Telenutrition – An Ever Changing Journey

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Learning Objectives

Route For Our Telenutrition Journey

- Define Telehealth and Telenutrition
- Explain the rational for Telenutrition Services
- Identify the approved methods of Telenutrition
- Explain Telenutrition laws and requirements
- Describe the documentation and billing processes
Start of Telehealth
Start of Telenutrition

Mary Ann Hodorowicz, MBA, RD, LDN, CDE
Joanne Shears, MS, RD, LN

- Presented in 2012
- Called for:
  - more research
  - more publications
Published Research on Telenutrition
Peer Reviewed Journals & Academic Journals (EBSCO)

2012
- Tele-medicine = 5,167
- Tele-pharmacy = 24
- Tele-nutrition = 0

2016
- Tele-medicine = 7,423
- Tele-pharmacy = 36
- Tele-nutrition = 3
Direction of Telehealth

The use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration. Telehealth will include both the use of interactive, specialized equipment, for such purposes as:

- health promotion
- disease prevention
- diagnosis, consultation therapy
- nutrition intervention /plan of care
- non-interactive (or passive) communications

- over the Internet, video-conferencing, email or fax lines, and other methods of distance communication for broad-based nutrition information.

Academy of Nutrition and Dietetics
Where is this journey leading us?
Telecare

Remote monitoring of an individual’s condition or lifestyle in order to manage the risks of independent living.

Designed for people with social care needs.

- Automatic movement sensors
- Fall sensors
- Bed Occupancy sensors
Our Telenutrition Direction

The interactive use, by a RD or RDN, of electronic information and telecommunications technologies to implement the Nutrition Care Process:

- Nutrition assessment
- Nutrition diagnosis
- Nutrition intervention/plan of care
- Nutrition monitoring and evaluation

- with patients or clients at a remote location, within the provision of their state licensure as applicable.

Academy of Nutrition and Dietetics
Updated CMS Provisions

- Permit hospitals and CAHs to implement new credentialing and privileging process for physicians and practitioners providing telehealth services.

- **Removal of unnecessary barriers** to telehealth may enable patients to receive medically necessary interventions in a more timely manner.

- **Enhanced patient follow-up in the management of chronic disease conditions.**

- Provide more flexibility to small hospitals and CAHs in rural areas and regions with limited supply of primary care and specialized providers.
A Direction of Progress

Improved
- Nutrition and health outcomes
- Quality of care
- Quicker diagnosis and treatment
- Access
- Revenue
- Patient involvement
- Collaboration

Decreased
- Cost
- Service duplication
- Travel
- Hospitalization
- Reduced professional isolation
Telenutrition Opportunities

- Face to Face audio visual medium
- Tele-buddy monitoring systems
- Video learning modules
- Mobile applications
- Phone calls
- E-mail

REDUCE BARRIERS
Potential Revenue & Documented Productivity

Based on 10 outpatient dietitians

Each RDN spends ~2 hours per week communicating with patients via phone or email.

\[
\begin{align*}
20 \text{ hrs/wk} & \times 4 \text{ wks/m} = 80 \text{ hr/m} \\
& \times 320 - 15 \text{ min. increments} \\
& \times $25.00 \\
& = $8,000 \text{ per month}
\end{align*}
\]

Transition “No show” and “Cancellation” appointment time.

\[
\begin{align*}
5 \text{ app/wk} & \times 4 \text{ wk/m} = 20 \text{ app/m} \\
& \times 80 - 15 \text{ min. increments} \\
& \times $25.00 \\
& = $2,000 \text{ per month}
\end{align*}
\]

100 hrs/m in documented productivity. ~$120,000 per year in potential revenue.
Methods of Telenutrition I

**Real-time communication = Synchronous**

- The **primary method** of Telenutrition

- Consists of practitioner and patient **present at the same time**, but in different locations.

- Requires two sites:
  - “originating site”- location of the patient
  - “distance-site”- location of practitioner

- **Live**, interaction video conferencing requires **high quality**, **reliable**, and **secure** telecommunications.
Methods of Telenutrition II

**Store and Forward = Asynchronous**

- Transmission of data or records
- Forms of education
  - Prepared learning modules
  - Interactive education modules
  - Prerecorded teaching video
- Aids to promotes the client’s self-care behaviors
Technology For Telenutrition

- Broadband Internet - reliable rate of data transmission
- Encrypted internet connection to prevent interception
- Business grade videoconferencing
HIPAA Considerations

- **Encryption**: for securing the chat sessions and the voice and video phone calls for the safe transmission of **ePHI**.
- **Wire Tap**: the need for a platform that can prevent wire tapping.
- **Business Associate Agreement (BAA)**: an agreement with providers that you used for your ePHI is a requirement of HIPAA.

**HIPAA Requirements**:
- Provide archives of chats.
- Provide audit trails of usage.
- Provide notifications in case of a breach.
- Provide administrative emergency access to previous chat histories.
HIPAA Security:
Sets national standards for the security of electronic protected health information

Compliant Software
- Vsee
- Secure Video
- Vidyo
- Hipaachat
- Talk to an Expert

Non-Compliant Software
- Skype
- FaceTime
Controlled Environment

- Whenever possible utilize a designated Telehealth space.
- Ensure adequate lighting and sound.
- Remove all clutter.
- Check in your rearview mirror.
Telenutrition Travel Buddies

**System-wide**
- Current Telehealth administrators
- Compliance
- Coders & Finance
- Schedulers
- Information Technology Services
- Patient Education Services
- Communications/Marketing

**Project team**
- Project Sponsor
- Project Owner
- MD Champion
- Facility ITS
Travel Equipment & Supplies?

- Gap Analysis
- Complexity Analysis
- Strategic Plan
State Telemedicine Gaps Analysis – Coverage & Reimbursement
### Telemedicine in New Mexico

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<th>PARITY</th>
<th>Private Insurance</th>
<th>Medicaid</th>
<th>State Employee Health Plan</th>
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**Medicaid**
- True parity under NM Medicaid for FFS and managed care plans.
- All services are covered via telemedicine including school-based, dental, home health, hospice, and rehabilitation.
- 1 of 3 states with coverage for services provided by a behavioral analyst. These specialists are critical for the treatment of autism spectrum disorders.
- No limits on patient setting.
- No coverage for phone calls or remote patient monitoring.
- No coverage for skilled nursing therapies, or RPM under home health benefit.

**Innovative Payment or Service Delivery Models**
- State-wide Network
- Medicaid Managed Care
- Medicare-Medicare Dual Eligibles
- Health Home
- HCBS Waiver
- Corrections
- Other

### Telemedicine in New York

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**Medicaid**
- Bordered by VT which has a parity law.
- No telemedicine parity law despite a multi-year effort to introduce legislation regarding coverage under private insurance and Medicaid.
- Medicaid imposes restrictions on the patient settings (includes home and school), covered services and designates eligible distant site providers (physician specialists and certified diabetes and asthma educators) as a condition of payment.
- It also prescribes eligible distant site provider settings.
- Coverage for interactive audio-video only.
- Remote patient monitoring covered under home health benefit.

**Innovative Payment or Service Delivery Models**
- CMS approved duals proposal includes coverage for telemedicine.
- CMS approved health home proposal gives providers the option to use technology conferencing tools including audio, video, and/or web deployed solutions to support care management/coordination activities.
Licensure Provision

- RDs or RDNs in states without licensure laws must be credentialed and privileged by the traditional route, by each hospital in which they practice.

- Practitioners providing patient care services in other states must be licensed and/or meet other applicable standards that are required by state or local laws in both the state where the practitioner is located and the state where the patient is located.
Authorized Distant Site Practitioners

- Physicians
- Physician assistants
- Nurse practitioners
- Nurse midwives
- Clinical nurse specialist
- Clinical nurse anesthetists
- Clinical psychologist
- Clinical social workers
- REGISTERED DIETITIANS OR NUTRITION PROFESSIONALS.
Authorized Originating Sites

- Physician or practitioner offices
- Hospitals
- Critical Access Hospitals
- Rural Health Clinics
- Federally Qualified Health Centers
- Renal Dialysis Centers (Hospital or CAH-based)
- Skilled Nursing Facilities
- Community Mental Health Center
- Check with commercial payers
Verify Locations

- Medicare reimburses for Telehealth services when the originating site (where the patient is) is in a **Health Professional Shortage Area** (HPSA) or in a county that is outside of any **Metropolitan Statistical Area** (MSA).

- Patient location matters
  - It’s not the distance from the provider
  - Healthcare provider shortage area
  - Population of an area

- Location Finder
Site of Service

- Verify that the Site of Service is the same between the originating site and the distance site.
  - How the space is licensed? **Check with your Operations Officer.**

- **SOS 11 - Physician Office Space**
- **SOS 19 – Off-campus Outpatient Hospital Space**
  - A portion of an off-campus hospital diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization
- **SOS 22 – Outpatient Hospital Space**
  - A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
Who’s paying for this journey?
CPT Codes

- CPT codes are owned and written by The American Medical Association
  - Physicians are providing a service and need a corresponding code for billing.
- New codes are approved by
  - Demonstrated improved outcomes
  - Lobbying
  - Government mandate

- CMS uses CPT codes & creates their own codes
  - G codes
    - Modifiers
    - Restrictions
    - Clarifiers
Billing ≠ Reimbursement

- Just because you have a CPT code doesn’t mean you’re going to get reimbursed.

- If you bill an insurance company or CMS and you are not reimbursed you must bill the patient.
  - Medicaid is the exception.

- Medicare will only pay for “face-to-face,” interactive video consultation services where the patient is present.
Medical Nutrition Therapy Codes

Face to Face Interaction
- 97802 - Nutrition Assessment
- 97803 - Nutrition Follow-up
- 97804 - Group Medical Nutrition Therapy

Telephone Interaction
- 98966 - (5 - minutes)
- 98967 - (11 - 20 minutes)
- 98968 - (21 - 30 minutes)

Email only
- 98969 - Online assessment and management service provided by a qualified non-physician health care professional, internet or electronic communications.

Super-bill
- 99372 - Provider does not submit the bill: clients can submit for reimbursement

Healthcare Common Procedure Coding System (HCPCS)
CPT Code Modifiers

- Telehealth Modifiers - valid when billed with HCPCS codes
  - **GT** – *synchronous* interactive audio and video CPT
  - **GQ** – *asynchronous* telecommunication system - transmission of data
    - Alaska and Hawaii are the only two states approved for asynchronous telecommunication reimbursement.

- **Q3014** - code filed by originating site.
Example - Nutrition Assessment Bill

- Bill simultaneously

- **Q3014** – Local PCP office (originating site) - generates a bill using this code.

- **97802 GT** (GT modifier) - Dietitian generates a bill using this code.
Medicare Codes – don’t use modifiers

- **Billed by Dietitians**
  - G0270 - Medicare- Individual Medical Nutrition Therapy
  - G0406, G0407, G0408 - Follow-up in-patient TeleHealth consultations
  - G0108 and G0109 - Individual and group diabetes self-management training (DSMT) 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
  - G0420 and G0421 - Individual and group kidney disease education (KDE) services

- **Billed by the Primary Care Provider**
  - G0447 - Face-to-face behavioral counseling for obesity
  - G0446 - Annual, face-to-face Intensive behavioral therapy for cardiovascular disease
Billing and Medical Record Documentation Requirements (adapted from AHIMA Practice Brief)

Billing Requirements

- **Time based codes** must have documentation of time.

- Documentation must support the billing codes.

- Codes are not reported if the telephone/Internet discussion lasts less than 5 minutes.
Medical Record Documentation Requirements

- Patient name and Identifiers
- **Patient location**
- Date of service
- Duration of service
- Referring physician
- **Consulting RD/RDN location**
- Type of evaluation performed: Note that the consult was held via Teleservices.
- Informed consent
- Medical Nutrition Therapy note
- Recommendations for further treatment.
- A consultative report should be routed to the referring physician in a timely manner.
- All electronic communications in regards to the consult (faxes, digital pictures, etc.) should be added to the patient’s medical record.
Additional Resources

- [http://www.eatright.org/search?keyword=telehealth](http://www.eatright.org/search?keyword=telehealth)


- [http://ctel.org/](http://ctel.org/)
Opportunities -

“Let’s try it without the parachute.”
“THE DOCTOR OF THE FUTURE WILL NO LONGER TREAT THE HUMAN FRAME WITH DRUGS, BUT RATHER WILL CURE AND PREVENT DISEASE WITH NUTRITION.”

-THOMAS A. EDISON