cal and FQHC's/RHC's

There are a number of factors that determine how to bill for telemedicine services.

Two principles form the foundation:

- The place determined to be the provider site is the billing site and
- A provider can, under certain circumstances, enter the four walls virtually using telemedicine

The factors that determine the billing scenario are:

- Where the patient is physically located
- Characteristics of the specialty provider site
- Payment arrangement with the specialty provider
- If there is medical reason for a provider to be present with the patient.




Medi-Cal and FQHC's/RHC's



Things to Consider

FQHC and RHC sites are not eligible to bill an originating site fee or transmission charges for fee-for-service Medi-Cal. The cost of these services should be accounted for in the PPS or AIR calculation.

Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.



Medi-Cal Managed Care Plan (MCP)

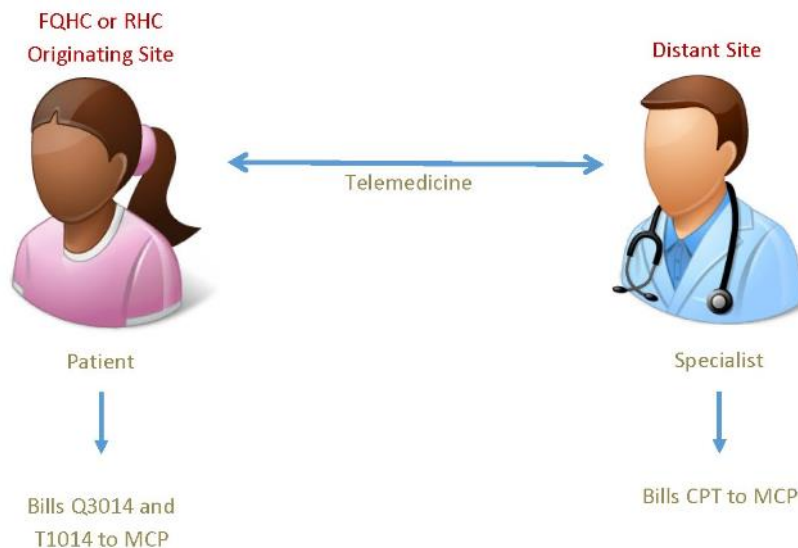
Scenario 1

FQHC/RHC Originating Site to a Distant Site

- Patient is physically present at the FQHC or RHC
- Specialist is a MCP contracted provider not physically present at the FQHC or RHC
- FQHC or RHC and Specialist have an agreement to provide services, but the FQHC or RHC does not compensate the specialist
- No medical reason for a provider to be present with the patient at the FQHC or RHC Site

Outcome

- MCP Contracted Specialist is the Distant Site and can bill MCP
- FQHC or RHC is the Originating Site, did not provide a medical service, and cannot bill PPS for a face-to-face. However, the FQHC or RHC, *in most instances*, can bill an Originating Site fee and Transmission fee to the MCP



Medi-Cal Fee-For-Service

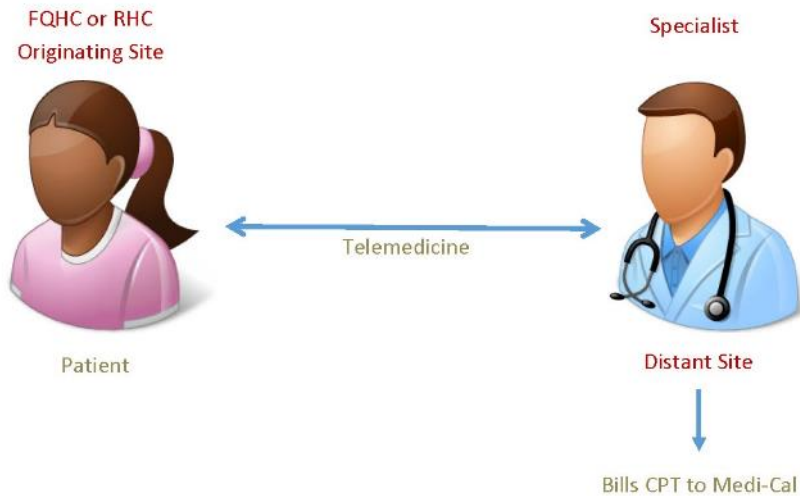
Scenario 1a

FQHC/RHC Originating Site to a Distant Site

- Patient is physically present at the FQHC or RHC
- Specialist is a Medi-Cal fee-for-service provider not physically present at the FQHC or RHC
- FQHC or RHC and Specialist have an agreement to provide services, however the FQHC or RHC does not compensate the specialist
- No medical reason for a provider to be present with the patient at the FQHC or RHC Site

Outcome

- Medi-Cal specialist is the Distant Site and can bill fee-for-service rate
- FQHC or RHC is the Originating Site, did not provide a medical service, and cannot bill PPS for a face-to-face



*Per the Medi-Cal handbook:
FQHCs, RHCs, and IHS clinic PPS
sites may not bill for originating
site or transmission fees.

Medi-Cal Managed Care Plan (MCP)

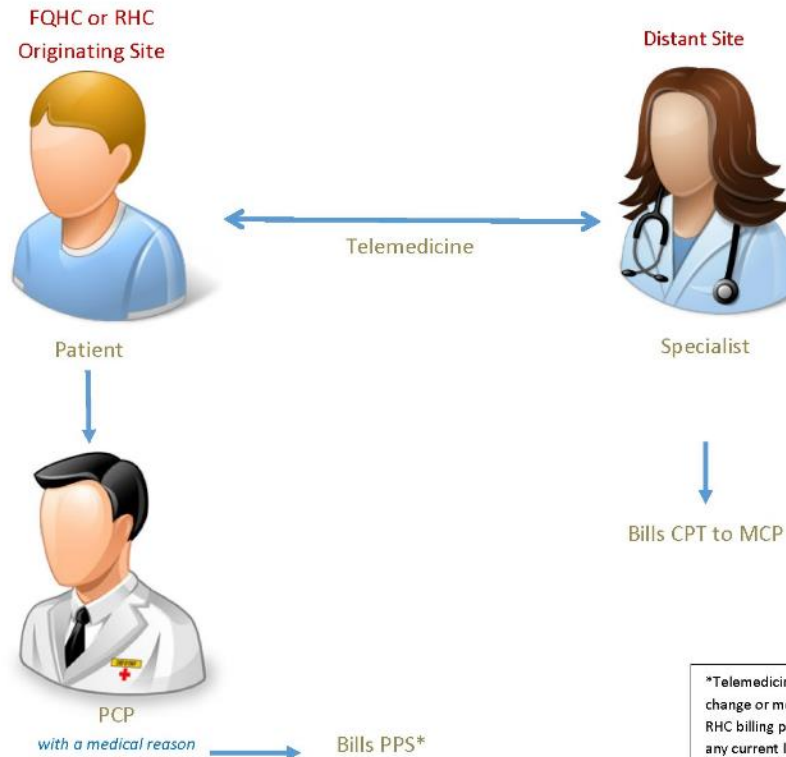
Scenario 1b

FQHC/RHC Originating Site (Provider Present) to a Distant Site

- Patient is physically present at the FQHC or RHC
- Specialist is a Medi-Cal fee-for-service provider not physically present at the FQHC or RHC
- FQHC or RHC and Specialist have an agreement to provide services, however the FQHC or RHC does not compensate the specialist
- Medical reason for a provider to be present with the patient at the FQHC or RHC Site

Outcome

- Medi-Cal Specialist is the Distant Site and can bill fee-for-service
- FQHC/RHC is the Originating Site, provided a medically necessary service, and can bill PPS for a face-to-face visit



*Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.

Medi-Cal Fee-For-Service

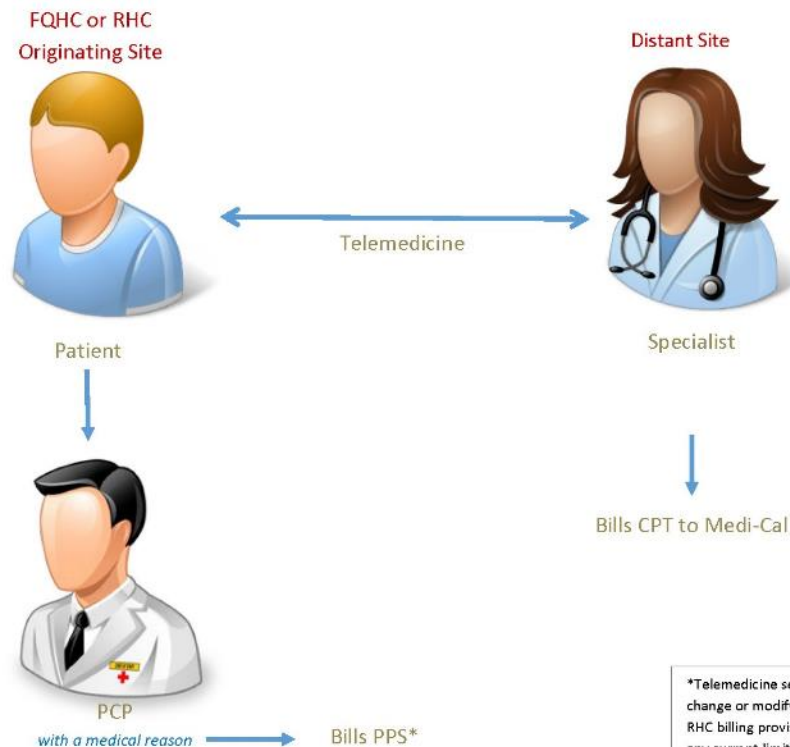
Scenario 1c

FQHC/RHC Originating Site (Provider Present) to a Distant Site

- Patient is physically present at the FQHC or RHC
- Specialist is a Medi-Cal fee-for-service provider not physically present at the FQHC or RHC
- FQHC or RHC and Specialist have an agreement to provide services, however the FQHC or RHC does not compensate the specialist
- Medical reason for a provider to be present with the patient at the FQHC or RHC Site

Outcome

- Medi-Cal Specialist is the Distant Site and can bill fee-for-service
- FQHC/RHC is the Originating Site, provided a medically necessary service, and can bill PPS for a face-to-face visit



*Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.

Multiple Managed Care Plans and Fee-For-Service Medi-Cal

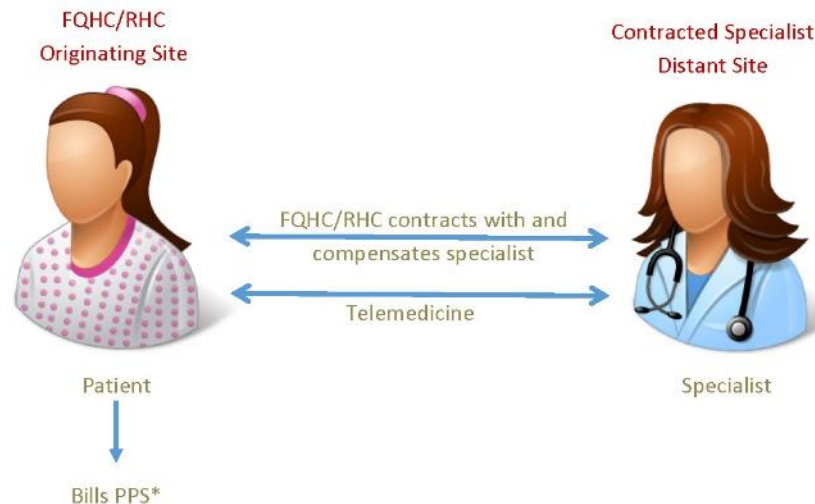
Scenario 2

FQHC/RHC Originating Site to Contracted Distant Site

- Patient is physically present at FQHC/RHC Site
- Specialist is not physically at the FQHC/RHC
- FQHC/RHC and Specialist have a written agreement to provide services. FQHC/RHC compensates Specialist outside of an insurance plan.
 - *The agreement should be in writing and clearly state: The time period during which the agreement is in effect; the specific services it covers; any special conditions under which the services are to be provided; and the terms and mechanisms for billing and payment. (See BPHC Policy Information notice 98-23)*
- FQHC or RHC has credentialed the contracted provider in house and with the health plan (if applicable)
- Specialist virtually enters FQHC site via telemedicine

Outcome

- FQHC/RHC becomes the Distant Site and can bill PPS for a face-to-face visit



*Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.

Medi-Cal Fee-For-Service

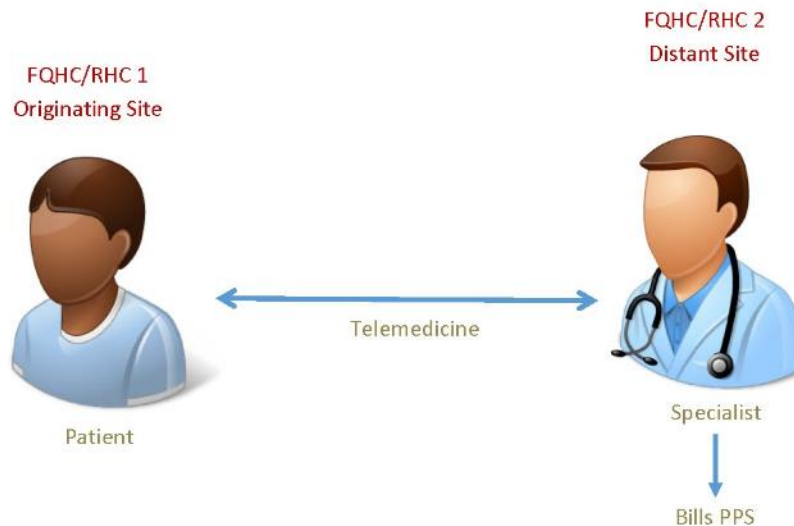
Scenario 3

FQHC/RHC Originating Site to FQHC/RHC Distant Site

- Patient is physically present at the FQHC/RHC 1
- Specialist is physically at and receives compensation from FQHC/RHC 2
- FQHC/RHC 1 and FQHC/RHC 2 have an agreement to provide services, however FQHC/RHC 1 cannot compensate FQHC/RHC 2
- No medical reason for a provider to be present with the patient at the FQHC/RHC 1 Site

Outcome

- FQHC/RHC 2 is the Distant Site and can bill PPS for a face-to-face visit
- FQHC/RHC 1 is the Originating Site, did not provide a medical service, and cannot bill PPS for a face-to-face visit



*Per the Medi-Cal handbook: FQHCs, RHCs, and IHS clinic PPS sites may not bill for originating site or transmission fees.

*Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.

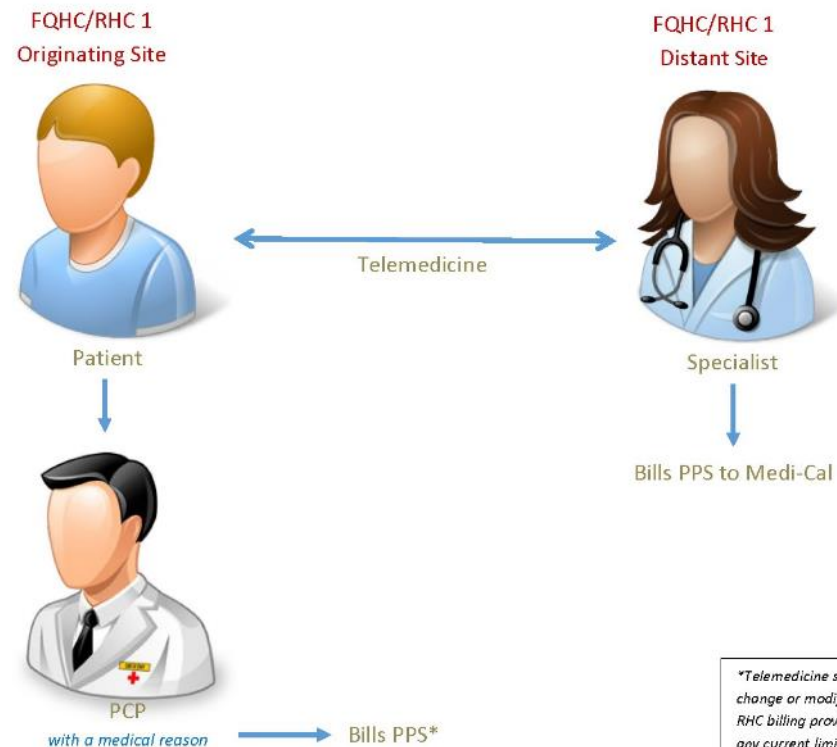
Scenario 3a

FQHC/RHC Originating Site (Provider Present) to FQHC/RHC Distant Site

- Patient is physically present at the FQHC/RHC 1,
- Specialist is physically present at and receives compensation from FQHC/RHC 2
- FQHC/RHC 1 and FQHC/RHC 2 have an agreement to provide services, b FQHC/RHC1 cannot compensate FQHC/RHC 2
- Medical reason for a provider to be present with the patient at the FQHC/RHC 1 Site

Outcome

- FQHC/RHC 2 specialist is the Distant site and can bill PPS for a face-to-face visit
- FQHC/RHC 1 is the Originating Site, provided a medically necessary service, and can bill PPS for a face-to-face visit



**Telemedicine services do not change or modify other FQHC or RHC billing provisions, including any current limits on patient visit frequency.*

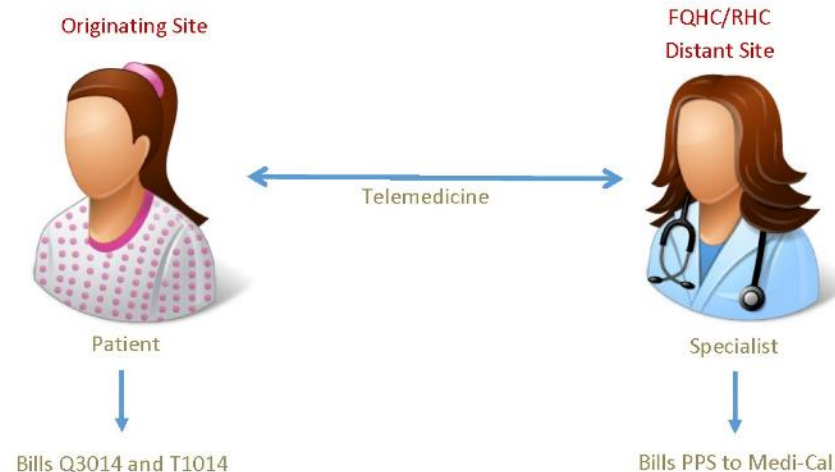
Scenario 4

Non FQHC/RHC Originating Site to FQHC/RHC Distant Site

- Patient is physically present at a Clinic Site
- Specialist is physically located at and receives compensation from FQHC/RHC
- Clinic site and FQHC/RHC have an agreement to provide services, however Medi-Cal does not compensate FQHC/RHC
- No medical reason for a provider to be present with the patient at the Originating Site

Outcome

- FQHC/RHC is the Distant Site and can bill PPS for a face-to-face visit
- Non FQHC/RHC Clinic site is the Originating Site, did not provide a medical service, and cannot bill for a face-to-face visit. However, the clinic site can bill an Originating Site fee and Transmission fee



Multiple Managed Care Plans and Fee-For-Service Medi-Cal

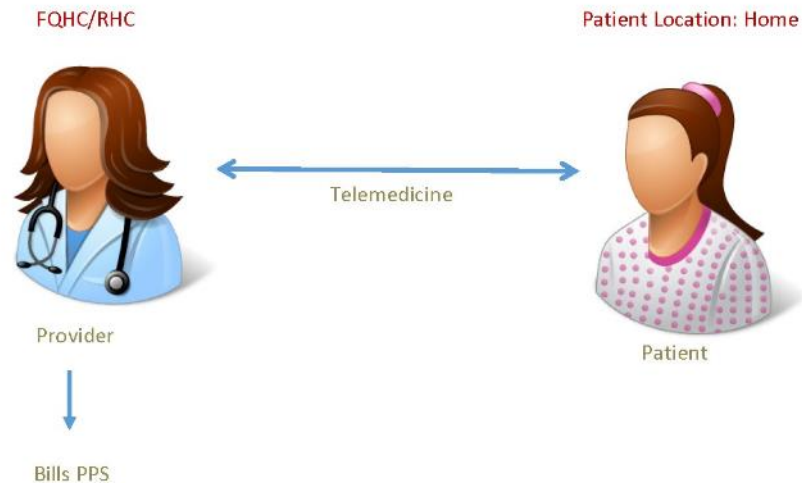
Scenario 5 FQHC/RHC to Patient Home *

- Provider is physically located at and receives compensation from FQHC/RHC
- Patient is an established patient and is not physically present at FQHC/RHC. In this example we will use the patient's home.

*Please check with your plan for eligibility

Outcome

- FQHC/RHC is the Distant Site and can bill PPS for a face-to-face visit





Medi-Cal Questions and Resources

Questions about claims and billing may be directed to the Medi-Cal Telephone Service Center (TSC) at 1-800-541-5555 or via email to: Medi-CalOutreach@Xerox.com.

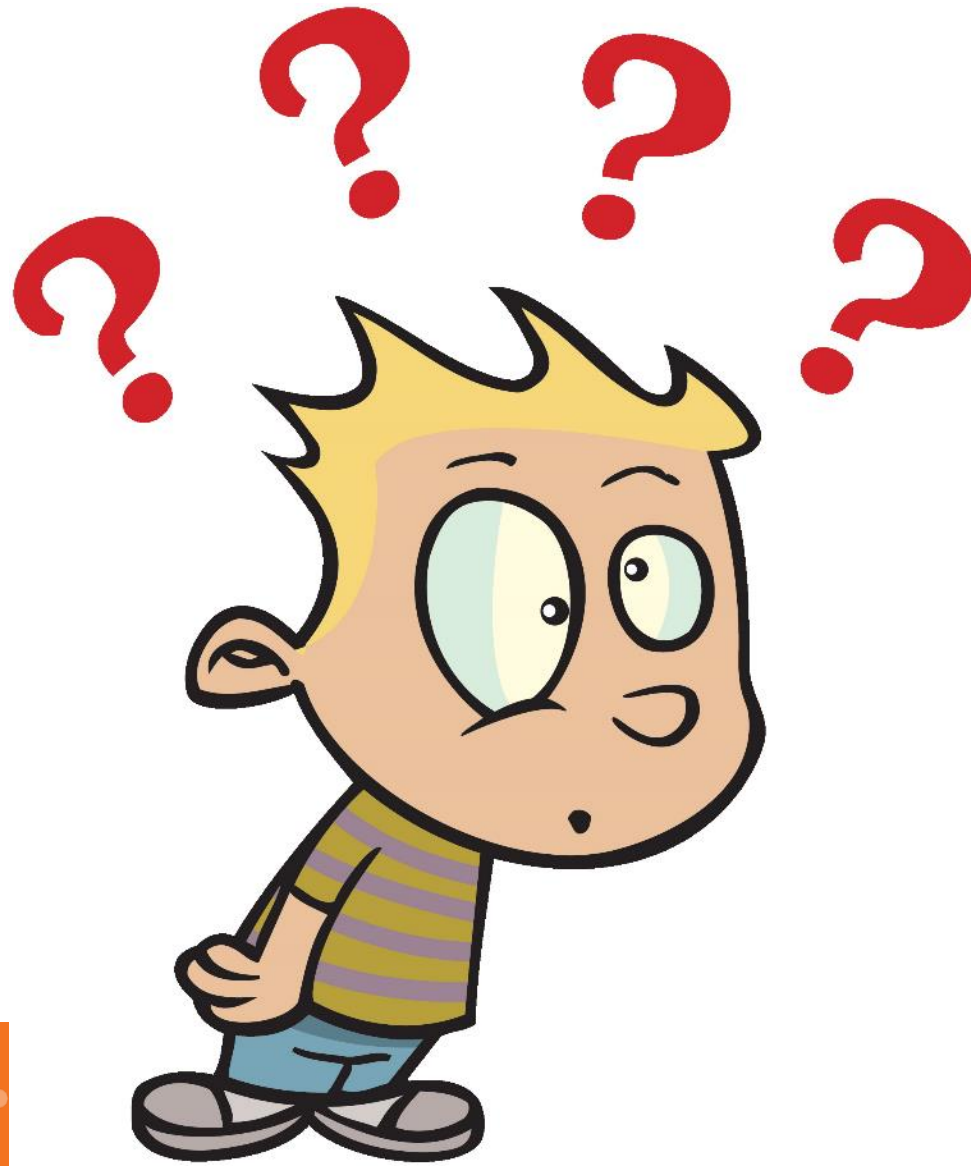
Providers may email questions about Medi-Cal telehealth policy to: Medi-Cal_Telehealth@dhcs.ca.gov

California Department of Health Services - Medi-Cal Program Telehealth Webpage

<http://www.dhcs.ca.gov/provgovpart/Pages/Telehealth.aspx>



Questions?





20 Questions to ask a provider *before signing the contract*

The pros and cons of common
contracting models

Sustainability worksheet
for contracted services

Kathy Chorba

CTRC Executive Director

chorbak@ochin.org



20 Questions to Ask a Provider:

→ Why create this resource?

Finding telehealth specialty service providers is not as difficult as it has been in the past.

The challenge is to find specialty service providers that will meet the unique needs and requirements of your clinic organization.

Each provider and clinic organization will have similarities and differences in practice and business models as they pertain to providing healthcare via telemedicine.

Before contracting with any specialty service provider group, we invite clinics to consider adding the questions listed in this presentation to their existing process for vetting potential partners.

Specialties available

Payment model

Rates

Appointment times

Credentialing policy

Specialist bio /
qualifications

Established referral
guidelines

Staffing requirements

Direct patient care or
consultation only

Medication refills

Specialist continuity

20 Questions to ask a specialty service provider prior to signing the contract

Finding telehealth specialty service providers is not as difficult as it has been in the past. The challenge is to find those that will meet the unique needs and requirements of your clinic organization. Each provider and clinic organization will have similarities and differences in practice and business models as they pertain to providing healthcare via telemedicine. Before contracting with any specialty service provider group, we invite clinics to consider adding the following questions to their existing process for vetting potential partners.

What specialties are available through this provider group?

Some specialty provider groups offer one specialty only (such as Behavioral Health) and others offer a wide variety of specialties (including Behavioral Health). Some clinics prefer the "one stop shop" for all their specialty needs, simplifying the contracting, credentialing, referral process and workflow, and other clinics prefer to shop around and find the best price for each specialty.

Does the provider group contract with your payer(s), bill you by the hour or block of time or patient seen, etc?

There are several billing models used by specialty provider groups, and it's important to discuss these and establish a model that's mutually beneficial in advance. These items will help determine the financial model that best fits your program. **Note:** Before you negotiate, you should know how many referrals you think you will have for each specialty and how soon you will be able start.

What are the rates for live video and store & forward? Are they the same for adult and pediatric?

Depending on the specialty services needed, as well as volume and modality for each specialty, rates will vary. Rates for store and forward specialties will typically be lower than live video specialties, and new patient appointments may be more expensive than follow-up appointments. Also, rates may vary according to the volume of patient referrals you anticipate sending to the specialty group. Keep in mind if a specialty group bills by the hour, it is important to know the time required for new and follow-up patients (see the next question). If the specialty group bills by the completed encounter, the rates may be higher than the hourly rate.



California Telehealth Resource Center

Turn around time for
chart notes

Cancellation /
no show policy

Patient double-
booking

Back up plan for tech
failure

Technical support
available

Non-consult
communication policy

Method of
communication
during consult

Post-consult
correspondence
policy

Onboarding process

Specialty Service Provider Relationships:

Advantages and Disadvantages of the Most Common Contracting Models

Model	Advantage	Disadvantage
Originating site purchases blocks of time from distant site	<u>Originating Site</u> : Guaranteed access to specialist	<u>Originating Site</u> : Risk assumed for no-show patients
	<u>Distant Site</u> : Guaranteed payment for time reserved	
Originating site pays per patient seen	<u>Originating Site</u> : No pressure to fill blocks of time	<u>Originating Site</u> : Possible excessive wait time for appointment
		<u>Distant Site</u> : Difficult to forecast volume to plan for coverage. AND Assume risk for no-show patients
Originating site pays the delta between distant site's cost and collections	<u>Originating Site</u> : Only pays a portion of the specialty visit cost	<u>Distant Site</u> : Assumes the administrative cost & burden of billing patient insurance & balance billing originating site
Health Plan contracts directly with specialty service provider	<u>Originating Site</u> : Most sustainable model as the originating site no longer has to pay for specialty care	<u>Originating Site</u> : <ul style="list-style-type: none"> Initial start-up delays in as health plans are slow to contract with new providers. Limited to those providers offered through the health plan
	<u>Distant Site</u> : Contracting with a health plan allows the specialty group to expand access to multiple sites, thereby increasing service volume	
On-demand, 24/7 coverage (hospital ED, ICU & In-patient)	<u>Originating Site</u> : Guaranteed access and coverage when needed	<u>Originating Site</u> : May pay for time that's not utilized
	<u>Distant Site</u> : Guaranteed payment for time reserved	<u>Distant Site</u> : May provide more services than originally estimated

Quiz!

When paying a specialty service provider by the hour, when is the \$250/hr specialist less expensive than the \$200/hr specialist?

Answer: When the \$250/hr specialist can fit more patient visits into each hour.

Provider A: \$250/hr

Initial 40, and f/u 20 = 60 min = \$250 for 2 visits

Provider B: \$200/hr

Initial 60, and f/u 30 = 90 min = \$300 for 2 visits

CTRC Sample Telehealth Sustainability Worksheet

This worksheet is provided as a basic tool to assist in business model development for FQHC/RHC/IHS and is based on the model of purchasing blocks of time

Instructions: Insert your data into the blue cells. All remaining cells will be automatically populated based on the information entered.

		Number	
Appointment type:	Minutes	of visits	Hours
Initial			#VALUE!
Established			#VALUE!
Total number of visits per block of time purchased		#VALUE!	#VALUE!

Patient volume	#VALUE!
Specialist hourly rate	
Specialty cost per block of time reserved	#VALUE!
Clinic collection rate per encounter (PPS rate)	
Amount clinic collects if 100% billable	#VALUE!
Average No Show rate for clinic (or specialty)	
Clinic collection minus No Show rate	#VALUE!
Clinic uninsured rate	
Adjusted clinic collection minus No Show rate	#VALUE!
Staffing and overhead per hour	
Staffing and overhead per block of time purchased	#VALUE!
Variance	#VALUE!

Note: This calculation does not include sliding fee collection

To download this interactive worksheet, visit:

caltrc.org/knowledge-center/best-practices/sample-forms/

CTRC Sample Telehealth Sustainability Worksheet

Illustration of the start-up phase (typically months 1-3)

This worksheet is provided as a basic tool to assist in business model development for FQHC/RHC/IHS and is based on the model of purchasing blocks of time

Instructions: Insert your data in to the blue cells. All remaining cells will be automatically populated based on the information entered.

Appointment type:	time (min)	# of visits	total hours
Initial	40	12	8.00
Established	20	0	0.00
Total number of visits per block of time purchased		12	8.00

Patient Volume	12
Specialist hourly rate	\$ 200.00
Specialty cost per block of time reserved	\$ 1,600.00
Clinic collection rate per encounter (PPS rate)	\$ 165.00
Amount clinic collects if 100% billable	\$ 1,980.00
Average No Show rate for clinic (or specialty)	15%
Clinic collection minus No Show rate	\$ 1,683.00
Clinic uninsured rate	5%
Adjusted clinic collection minus No Show rate	\$ 1,598.85
Staffing and overhead per hour	\$ 20.00
Staffing and overhead per block of time purchased	\$ 160.00
Variance	\$ (161.15)

Note: This calculation does not include sliding fee collection

For more information or assistance with this spreadsheet, please contact us!
California Telehealth Resource Center, www.caltrc.org

CTRC Sample Telehealth Sustainability Worksheet

Illustration of the growth phase (typically months 4-6)

This worksheet is provided as a basic tool to assist in business model development for FQHC/RHC/IHS and is based on the model of purchasing blocks of time

Instructions: Insert your data in to the blue cells. All remaining cells will be automatically populated based on the information entered.

Appointment type:	time (min)	# of visits	total hours
Initial	40	9	6.00
Established	20	6	2.00
Total number of visits per block of time purchased		15	8.00

Patient Volume	15
Specialist hourly rate	\$ 200.00
Specialty cost per block of time reserved	\$ 1,600.00
Clinic collection rate per encounter (PPS rate)	\$ 165.00
Amount clinic collects if 100% billable	\$ 2,475.00
Average No Show rate for clinic (or specialty)	15%
Clinic collection minus No Show rate	\$ 2,103.75
Clinic uninsured rate	5%
Adjusted clinic collection minus No Show rate	\$ 1,998.56
Staffing and overhead per hour	\$ 20.00
Staffing and overhead per block of time purchased	\$ 160.00
Variance	\$ 238.56

Note: This calculation does not include sliding fee collection

For more information or assistance with this spreadsheet, please contact us!
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CTRC Sample Telehealth Sustainability Worksheet

Illustration of the maintenance phase (typically months 7 & beyond)

This worksheet is provided as a basic tool to assist in business model development for FQHC/RHC/IHS and is based on the model of purchasing blocks of time

Instructions: Insert your data in to the blue cells. All remaining cells will be automatically populated based on the information entered.

Appointment type:	time (min)	# of visits	total hours
Initial	40	4	2.67
Established	20	16	5.33
Total number of visits per block of time purchased		20	8.00

Patient Volume	20
Specialist hourly rate	\$ 200.00
Specialty cost per block of time reserved	\$ 1,600.00
Clinic collection rate per encounter (PPS rate)	\$ 165.00
Amount clinic collects if 100% billable	\$ 3,300.00
Average No Show rate for clinic (or specialty)	15%
Clinic collection minus No Show rate	\$ 2,805.00
Clinic uninsured rate	5%
Adjusted clinic collection minus No Show rate	\$ 2,664.75
Staffing and overhead per hour	\$ 20.00
Staffing and overhead per block of time purchased	\$ 160.00
Variance	\$ 904.75

Note: This calculation does not include sliding fee collection

For more information or assistance with this spreadsheet, please contact us!
California Telehealth Resource Center, www.caltrc.org

We're here for you!



Let's
Talk!

YOUR RESOURCE FOR TELEHEALTH SUCCESS

**CALIFORNIA
TELEHEALTH
RESOURCE
CENTER**

TRC

Kathy J. Chorba, Executive Director
Rebecca Picasso, Program Director
Jeanne Russell, Program Coordinator

Aislynn Taylor, Training and Outreach Coordinator

Contact us! 877-590-8144 www.caltrc.org

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Payer Discussions

Small group discussions about billing and reimbursement policy for telehealth visits with health plan partners.



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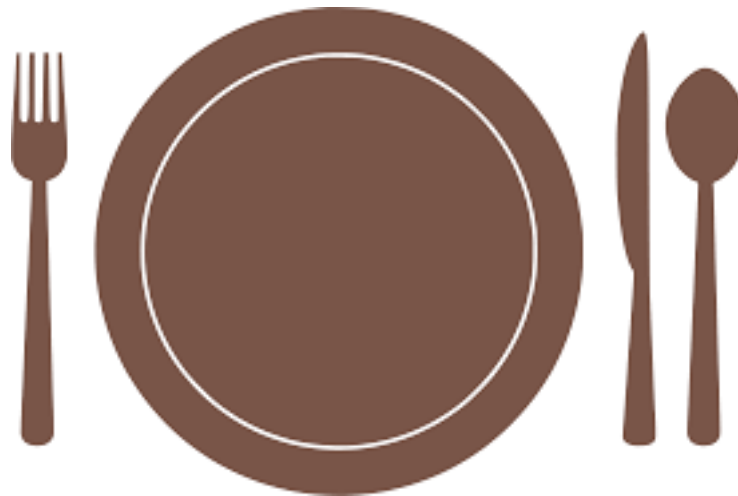


A Public Entity

Inland Empire Health Plan



Lunch



Q1: ACTIVITIES

- *To what extent were the SMTSN elements implemented?*
- *Which features of the initiative contributed to impact?*

Q2: CHALLENGES AND FACILITATORS

- *What are the barriers/facilitators to telehealth? To SMTSN?*

Q3: OUTCOME

- *What was the impact of the initiative on telehealth utilization? Wait time among telehealth users?*

Our evaluation aims to answer several research questions

Q4: ADDITIONAL COSTS

- *What additional costs were incurred by the health centers to implement and maintain increased volume of telehealth?*

Q5: SUSTAINABILITY

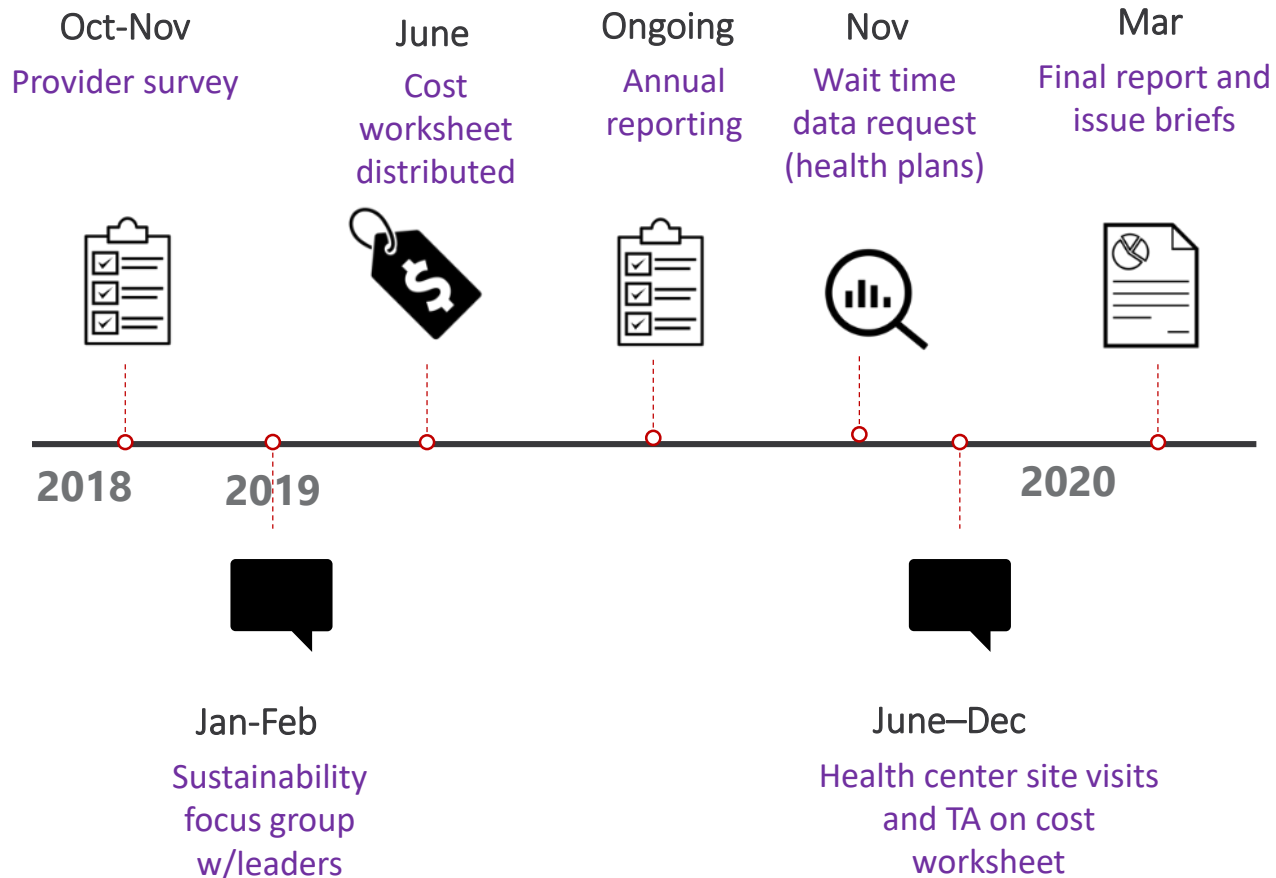
- *How can the initiative be sustained in health centers?*

Q6: LESSONS LEARNED

- *What lessons were learned from the initiative?*
- *What are the implications for replication and scale-up?*

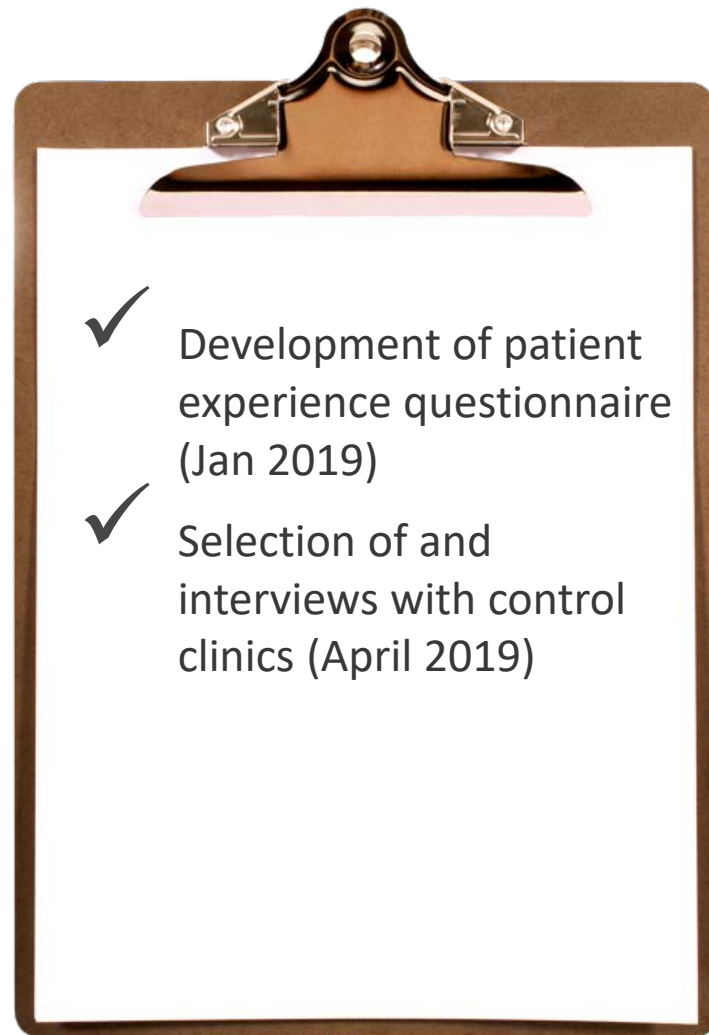
EVALUATION TIMELINE

Activities that involve SMTSN stakeholders

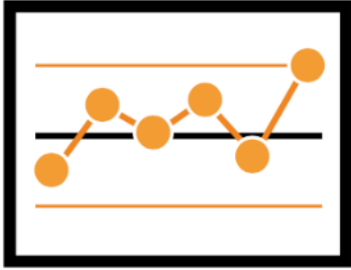




Additional RAND evaluation activities



What's Next? Program Updates



Submit
Monthly Data



Check Ins
with Jeanne



Progress
Report



Training
Requests



Provider
Surveys



Telehealth Coordinator Online Training Modules

This eTraining provides an introduction to key concepts and resources to assist Telehealth Coordinators in building the knowledge and skills needed to successfully fill their role. It can also be used as a refresher course for those looking to revisit core information and/or update their skills.



Visit: www.telehealthtrain.org

2019 Telehealth Summit

SAVE THE DATE: May 21-23, 2019
Hyatt Regency Mission Bay, San Diego





Peer-to-Peer Problem Solving Sessions



Each participant that's sharing has 12 to 15 minutes for their challenge

- 3 to 4 minutes to describe the challenge
- 1 to 2 minutes to answer clarifying questions
- 5 to 7 minutes to listen to group brainstorm ideas
- 1 to 2 minutes to summarize ideas

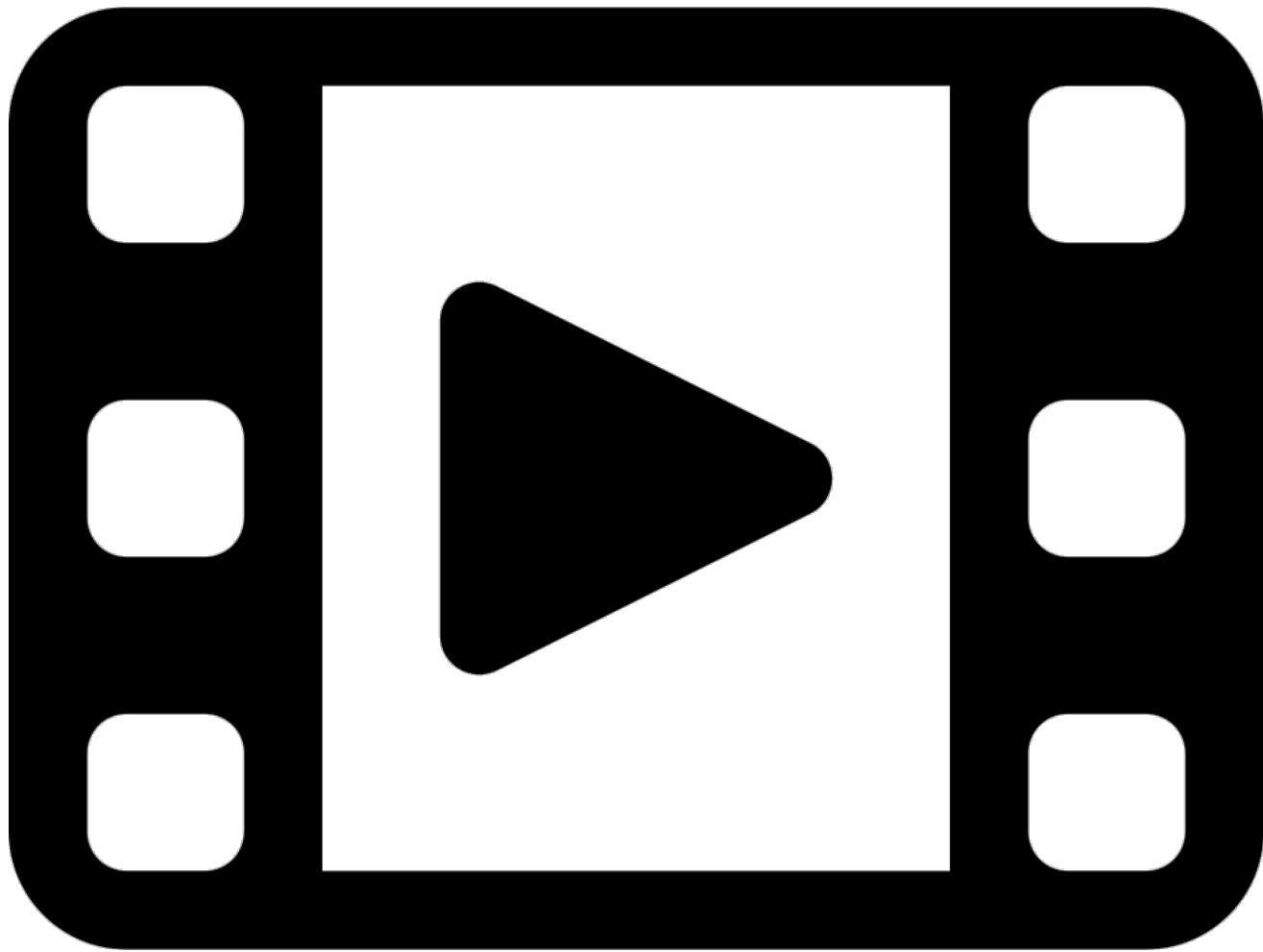
Take a break!





Talking about Telehealth: Inspiring Change Through Storytelling

Cyndee Lake, Chief Purpose Officer & Co-Founder,
Blank Page





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Thank you!

Please fill out the evaluation form