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What's Happening in Telehealth Policy?

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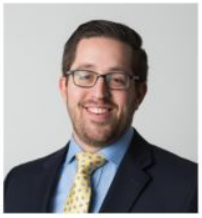
Presenters



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Tim Swinfard
Chief Executive Officer
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Agenda

1. A federal policy update
2. Update on National Council activities and priorities for 2019
3. Discussing the provider perspective

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Telemental Health and Telepsychiatry

1. Creating a physician-patient relationship via telemedicine
2. Use of telepsychiatry for Baker Act/involuntary commitment at hospitals
3. Billing opportunities in Medicare and via virtual check-ins

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Establishing a Doctor-Patient Relationship

- Establishing a valid doctor-patient relationship is important because a valid relationship is required prior to a physician issuing an Rx.
- What constitutes a valid doctor-patient relationship varies from state to state.
- Many states do not require an in-person examination to establish a physician-patient relationship.

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Doctor-Patient Relationship

Some states explicitly allow a physician-patient relationship to be established via telemedicine, e.g., Kansas. HB 2028, § 3(b).

- The next question is what modality is required to establish the relationship via telemedicine.
- Kansas, for example, requires that telemedicine be provided by means of real-time, two-way interactive audio, visual, or audio-visual communications, including the application of secure video conferencing or store-and-forward technology. HB 2028, § 2(a)(5).

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Doctor-Patient Relationship

- A number of states' laws and rules do not address whether telemedicine may be used to establish a physician-patient relationship, e.g., **Michigan**.
  - Similarly, Michigan's laws and rules are silent as to required modality.
- **Iowa**: physicians may establish a valid physician-patient relationship "through telemedicine, if the standard of care does not require an in-person encounter, and in accordance with evidence-based standards of practice and telemedicine practice guidelines that address the clinical and technological aspects of telemedicine." Iowa Admin. Code r. 653-13.11(7)(b).
- Iowa's laws and rules do not address what modality is required to establish the physician-patient relationship.

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Baker Act FAQs

- In **Florida**, telemedicine may be used to form the basis of a professional certificate initiating a Baker Act involuntary examination provided an examination of the person within the preceding 48 hours (whether in person or by telemedicine) and must conclude that the individual meets criteria for examination. *See* F.S. §394.455.
- Telemedicine may be used by staff of a Baker Act receiving facility to:
  - Conduct the "initial mandatory involuntary examination".
  - Form the basis of a second opinion supporting involuntary inpatient placement.
- Telemedicine may NOT be used by staff of a Baker Act receiving facility to:
  - Form the basis of a *first* opinion supporting involuntary *inpatient* placement.
  - Form the basis of a *first or second* opinion supporting involuntary *outpatient* placement.

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Baker Act FAQs

Telemedicine may be used by staff of an ED to authorize a patient's release from involuntary examination under the following circumstances:

- The ED is part of a Baker Act receiving facility, the patient's release must be authorized by a psychiatrist, clinical psychologist, or ED attending physician.
- The ED is not part of Baker Act receiving facility, then release may be authorized by any physician. No receiving facility needs to be involved.

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Virtual Check-Ins

- The Centers for Medicare and Medicaid Services (CMS) final rule for the 2019 Physician Fee Schedule introduced a new code: Virtual Check-Ins, officially titled "*Brief Communication Technology-Based Service*". 83 F.R. 59452 (Nov. 23, 2019).
- On Jan. 1, 2019, Medicare started covering virtual care services.
- HCPCS code: G2012.
- Virtual Check-In is defined as: "Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management (E/M) services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion).

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Virtual Check-Ins

- Modality: The code allows audio-only real-time telephone interactions in addition to synchronous, two-way audio interactions that are enhanced with video or other kinds of data transmission.
- Co-Payment: As a Medicare Part B service, the patient is responsible for a co -payment for the service.
- Consent: Patient consent is required for this service, due in part to the fact that there is a patient co-pay.
- Patient Restrictions: CMS limits this code to established patients only.
- Care Delivery: Only physicians and qualified health care professionals are allowed to bill for this service.
- Frequency Limits: None.

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Virtual Check-Ins

- Documentation Requirements: consistent with the requirements for other Medicare covered physician services.
- Location Requirements: The patient need not be located in a rural area or any specific originating site; the patient can be at home.
- Timeframe Limitations:
  - If the Virtual Check-In originates from a related E/M service provided within the previous 7 days by the same physician or other qualified health care professional, then the service is considered bundled into that previous E/M service and G2012 would not be separately billable (provider liable).
  - If the Virtual Check-In leads to an E/M service with the same physician or other qualified health care professional within the next 24 hours or soonest available appointment, then this service is considered bundled into the pre- or post-visit time of the associated E/M service, and therefore, would not be separately billable (provider liable).

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SUPPORT for Patients and Communities Act (H.R. 6)

- Beginning on July 9, 2109, Medicare coverage of telehealth services will extend to beneficiaries in their homes as to only beneficiaries who reside within certain geographic rural areas and who seek such services at specific "originating sites," which excludes the beneficiary's home.

42 U.S.C. § 1395m.

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SUPPORT for Patients and Communities Act (H.R. 6)

- The Act **eliminated coverage restrictions** for an eligible telehealth individual with a substance use disorder diagnosis for purposes of treatment of such disorder or co-occurring mental health disorder.
- The result is that care providers may now be reimbursed for providing eligible substance use disorder services to Medicare beneficiaries in their homes via telehealth.

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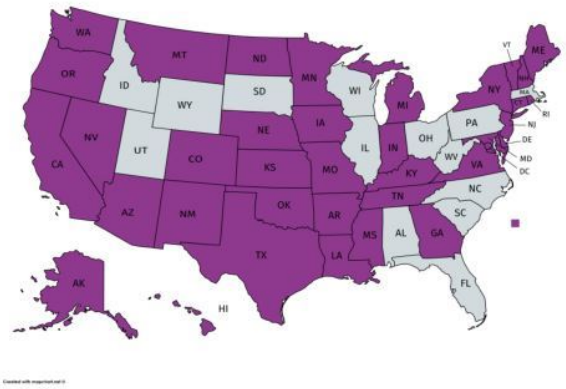
Telehealth Commercial Insurance Laws



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Thank you

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Ryan Haight and the National Council

- The Ryan Haight Act prohibits the dispensing of controlled substances via the internet
- Exceptions:
  - Prescriber previously conducted at least one in-person medical evaluation of the patient.
  - Registered at a hospital/clinic

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Ryan Haight and the National Council

- **Special Registration for Telemedicine Act of 2018**
  - Requires the Drug Enforcement Administration (DEA) to activate a special registration to allow community mental health and addiction treatment centers to register with DEA to provide controlled substances.

Cheri Bustos (D-IL)

Buddy Carter (R-GA)

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Ryan Haight and the National Council

- **Improving Access to Remote Behavioral Health Treatment Act of 2018**
  - Would increase access to medication-assisted treatment (MAT) at community behavioral health clinics in underserved areas through Ryan Haight.
  - Would add community mental health center to definition of "hospital or clinic" under Ryan Haight Act.

Doris Matsui (D-CA)

Gregg Harper (R-MS)
Retired

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Ryan Haight and the National Council

- **Next Steps**
  - DEA execution of Special Registration for Telemedicine Act of 2018
  - Reintroduction of Improving Access to Remote Behavioral Health Treatment Act of 2018
  - Working with members on state-by-state basis to learn more

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Tim Swinfard, CEO
Compass Health Network

Compass Health Network

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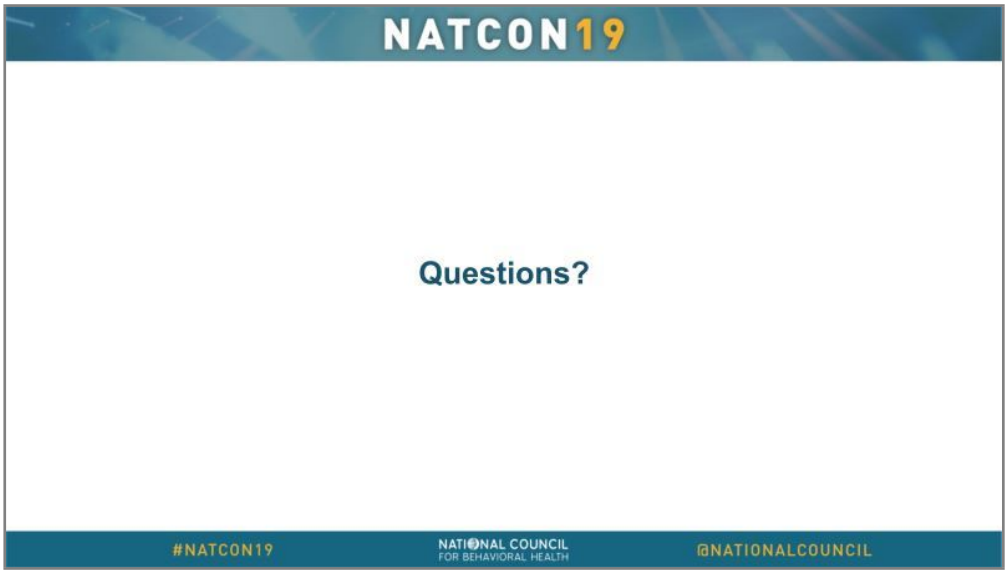
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Questions?
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