East Carolina University

The Telemedicine Center East Carolina University

ECU Telehealth history

- First consult in 1992
- Expansion to cover rural hospitals -1994 – Roanoke Chowan Hospital, Ahoskie & Chowan Hospital, Edenton
- First Emergency / Trauma Links in Regional Southeast US -1996 - Pungo Hospital & Naval Hospital in Camp Lejeune
- Advanced Telemedicine Training Center with more than 600 attendees representing 28 countries from 1997
- "Center of Excellence" status by University of North Carolina General Administration since 1999
- First Residency School for Special Needs Children in US. 2001, Eastern NC School for the Deaf, Wilson

BRODY SCHOOL OF MEDICINE East Carolina University

ECU Telehealth Clinical Applications

- Dermatology
- Pediatric & Spec Services
- Cardiology Adult & Pediatric
- Mental Health/ Psychology
- Pulmonary
- Rheumatology
- Gastroenterology
- Internal Medicine
- Endocrinology/ Diabetic
- Rehab/ TBI Clinic/ Wound Management
- High Risk OB
- Neurology
- Radiology
- OB/High Risk/ NCIU "Hello Mommy"
- Home Health Care

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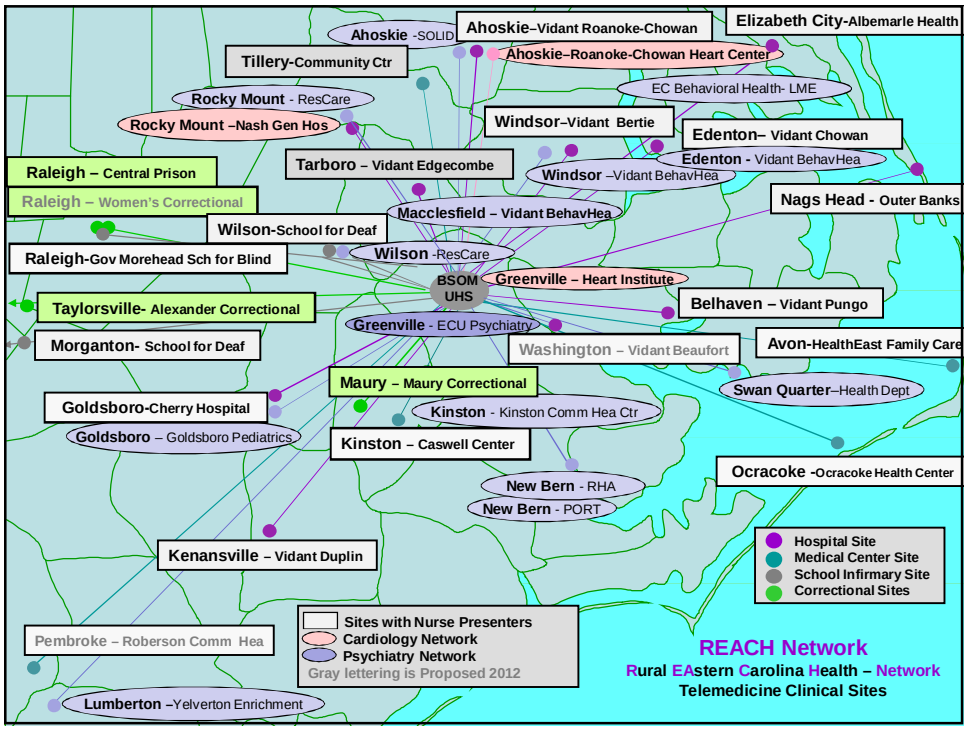


NC Medical Board TM Policy Statement

"Telemedicine" is the practice of medicine using electronic communication, information technology or other means between a licensee in one location and a patient in another location with or without an intervening health care provider…. telemedicine is a potentially useful tool that, if employed appropriately, can **provide important benefits to patients, including: increased access to health care, expanded utilization of specialty expertise, rapid availability of patient records, and the reduced cost of patient care**….licensees practicing via telemedicine will be held to the **same standard of care as licensees employing more traditional in-person medical care**.

NC Medical Board Policy Statement

Examinations— Licensees using telemedicine technologies to provide care to patients located in North Carolina must provide an appropriate examination prior to diagnosing and/or treating the patient. However, this examination need not be in-person if the technology is sufficient to provide the same information to the licensee as if the exam had been performed face-to-face.
Other examinations may also be considered appropriate if the licensee is at a distance from the patient, but a licensed health care professional is able to provide various physical findings that the licensee needs to complete an adequate assessment.

Reimbursement Set by CMS

Medicare reimbursement expanded when Congress passed the *Balanced Budget Act of 1997* (BBA), which mandated that Medicare reimburse telehealth care to follow set criteria.

CMS guidelines for payment include:

- **Where**: Originating (patient) sites must be in a HPSA or county outside of MSA
- **Who**: Distant site practitioner may be a MD, NP, PA, Nurse Midwife, CNS, CP CSW, Dietitian or Nutritionist
- **What**: List of professional services furnished via telehealth is limited but extended greatly in the last six years
- **How** : Telehealth use must be interactive audio and video; exception is only within Alaska or Hawaii where "store and forward" is allowed

CMS eligible originating sites

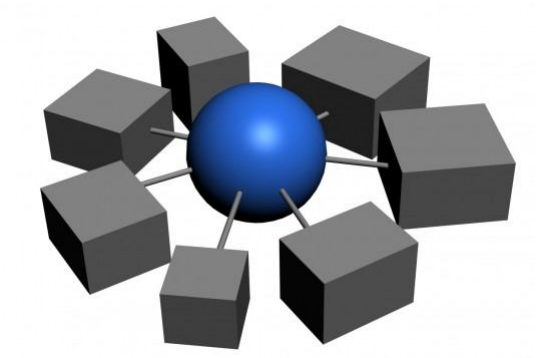
- **The offices of physicians or practitioners**
- **Hospitals**
- **Critical Access Hospitals (CAH)**
- **Rural Health Clinics (RHC)**
- **Federally qualified Health Centers**
- **Hospital-based or CAH-based Renal Dialysis Centers**
- **Skilled Nursing Facilities (SNF)**
- **Community Mental Health Centers (CMHC)**

Note : Independent Renal Dialysis Facilities are not eligible originating sites at this time. No site within an urban area or Non HPSA originating site

CMS Billable Codes for Telehealth

Telehealth (TH) consultations, emergency department or initial inpatient	G0425 – G0427
Follow-up inpatient TH consultations furnished within hospitals or SNFs	G0406 – G0408
Office or other outpatient visits	CPT 99201 – 99215
Subsequent hospital care services, with the limitation of 1 TH visit every 3 days	CPT 99231 – 99233
Subsequent SNF services, with the limitation of 1 TH visit every 30 days	CPT 99307 – 99310
Individual and group kidney disease education services	G0420 – G0421
Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training	G0108 – G0109
Individual and group health and behavior assessment and intervention	CPT 96150 – 96154
Individual psychotherapy	CPT 90804 – 90809
Pharmacologic management	CPT 90862
Psychiatric diagnostic interview examination	CPT 90801
End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment	CPT 90951, 90952, 90954, 90955, 90957, 90958, 90960, & 90961
Individual and group medical nutrition therapy	G0270 and CPT 97802 – 97804
Neurobehavioral status examination	CPT 96116
Smoking cessation services	G0436, G0437 and CPT 99406, 99407

The Hub and Spoke Model



http://www.themarketingbit.com/infographics/infographics-17-traffic-building-tips/

NC Hub vs Spoke Reimbursement

Payer	Part B (Hub)	Part B (Spoke)	Part A (Hub)	Part A (Spoke)
Medicare & Medicaid	Yes, but limited	Yes	No	Yes
Tricare	Yes	Yes	No, unless contracted	Yes
BC/BS	Yes	Yes	No	Yes
Other commercial	Yes	Yes	No	Yes, but not all

Cloud Telehealth (Direct Access Model)

http://www.techiemum.com/2012_06_01_archive.html

Home monitoring

Home monitoring is a data transfer from a medical device without interactive video/audio. Home monitoring is under the Telehealth umbrella but follows separate billing and reimbursement.

- Proven to decrease readmissions
- Reimbursable rural or urban
- Ideally better health outcomes
- Requires little infrastructure & equipment at home

Licensure and Credentialing

- Health professional must be licensed within the state where they wish to administer care
- State Medical Boards or Specialty Boards are granted the right to regulate or refuse use of telemedicine
- July 2011 CMS Ruling allows that the telehealth provider only be credentialed once within the state to extend services to multiple sites as long as:
  - ✓ Provider entity has a Business Agreement in place with patient site
  - ✓ And provider performs no "in-person" services at that site

ECU Telehealth Outcomes

- High patient satisfaction (92% >)
- Increased Physician/Healthcare provider usage
- Patient convenience
  - Reduced travel
  - Less time away from work/school
  - More accessible from and with local healthcare entities
- Patient compliance
  - e.g. better show rates for TH visits
  - 7 - 10% general no-show rate for all TH as compared to 35 – 42% No Show rate (TBI percentages)
- Continuity of care
  - Referring MD or practitioner in the loop
  - Faster turnaround of consultant's findings

TeleHealth

promoters	inhibitors
ACA and Federal Programs	Infrastructure still not universally available
Decrease in readmission/home monitoring	Reimbursement
At home triage (ED relief)	Workload integration
Manpower redistribution	Regional physician availability and interest
System cost savings	Rural health restrictions
Enhance access to specialty services	Concerns about quality
Technical advances address interoperability, record integration and mobility	Licensing and prescribing issues
Reduction in length of hospital stays	Ability of patients to directly access
24/7 virtual doctor visits	Not all systems integrated
Use in training, education and supervision	Lack of TM protocols and guidelines

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Thank you.