Telehealth in Medicare: What It Is and Isn't (Jurisdictions B & C)

Length: 13:45
Date Recorded: 08.17.2018

Hello and welcome to a special edition of Medicare Minute MD[SM]. I'm Dr. Robert Hoover, Medical Director at CGS Administrators, LLC (CGS) the Jurisdiction C DME MAC. This special video segment is produced in collaboration with Noridian Healthcare Solutions, the Jurisdiction A and D DME MAC.

Today, I'm going to talk about Medicare's rules for telehealth. I'll also cover some of the pitfalls of doing telehealth for physicians and non-physician practitioners that may have been approached by marketing companies working with DME suppliers.

Throughout this presentation you'll note that I'll be careful in my use of the terms "telehealth" and "telemedicine." I'll use the word "telehealth" in reference to interactions with a Medicare patient. Telehealth is a specific benefit in Medicare. I'll use the term "telemedicine" to describe the more general concept of interacting with a patient via other than a face-to-face encounter.

Medicare pays for a limited number of Part B services furnished by a physician or practitioner to an eligible beneficiary via a telecommunications system. For eligible telehealth services, the use of a telecommunications system substitutes for an in-person encounter. There are multiple arrangements possible for telehealth services, some legally complaint and some not legally compliant. The Centers for Medicare & Medicaid Services published an excellent MedLearn Matters article in February 2018 that discusses when Medicare will reimburse physicians and non-physician practitioners for telehealth encounters. The MLM article summarizes the Medicare rules around telehealth, the practitioners at the distant site that are qualified to bill for telehealth visits and the services that are eligible for reimbursement under telehealth. That MLM article and additional information about telehealth are available on the CGS web site where you accessed this video.

Let's go over some of the key points of Medicare's telehealth rules. First, and maybe the most important, is that a qualified telehealth visit involves more than just a phone call with the beneficiary. As a condition of payment, you must use an interactive audio and video telecommunications system that permits real-time communication between you, at the distant site, and the beneficiary, at the originating site. Asynchronous "store and forward" technology, the transmission of medical information that the physician or practitioner at the distant site reviews at a later time, is permitted only in Federal telemedicine demonstration programs in Alaska and Hawaii.

So what do the terms "originating site" and "distant site" mean? An originating site is the location of an eligible Medicare beneficiary at the time the service furnished via a telecommunications system occurs. Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in either:

- A county outside of a Metropolitan Statistical Area or MSA; or,
- A rural Health Professional Shortage Area or HPSA located in a rural census tract.

The Health Resources and Services Administration determines HPSAs, and the Census Bureau determines MSAs. You can access HRSA's Medicare Telehealth Payment Eligibility Analyzer to determine a potential originating site's eligibility for Medicare telehealth payment.

Entities that participate in the Alaska and Hawaii telemedicine demonstration project approved by (or receiving funding from) the Secretary of the U.S. Department of Health & Human Services as of December 31, 2000, qualify as originating sites regardless of geographic location.

Each calendar year, the geographic eligibility of an originating site is established based on the status of the area as of December 31st of the prior calendar year. Such eligibility continues for the full calendar year.

On your screen now you'll see the sites authorized by law as originating sites. Note that this is a discrete list and only the sites listed are authorized by Medicare to serve as originating sites.

The distant site is the location of the practitioner who is evaluating the beneficiary for their medical condition. For example, let's say you're an internist in a rural location that's in a county outside of an MSA – a qualified originating site. You're seeing a patient with an unusual skin condition and you'd like to consult with a dermatologist. Both you and the dermatologist have established a secure video and audio system and you, the beneficiary and the dermatologist have a consult. This would qualify as a telehealth visit under Medicare because:

1. There's a qualified originating site;
2. There's a qualified distant site practitioner; and,
3. You used both audio and video technology to conduct the visit.

As you can see, there are specific conditions that must be met in order to have a qualified telehealth visit and bill those services to Medicare. Now let's turn to some examples of visits that do not qualify as telehealth services.

If you watch any television lately you've probably gotten tired of the commercials advertising back and knee braces "at no cost to you, if you qualify." These ads provide a 1-800 number and tell you to "Call now to see if you are eligible for a knee or back brace." So you might ask "Dr. Hoover, what does this have to do with telehealth?"

Nothing and everything. I'll explain. First let's talk about a common telemedicine arrangement with which you might be familiar.

Today we're all busy, often without enough time to visit our doctor for minor ailments like a sore throat or a skin rash. Enter a telemedicine company. A typical telemedicine company has contracts with many physicians who practice in multiple states. The telemedicine company contracts with, and is paid by, either:

1. Self-funded employers that pay a membership fee for their employees; or,
2. Health plans, for the benefit of their subscribers; or,
3. Patients who pay a per-visit fee.

These arrangements are growing in number and you may even offer this option as part of the benefits package for your employees.

Now let's go back to that commercial for the back and knee braces. In some of these arrangements, there are 3 entities involved:

1. A lead generation company; and,
2. A telemedicine company that enters into 1099 independent contracts with physicians; and,
3. A DME supplier.

These telemedicine companies and their contracted physicians are NOT paid by employers, health plans or patients – but rather – are directly or indirectly paid by the DME supplier, the one dispensing the braces and billing Medicare.

On your screen now follow with me as I describe one of these arrangements. The first graphic shows the workflow. A second graphic will follow the payments:

First, the beneficiary calls the 1-800 number established by the lead generation company.

The lead generation company sends the leads to the telemedicine company and the DME supplier.

The telemedicine company contacts the beneficiary (or interested party) and schedules a phone call with a physician contracted with the telemedicine company.

After this encounter, the physician signs an order for braces.

The telemedicine company sends the orders to the DME supplier.

And the DME supplier mails the brace to the patient.

In this next graphic, you'll see where the payments are going.

Following a call from the beneficiary or interested party, DME supplier purchases leads, in other words the names and contact information of Medicare beneficiaries, who have contacted the 1.800 number provided by the lead generation company.

That payment funds the lead generation company who then pays a portion to the telemedicine company.

The telemedicine company then pays their contracted physicians to contact the beneficiary, have a phone conversation and generate the prescription.

The DME supplier obtains the prescription, bills Medicare for the brace and the beneficiary for the Medicare co-pay.

While there are a number of variations of this example, in the end the DME supplier is paying the ordering physician.

So you might ask "What's wrong with this arrangement?" Several things. First, this type of arrangement does NOT meet the Medicare telehealth statutory benefit requirements. The telemedicine physician is simply making, or taking, phone calls to and from beneficiaries from all over the country. There is no video component to the encounter and no regard for originating site restrictions. In some cases, the lead generation company has completed a "screening interview" with the beneficiary and the physician is simply signing off on those notes.

Second, in these types of arrangements, the ordering physician does not bill Medicare for the audio encounter. If a claim IS billed, in the event of a Medicare audit, the claim would likely not be paid since it was not a valid telehealth service.

Finally, many of the types of braces prescribed, as detailed in the DME MAC local coverage policies, require a face-to-face visit with the patient in order to perform physical exam maneuvers on the impacted joint or area of the body. A simple phone call to obtain subjective information from the patient without an accompanying examination does not meet the requirements for most braces paid for by Medicare.

So let's review what I've covered here.

First, a qualified Medicare telehealth visit has requirements for the type of contact with the patient – audio and video system capabilities. There must be a qualified originating site, a qualified distant site practitioner type and a qualifying encounter type.

Second, in a proper telemedicine arrangement, the ordering physician does not receive any compensation, direct or indirect, from a DME supplier. Furthermore, the telemedicine company gets paid for its services from either self-funded employers that pay a membership fee for their employees, a health plan that offers telemedicine to its subscribers, or patients who pay a per-visit fee. Said another way, in a proper arrangement, there is no direct or indirect financial relationship between the person or entity ordering the product (i.e., the ordering physician) and the entity furnishing the product (i.e., the DME supplier).

So the bottom line is this: Physicians considering telemedicine contracting arrangements should enter into these agreements with care. In this video, I've covered the Medicare requirements for

telehealth and the common schemes that may cause you to run afoul of the Medicare statutes. There may also be state laws that govern the practice of telemedicine in your state and the states where you may be consulting with patients. For example, some states require that the treating practitioner personally maintain patient records, obviously in a secure, HIPAA compliant manner and for a specific amount of time – 7 years for Medicare. With some telemedicine arrangements, the records of patient encounters are maintained by the telemedicine entity, which may or may not, comply with your state laws. Even in legitimate telemedicine or Medicare-compliant telehealth arrangements, if you do not control your patient records, you may have difficulty obtaining the records and justifying your billing to Medicare in the event of an audit. Not properly maintaining and providing access to your records to Medicare may result in the possible revocation of your billing privileges to Medicare and termination of Medicaid billing eligibility. Engagement of an attorney knowledgeable in healthcare matters may be warranted before entering into telemedicine arrangements.

That does it for this edition of Medicare Minute MD[SM]. As with all of CGS' educational offerings, this is only a summary of certain policy requirements. I encourage you to read the MedLearn Matters article and the other materials on Medicare's telehealth benefit that I've posted on our CGS website.

Thank you for watching and have a nice day.

