

# Nebraska Medicine

Summer 2012 | Volume 11, Number 2

## *Telehealth in Nebraska*

Using  
technology  
to improve  
patient access  
to care



Nebraska  
Medical  
Association

*Advocating for Physicians and the Health of all Nebraskans*

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# Why is Telehealth Important to Health Care in Nebraska?

by Joann Schaefer, MD

Chief Medical Officer, State of Nebraska  
Director, Division of Public Health,  
Nebraska Department of Health and  
Human Services

The challenges of practicing medicine in a predominantly rural state are well-known to the providers located in much of Nebraska: healthcare professional shortage areas, a lack of specialists, an aging population, rising chronic disease, patients who must travel many miles for care, a significant dearth of mental health providers.... issues it seems that are long-standing, and discussed often but that also won't resolve themselves in the near future. Regardless of these challenges, physicians must offer the same level of care in rural areas as the patients receive in urban areas.

The topic of this month's NMA magazine is Telehealth, so it's no secret that Telehealth is presented as a solution to some of these ills. Does Telehealth really play a viable role in helping providers enhance the level of care they can provide their patients close to home? Can physicians provide excellent care to a patient if the patient is located

200 miles away instead of in the same exam room? If so, does it work for every situation or just some specialties? Is it a panacea or second-class care?

The answer to the last question is that Telehealth is neither. It will not solve every ill, but it also is far from second-class care. Every year, in Nebraska and across the nation, thousands of patients receive specialty, and sometimes, primary, care through two-way interactive video without leaving their jobs, families and homes.

In Nebraska, it is estimated that over 4,000 clinical consults will be provided by Telehealth this year. These will occur at one of the 117 sites on the Nebraska Statewide Telehealth Network by the 70+ providers who have decided that Telehealth is an effective method for reaching their patients.

In Nebraska, around 67 percent of these will be mental health consults, a blessing for many patients who may not otherwise receive this help. But, the consults will also include chronic disease counseling, geriatrics, neonatology, neurology, nephrology, infectious disease, oncology, orthopedic care, trauma care, wound care, cardiol-

gy, surgery follow-up and other specialty consults. Intake coordinators will help emergency departments determine if a presenting patient needs advanced psychiatric care. Pharmacists will provide Tele-pharmacy services to hospitals that don't have full-time services. A tertiary care center will provide bedside monitoring at critical access hospitals. Compassionate calls will connect a deployed soldier with his wife and baby in the maternity department. Neurologists will begin considering how Tele-stroke care can save lives by going into rural hospital emergency departments through video during the critical minutes when appropriate intervention means the difference between life and death. And, Veterans Affairs will begin a beta-project that will hopefully set the stage for expanding care to rural veterans across Nebraska and across the nation. Many will begin to implement Telehealth on mobile tablets and laptops to allow practitioners to connect with their patients easily and from any location.

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# Telehealth 101:

## *Implementing Telehealth into Your Practice*

by Laura Meyers, BS  
Grant Project Manager

Nebraska currently has over 115 sites connected to the Nebraska Statewide Telehealth Network, including hospitals, health departments, rural health clinics, mental health clinics, physician offices and the State of Nebraska Department of Health and Human Services. With the number and geographical disbursement of these sites, it is easy to find locations for both a physician and his or her patient to engage in Telehealth services with very little travel. The sites are genuinely very welcoming to both and go out of their way to make accommodations to support these interactions. Physicians routinely go to their nearest Telehealth location, many setting up full outreach clinics in which they transition easily between patients located across the state via two-way video.

However, many practitioners, already busy, may find that leaving their office setting during the day is a challenge, making it difficult to truly incorporate Telehealth into their practice. For these practitioners, setting up a Telehealth program in the office would allow an easy transition between the face-to-face patient in one exam room and the Telehealth patient in the next. Physicians may find that using Telehealth either in the hospital or clinic setting actually allows them to expand the number of patients they

are able to accommodate without raising costs, saving their patients precious travel time and money, and perhaps expanding the area they serve.

If this describes you, where should you start?

- **Contact the Nebraska Statewide Telehealth Network**

The Nebraska Statewide Telehealth Network (NSTN) has been in existence since 2005, with many of its organizations boasting Telehealth technologies since the 90s and before. As such, the NSTN has individuals that can help walk you through set-up. You can find a complete list of hub sites at the end of this article.

- **Determine the services you wish to provide via Telehealth.**

While Telehealth lends itself well to most specialties, it doesn't work for every type of consult. Members of the NSTN can discuss with you past successes both within the state and on a national or international level. They can also help provide links to research regarding peripheral devices that may help in effectively diagnosing and treating patients using Telehealth. Telehealth use evolves daily; if it isn't being done currently, it doesn't mean it can't be done. The NSTN needs individuals who will push the boundaries.

- **Determine your target patient population.**

What patients are you trying to serve? Where are they located? With over 115 sites, there is a high likelihood that your patient may be seen at a site very near his or her home. This is especially appealing to patients who

need to be seen only for follow-up care or on a routine basis for chronic disease management. Traveling 15 minutes to the local critical access hospital instead of two hours to your office may result in increased compliance with visits and a higher likelihood that the patient will wish to continue seeing you as a provider. In addition, Telehealth consults may help you supplement outreach clinics you already provide in communities. If you normally see 25 patients when you travel to your clinic, but determine that you can see 10 of these by Telehealth, you may find that your onsite clinic is shortened or that you can increase the number of patients you see while there. In addition, nearly every hospital in Nebraska has Telehealth technology in their emergency department, so if your need is to provide care to the emergently presenting patient, this is an option. Is your patient out-of-state? As long as you are licensed in the state in which the patient is located, the NSTN can get you there.

- **Assess your technology needs.**

Telehealth technology isn't complicated. If you can run a remote control or your smartphone, you can easily initiate Telehealth. Technology ranges from the more "permanent" and more expensive traditional Telehealth camera, which may be mounted on a television, to mobile carts, laptop computers and, finally, to tablets. For the physician office, it is highly likely that laptops computers or tablets may be sufficient for your needs. Desktop, laptop and mobile technologies are relatively

*(continued on Page 4)*



inexpensive, require smaller bandwidth for high definition resolution, meet HIPAA requirements and may fit better into a busy office. The NSTN has recently initiated a grant funded pilot project that helped build the centralized infrastructure needed to allow mobile technology use. If becoming part of the pilot project is of interest to you, please contact one of the individuals listed at the end of this article.

At times, practitioners find that peripheral devices, such as otoscopes and stethoscopes, may help with diagnosis via Telehealth. If you believe that your practice may require peripheral devices, such as otoscopes or stethoscopes, there will be more cost involved. The NSTN can help you locate data on these technologies.

Once you determine the appropriate camera technology for your practice, you will need to consider how you will achieve connectivity. Within the NSTN, sites are connected by dedicated T-1 lines and fiber lines, which can be costly. As desktop and mobile technologies come into practice, organizations find that they can utilize existing internet connectivity, a less expensive option. If your organization has broadband Internet along with a relatively new workstation you should have no difficulty in connecting. Most Telehealth interactions are 385 kbs. Mobile technology behind the scenes will manage unstable networks.

- **Become credentialed/privileged at the patient site.**

In order to provide services to a patient, you will need to be credentialed and privileged at the patient site. However, through a new ruling by

CMS, hospitals can now “credential by proxy.” While the hospital medical staff bylaws must delineate for this method of credentialing, once they do, the process becomes fairly simple. Work with the hospital at which you currently have privileges to arrange for this service. You will also likely need to have a nurse at the patient site willing to present the patient, submit patient history and data to you, and do on-site vital signs. Many rural hospitals are happy that you are serving your patients and can usually assist.

- **Contact your malpractice carrier.**

According to a study done by the Center for Telehealth & e-Health Law (CTEL), “Overall, telemedicine providers are held to the same standard of care as those who administer health care services without the use of telemedicine technologies” (Natoli, Christa M. "Summary of Findings: Malpractice and Telemedicine." [www.ctel.org](http://www.ctel.org). Center for Telehealth & E-Health Law, Dec. 2009. Web. 11 May 2012). The article goes on to say that “...after an exhaustive investigation of cases involving telemedicine malpractice actions.... providers have not been party to any litigious action involving telemedical malpractice.” The cases that were found involved writing prescriptions over the internet for patients without having examined the patient properly.

While this certainly indicates that the risk of litigation in using Telehealth is not of greater concern than that of general practice, it is still recommended that practitioners consider consulting their malpractice carrier.

- **Work with insurers and your billing staff.**

As referenced in Greg Billings’ article (Telehealth: An Overview of Reimbursement and Regulatory Issues), Medicare, Medicaid and over 60 insurance providers cover Telehealth services. This article provides an overview of how to bill for services provided.

- **Develop a Telehealth champion within your staff.**

The Nebraska Statewide Telehealth Network has found that the success of any Telehealth program is highly dependent upon the staff of an organization. If the staff is supportive of Telehealth, actively considers how it can be used and enthusiastically presents it to the patients and other providers, its growth is exponential.

For more information about Telehealth, please contact a Nebraska Statewide Telehealth Network hub site near you.

The desktop and mobile pilot project mentioned in this article is funded through a combination of monies awarded to the Nebraska Hospital Association Research and Education Foundation, through the following grant sources:

- U.S. Department of Health & Human Services, Health Resources and Services Administration, Grant No. H2AIT16619 (covering 57 percent of mobile technology project costs).
- Nebraska Information Technology Commission, Grant Agreement 90HT0041-03, State HIE Cooperative Agreement Program through the U.S. Department of Health and Human Services Office

*(continued on Page 15)*

# A Compassionate Call... Using Telehealth to Help Heal both the Patient and the Family

by Kathy Gosch, RN, C, FCN, BS, MS,  
Ed, Telehealth Coordinator  
Good Samaritan Hospital - Kearney

## When Travel is Cost-Prohibitive

What can we do? That's the dilemma when family is far away and can't afford to travel to see their loved one who is critically ill.

Recently, Good Samaritan Hospital admitted a gentleman to our ICU. He was unresponsive and in critical condition. The providers made contact with his family in Tennessee, and kept the family advised of their loved one's condition; however the nurses were unsure that they were able to adequately communicate the gravity of the patient's situation. In the meantime, the nurses also learned financial barriers prevented the family from traveling from Tennessee to central Nebraska.

Fortunately, Telehealth Services at Good Samaritan Hospital has the capability to connect to any entity that has videoconferencing equipment. What a blessing it is to have this equipment for such compassionate calls. Our program manager put the wheels into motion to determine the closest Tennessee location for our patient's family. By finding a site in Memphis, the patient's daughter was able to make a trip across town instead of across country and the patient's sister traveled no more than 30 minutes. Good Samaritan staff, including nursing, care management, the ethics committee, pastoral care and the patient advocate assembled

with the goal of more effectively communicating the patient's needs with the family, relying on the fact that a picture is worth a thousand words.

As the family sat at a TV in Memphis, our hospital staff reviewed the patient's condition, moving the camera around the ICU room, showing the family members the multitude of equipment, wires and tubes, and explaining the purpose of each piece in terms the family could understand. As the reader may imagine, they were very distressed to see their father/brother in such a critical condition. The picture and explanations prompted questions from the family that staff members were able to more effectively answer. At the end of the discussion, the camera was left on the patient for an extended period of time. This visual picture along with the explanations from our staff, allowed this family to come to see the full picture.

One sensed the hand of the Holy Spirit when everything fell into place; staff considered telehealth, connections were made, and our hospital had the opportunity to support quality care. This collaborative effort exemplifies the working relationships that can come together to bring compassionate services to patients in hospitals with video conferencing equipment. The family from Tennessee was able to say their good-byes and have closure at the death of their loved one. Although being present at such a time is the best scenario, the use of telehealth to compassionately serve families can be a valuable addition.

## Other Uses of Telehealth for Compassionate Care

The previous story represents only one of the many ways in which Telehealth has been used to help provide a bridge for family members, their loved ones and their providers. Telehealth has also been used to allow deployed soldiers to be present at or shortly after the birth of their babies. It has been used to link mothers to newborns when they were separated due to medical complications of one or the other. It was employed when hospitalized patients were in danger of missing important family events, such as graduations and funerals. All providers and hospitals know the value of taking care of the patient's emotional and spiritual well-being in addition to his or her physical well-being. Telehealth can and has helped with this journey.

In a recent nationwide example, a young terminal patient wished to go to the beach and escape her hospital room. A call went out across the listserv to Telehealth providers throughout the U.S. and several came forward to carry their mobile Telehealth technologies to the coast to give the patient views of the various beaches she craved. This may not mean a lot to many people, but to this patient, it was important.

At Good Samaritan Hospital, as well as throughout the Nebraska Statewide Telehealth Network, we are continuously striving to find new ways in which Telehealth can make a difference to the care of our patients. We welcome providers to come up with new ways that Telehealth can be of service in the continuum of patient care. □



# Bringing Mental Health Care to the Nursing Home Patient

by *Thomas Magnuson, MD*  
*University of Nebraska Medical Center*

Almost 10 years ago a nurse at an outstate nursing home asked me if I knew anything about Telehealth. She knew the distance between her facility and the UNMC campus precluded routine follow-up visits for the resident I had evaluated that day. She knew that their hospital used the Nebraska Statewide Telehealth Network for continuing education, but was unsure if clinical services also could be coordinated through this medium. I knew nothing about this as an option, but fortunately the IT people at UNMC (Max Thacker, Brenda Jeter and Pat Hoffman) did, showing patience with my lack of knowledge. They provided me the option to see my patients through the Nebraska Statewide Telehealth Network's connections across the state. This service, coordinated through the Geriatric Psychiatry division at UNMC, grew into a state-wide clinic to provide for the mental health needs of nursing home and assisted living residents across rural Nebraska.

Initially, I certainly experienced anxiety about the connection itself, the ability for me to communicate effectively and the response of both patients and providers. Links to critical access hospitals, offices and county health departments readily occurred and the few

times the connection broke down it was easily corrected. The residents of the facilities seemed little bothered by the technology, even those with dementia. Staff members and families embraced the approach as well, and expressed satisfaction with being able to attend the visits without added expenses and complications of driving to Omaha. Someone asked me once what training would be required to visit with patients and families through Telehealth. I informed this provider that if they have the training to sit on their couch and change the channel on the television with a remote control device they are ready. Naturally, mental health care is the ideal branch of medicine to employ this approach, but the developments in technology to allow other medical specialists to employ Telehealth are expanding almost daily.

With the help of our long-term care nurse, Vicki Adolf, RN, and the division's administrative assistant Tammy Anderson, a seamless process for scheduling, assessment and record-keeping was established. Facilities and providers receive copies of intake and follow-up notes, as well as letters outlining the care plan. Issues related to proper credentialing have been made easier by changes from CMS within the last year, but for us were never much trouble. Reimbursement is improving all the time, as mental health coverage via Telehealth is accepted by Medicare,

Medicaid and over 60 insurance carriers. Thirteen states mandate mental health plans sold to their residents provide for Telehealth.

Our service extends across the state, from Valentine to Nebraska City, Ogallala to Pender. Over 50 facilities in 43 locations received care from our clinic since 2004. We have taken the University's mission of serving a 500-mile campus seriously in order to provide needed specialty care to some of the most isolated and fragile residents of our state. With the incorporation of the Vidyo network by UNMC our services will now reach directly into the facilities themselves. Vidyo allows for secured connection across the internet and is readily and inexpensively added to the facility's existing computer. This means the travel to the originating (patient) site, whether across town or twenty miles away, will be eliminated for the nursing homes, creating even more cost savings as well as allowing for the care of very physically and psychiatrically compromised residents who would not endure even a short drive from the facility.

For more information about this service or providing clinical consultation via Telehealth, please contact the Nebraska Statewide Telehealth Network at [www.netelehealth.net](http://www.netelehealth.net). □





# Telehealth at the VA: *Caring for the Nation's Veterans*

by Ahsan Naseem, MD  
Associate Chief of Staff for Telehealth  
Veteran's Affairs

**T**elehealth services provide more timely access to primary and specialty care services and reduce travel for both Veterans and VA clinicians, especially in rural locations. In fiscal year 2012, the VA Telehealth Expansion Initiative has been integrated as part of the Telehealth Sub-Initiative within the T21 New Models of Care framework and will increase the number and types of clinical services available to Veterans in their local communities that may not have been provided in those locations by VA previously. The primary focus of the Expansion Initiative is Clinical Video Telehealth which enables VA clinicians, typically based at VA Medical Centers, to provide care using real-time video technologies to Veteran patients who receive their health care from VA community based outpatient clinics in their local communities.

In order to accomplish the task of expanding the current capacity of Clinical Video Telehealth and to further transform VA healthcare, a multi-disciplinary national workgroup was formed utilizing the project management model. The Telehealth Expansion workgroup is comprised of VISN level staff from all 21 VISNs representing telehealth, human resources, finance, contracting, information technology, and biomedical engineering working together

to efficiently and effectively meet the objectives established by the Secretary for the Expansion Initiative and overcome any challenges that are experienced jointly across VISNs. Between June and September 2011, the first objectives completed by the Telehealth Expansion VISN workgroup were the purchase of the necessary clinical video telehealth equipment to support expansion and the hiring of Facility Telehealth Coordinators at each VA medical center to lead and manage the medical center's telehealth program.

NWIHCS enjoys a distinct advantage of having assembled its team and implemented the Clinical Video Telehealth Program in a brief duration of time. Recruitment and training of staff, deployment of equipment, and establishment of an infrastructure were undertaken in a matter of short months. At present, NWIHCS delivers 22 Telehealth clinical specialties ranging from Audiology and Anesthesia Pre-Op to Oncology and Pulmonary Medicine, to seven CBOCs in its catchment area. These services allow for specialized care to be delivered to the rural veterans, with significant reduction in travel time. Presently, NWIHCS is pursuing a telehealth connection with Good Samaritan Hospital in Kearney, thereby allowing the VA care to be delivered in a conjunction with a community institution in Nebraska. Increased use over time is leading to more specialized care delivery such as Gynecological examinations and emphasis on women's health. Further, NWIHCS delivers care to VA medical centers in neighboring states



*Connecting families for special moments.*

such as South Dakota, where Surgery assessments are performed via Telehealth coverage from NWIHCS. The primary goal remains to increase depth of services and minimize travel for the rural veteran to access care.

As Veterans Affairs expands, we are working closely with the Nebraska Statewide Telehealth Network to determine how we can grow this service to include a larger number of sites within the Network, especially in areas that are very rural and require that veterans travel a significant distance to the nearest VA facility. The VA is considering a phased program, still in development, to achieve connectivity between the two networks. Good Samaritan serves as a beta site to develop necessary procedures. The VA hopes that this project will create a methodology for government and private sector Telehealth partnerships that can be replicated in other areas of the nation.

The program in NWIHCS is led by the author and Danielle Wheelden who is the Facility Telehealth Coordinator for NWIHCS. The Telehealth services continues to grow with more specialties coming on board to help improve the quality and diversity of care services available to the veteran. □





# Telepharmacy: *Helping to Enhance Medication Safety, Control Costs, Reduce Readmissions, Improve Outcomes*

by Lori Murante, PharmD  
Director, Alternate Site Pharmacies &  
Clinical Decision Support  
Nebraska Medical Center

The Nebraska Medical Center promotes safe medication practices by offering remote pharmaceutical care to critical access and community hospitals in the region. Our remote pharmaceutical care program, or Telepharmacy, offers prospective order review, order entry and verification for rural hospitals that often have difficulty attracting and retaining hospital pharmacists. The program is staffed 24x7 by experienced and knowledgeable hospital pharmacists who are dedicated to serving these remote sites.

The Nebraska Medical Center developed the remote pharmaceutical program in response to requests from rural hospitals for help. Launched in the summer of 2008, the program has grown to serve 12 rural hospitals in Nebraska, Iowa and Missouri in various capacities. Unique in our approach, the program tailors the services provided to meet the needs of individual sites, while maintaining a baseline service that addresses safe medication practice. A knowledgeable hospital pharmacist prospectively reviews all medications ordered for patients prior to any medications being administered to insure the safety of each patient.

Along with promoting the goal to enhance medication safety, the expanded and immediate access to pharmacists with unique knowledge of medications

supports nurses and health care providers in providing patient care. Medical professionals at these remote sites have access to the service and drug information resources 24 hours a day, every day of the year. Each site tailors their service level and hours of service to the needs of their patients.

Remote pharmaceutical care takes advantage of modern information technologies to coordinate with the health professionals at rural community hospitals. In that capacity, they work with the site-based pharmacists, doctors, nurses, and other providers in real time to address patient needs. The program takes advantage of various technologies implemented with health care grade security. Examples include: virtual private networks (VPN), toll free 800 voice and fax numbers, fax and document management services, and high definition video conferencing. These technologies empower our geographically distributed pharmacists to provide pharmaceutical care services to each site based on their needs and specifications, just as effectively as if they were actually on site.

Utilization of technology facilitates remote sites "sharing" pharmacist resources in a manner that allows them to expand access and realize controlled costs. In many instances, finding and retaining enough pharmacists to provide 24/7 coverage is not possible regardless of the costs involved. The 'shared' model of service works well. Staffing levels are flexed to accommo-

date fluctuations in workload and order volume, while maintaining individualized customer service and professionalism resources desired by our customers.

Each hospital served presents unique characteristics that must be addressed. All states are governed by differing pharmacy laws, statutes, and regulations regarding remote pharmaceutical care. Each site may have different hospital information systems, different pharmacy automation systems, and different formularies (drug lists) for the pharmacists to understand. The program must meet all legal requirements for each state where service is provided.

Staff expertise is assured and developed with the use of technology and webinars. We encourage self-learning and documentation for maintaining licensure as well as group learning webinars that may be focused on particular areas of need.

In the three and a half years that The Nebraska Medical Center has been offering the remote pharmaceutical care service, we are approaching 750,000 medication orders prospectively processed with close to 19,000 pharmacist interventions documented. We work continuously with our remote sites to identify opportunities to enhance the safety, quality and efficiency of care for patients. A recently launched pharmacist managed discharge follow-up service provides for a pharmacist to be involved in



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# Mobile Telehealth Technologies: *Putting Telehealth into the Hands of Patients and Providers*

by Max Thacker  
Associate Director  
for Information Technology Services,  
University of Nebraska Medical Center

**C**hallenge: To expand the existing telehealth infrastructure with emerging mobile technology.



While technology to support Telehealth has been available for many years, the recent emergence of mobile and desktop video presents a unique opportunity to make this technology more accessible to both patient and provider. The University of Nebraska Medical Center has had a long history of developing and using video conference technology to provide distance learning as well as Telehealth encounters. Over the years, UNMC's Information Technology Services has employed a variety of transport technologies including microwave, satellite and leased terrestrial circuits. Our aim has always been to provide the highest quality as well as the most reliable service possible. Communication using the public Internet and wireless mobile devices has dramatically impacted accessibility.

Our research to find the best solution to provide mobile and desktop video was based on several factors: It needed to operate with the UNMC existing video system as well as the existing Nebraska Statewide Telehealth Network. We expected it to be able to

be deployed on any device (PC, Mac, iPad, iPhone, and similar devices). The technology needed to be secure and maintain the highest audio and video quality on the public Internet. Additionally, it needed to be very easy for anyone to use.

After several months of evaluating different systems, we selected and installed a technology solution entitled "Vidyo." This system has been adopted within several Telehealth sites throughout the U.S. and globally. This is a web-based solution with an easy to download application to a computer or mobile device. Security is provided with both encryption and certificates (similar to Internet banking).

The video quality is high definition and the technology behind the scenes constantly monitors the network and adjusts to maintain a high quality video call. An additional feature allows users to share their desktop to show slides, documents or Power Point presentations.

For Telehealth encounters the system has been installed at nursing homes, clinics, provider offices, provider homes and patient homes. The system is also used to support educational opportunities for continuing education, for patients and supervision of residents and for students located away from the UNMC campus.

Currently the Vidyo desktop and mobile technology is a pilot program, funded by Federal grant sources. It is being used for telepsychiatry evalua-

tions, telepharmacy, clinical feeding supervision and other clinical specialties. As an educational institution, we are rapidly expanding the Vidyo system to serve distant students within our College of Nursing, Allied Health Professions and College of Medicine residents.

For providers interested in becoming part of this pilot project, or Telehealth in general, we encourage you to contact your local Telehealth hub coordinator or the author directly. See page 15 for contact information.

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- Nebraska Information Technology Commission, Grant Agreement 90HT0041-03, State HIE Cooperative Agreement Program through the U.S. Department of Health and Human Services Office of the National Coordinator, CFDA No. 93.719; Grant Number 90HT0041/01 (covering 43 percent of mobile technology project costs).



# Telehealth: *An Overview of Reimbursement and Regulatory Issues*

In other words, how do you get paid and what are the issues you have to navigate?

by Greg T. Billings  
Executive Director  
Robert J. Waters Center for Telehealth  
and e-Health Law (CTeL)

Telehealth continues to grow exponentially across the nation and worldwide as practitioners discover its role in enhancing the patient care continuum, especially for rural patients located in communities without immediate specialty care available.

Many practitioners, however, are concerned about perceived and real barriers to its implementation. Through the work of individuals and organizations like CTeL and the American Telemedicine Association, these barriers are beginning to fall making reimbursement and regulatory issues much less onerous to navigate. This article provides a simplified overview of the main reimbursement and regulatory issues. More information can be found at: [www.ctel.org](http://www.ctel.org).

## Telehealth Reimbursement

One of the most frequently asked questions when a physician considers Telehealth is whether he or she will be reimbursed. The answer is generally yes in Nebraska; Medicare, Medicaid and certain private payers do reimburse physicians for seeing patients via Telehealth.

**MEDICARE.** Medicare statutes define approved originating (patient) sites, approved practitioners and other requirements as delineated in the chart at right. Reimbursement codes and information are also included.

Medicare also requires the following:

- The beneficiary is responsible for coinsurance and deductible payments;
- The amount of reimbursement cannot exceed the current fee schedule of the consultant/practitioner;
- Beneficiaries cannot be billed directly for any facility or Telecommunications charges;
- Codes must be billed with a modifier

of "GT" for interactive audio and video telecommunications system, or "GQ" for asynchronous telecommunications systems.

The patient (originating) site can charge a facility fee of \$24.24, submitted with HCPCS code "Q3014 telehealth originating site facility fees", type of service "9 other items and services."

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Approved Patient Sites	Approved Practitioners
<ul style="list-style-type: none"> <li>• Office of a physician or practitioner</li> <li>• Critical access hospital</li> <li>• Hospital</li> <li>• Skilled nursing facility</li> <li>• Community mental health center</li> <li>• Federally qualified health center</li> <li>• Rural health clinic</li> <li>• Hospital based or critical access hospital-based renal dialysis center</li> </ul>	<ul style="list-style-type: none"> <li>• Physician</li> <li>• Physician Assistant</li> <li>• Clinical Nurse Specialist</li> <li>• Nurse Practitioner</li> <li>• Nurse midwife</li> <li>• Clinical psychologist</li> <li>• Registered Dietician/Nutrition Professional</li> <li>• Clinical Social Worker</li> </ul>
Other Requirements	Physician Fee Schedule Reimbursement Codes
<ul style="list-style-type: none"> <li>• The patient must be present for the encounter;</li> <li>• The encounter must involve interactive audio and video telecommunications, providing real time communication between the practitioner and the beneficiary;</li> <li>• The Medicare beneficiary resides in or uses the Telehealth system in a federally designated health professional shortage area, in a county not included in a Metropolitan Statistical Area, or is involved in a Federal Telemedicine Demonstration Project</li> </ul>	<ul style="list-style-type: none"> <li>• Inpatient consultations</li> <li>• Outpatient visits</li> <li>• Follow-up inpatient consultations</li> <li>• Psychiatrist diagnostic interview examinations</li> <li>• Nutrition therapy</li> <li>• Kidney disease education</li> <li>• End stage renal disease</li> <li>• Diabetes management training</li> <li>• Subsequent nursing facility visits</li> </ul>



# Telehealth: *An Overview of Reimbursement and Regulatory Issues (continued)*

Medicaid Reimbursement Includes:	Medicaid Reimbursement Does <u>Not</u> Include:
<ul style="list-style-type: none"> <li>• Medically necessary care provided via Telemedicine using real time, two-way interactive audiovisual transmissions;</li> <li>• Teleradiology services that meet the ACR standards;</li> <li>• Any service ordinarily covered by the state Medicaid program.</li> </ul>	<ul style="list-style-type: none"> <li>• Home Telehealth services;</li> <li>• Telephone conversations, email, fax between a provider and a patient;</li> <li>• Consultation between two health care practitioners.</li> </ul>
Other Requirements	
<p>Health Care Practitioners must:</p> <ul style="list-style-type: none"> <li>• Act within their scope of practice;</li> <li>• Be enrolled in the Medicaid program;</li> <li>• Be appropriately licensed, certified or registered by the Nebraska DHHS regulation and licensure agency for the service for which they will bill Medicaid.</li> </ul> <p>Services provided are subject to NMAP regulations 471 and 482 NAC, including but not limited to:</p> <ul style="list-style-type: none"> <li>• Services are medically necessary and appropriate to the client's condition;</li> <li>• Active treatment for mental health/substance abuse services met;</li> <li>• Service provided is the generally accepted standard of care.</li> </ul>	

**MEDICAID.** In Nebraska, Medicaid reimbursement is provided for essentially any service delivered by Telehealth that is ordinarily covered by the State Medicaid program. Telehealth practitioners and sites must apply to Medicaid as a Telehealth provider before reimbursement can take place. By definition, Telehealth consultation means any contact between a patient and a health care practitioner relating to the health care diagnosis or treatment of a patient through Telehealth. The chart above provides additional information.

Medicaid provider entities other than practitioners (such as hospitals) that bill for practitioner services may bill for Telehealth services when the practitioner providing the service meets the requirements. Each Telehealth site

must submit a letter (two copies) to the Department as required under 471 NAC 1-006.10C regarding quality assurance issues. A template of this letter can be found by contacting the Nebraska Statewide Telehealth Network at [www.netelehealth.net](http://www.netelehealth.net).

Thirteen states in the nation mandate private insurance payer Telehealth coverage. Unfortunately, Nebraska is not one of these states, but the Nebraska Statewide Telehealth Network has reported that practitioners have billed over 60 insurance providers.

## Credentialing and Privileging

If you are a specialist located in Omaha and you want to provide services to patients in 15 communities, do you need to be credentialed at each patient site? By a recent update in the

rule change, the answer is “no,” as long as the patient site allows credentialing by proxy in its bylaws.

The original CMS policy required that the originating hospital (patient site) had to fully credential and privilege all practitioners, including Telehealth practitioners, a significant cost and time barrier to provision of Telehealth clinical consultations. Joint Commission, on the other hand, allowed credentialing by proxy. With these two entities being in conflict, Telehealth champions lobbied for a change in CMS. As of July 5, 2011, credentialing and privileging by proxy is permitted through CMS final regulation, thus allowing the originating (patient) site to rely on the distant (physician) site for credentialing and privileging of the provider. A written agreement must exist between the two sites, a template of which can be found by contacting the Nebraska Statewide Telehealth Network.

Hospitals choosing this option for credentialing and privileging by proxy must ensure the following:

- The distant (physician) site is a Medicare-participating hospital;
- The distant-site practitioner is privileged at the distant-site hospital;
- The distant-site hospital provides a current list of the practitioner's privileges.
- The distant-site practitioner holds a license issued or recognized by the state in which the originating site hospital is located;
- The originating (patient) site hospital has an internal review of distant-site practitioner's performance and

*(continued on Page 12)*

# Telehealth: *An Overview of Reimbursement and Regulatory Issues (continued)*

provides this information to the distant-site hospital;

- Information sent from the originating-site to the distant-site must include all adverse events and complaints from Telemedicine services provided to the distant-site practitioner to the originating site hospital's patients;
- Originating site bylaws should reflect the credentialing and privileging process.

## **Licensure**

What if you want to practice in another state? Or, what if you want a specialist from another state to provide a consultation in Nebraska? Telehealth practitioners must meet licensing requirements in the state in which the patient receiving the service is located. These requirements are different in every state, so it is essential to know state law before “virtually” crossing the borders. In Nebraska, a physician who is in good standing in his own state can provide a consultation with a Nebraska-based physician on an incidental basis. Consultation is construed to mean evaluation of patient medical data and “incidental” is undefined. Kansas has a similar law, with “incidental” also undefined; however, the law specifies

that an unlicensed practitioner may not open an office or maintain or appoint a place to regularly meet patients. Iowa law requires licensure, and “incidental” is defined as a period no greater than 10 consecutive days or not more than 20 days in a calendar year. In South Dakota, any licensed physician can engage in consultation with a licensed practitioner. In Wyoming, a physician licensed to practice medicine in another state or country may consult with a Wyoming-licensed physician, and the Wyoming physician must notify the Wyoming Board of Medicine. The non-licensed physician can practice medicine in Wyoming, but not for more than seven days in a consecutive 52 week period.

So, can the lines between consultation and practicing be blurred? Key questions to ask:

- Is the relationship between the consulting practitioner and the primary practitioner at or near the same level?
- Or is the consulting practitioner at a significantly different level than the primary practitioner?

Practitioners are advised to consult the state board of medicine in the state they wish to practice Telehealth to ensure the consultation doesn't cross the

line into practicing without proper licensure.

Telehealth may present one of the biggest arguments for a uniform interstate licensure system. The Center for Telehealth and e-Health Law advocates that such a system establishes consistent licensure requirements and allow physicians to qualify for practice in another state without significant delays. CTel also supports definition of which law governs the professional conduct of a physician practicing across state lines and holding a license in both states; the reason being that CTel believes that physicians should not be subject to the demands of separate and inconsistent state laws when providing care to a single patient through telemedicine.

## **Other Legal Issues**

The Center for Telehealth and e-Health Law continuously monitors federal and state laws as they relate to Telehealth. We encourage practitioners to become involved in national discussions about important issues. And, of course, we advocate becoming involved in Telehealth; we truly believe it to be a benefit for both the physician and the patient in delivery of health care. □

# Why is Telehealth Important to Health Care in Nebraska?

*(continued)*

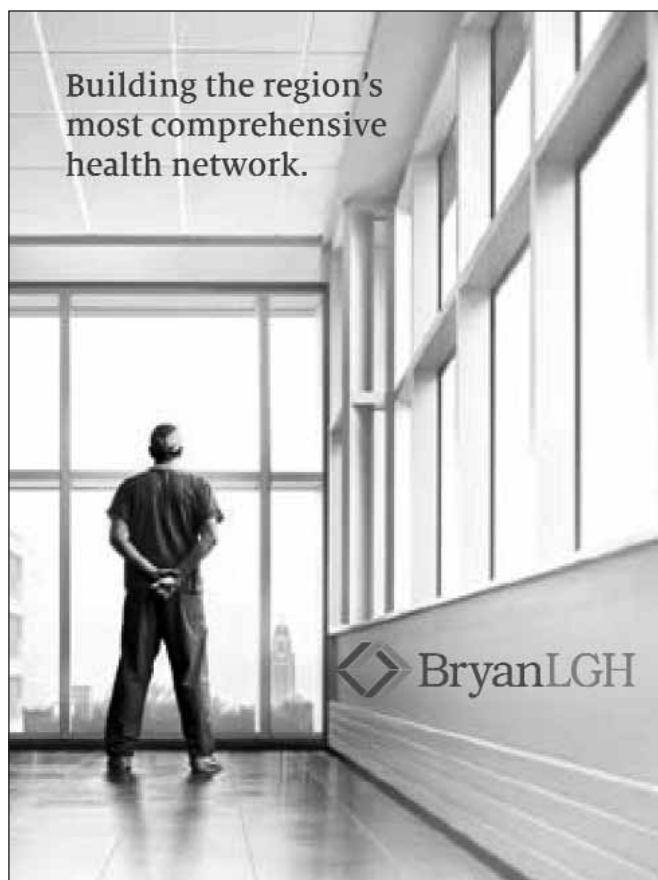
Yet, with all of these advances, there are many practitioners who are hesitant about trusting Telehealth. Providers were trained to be “hands-on” and have many questions about regulations, reimbursement and logistics. We hope this issue will help spur conversation and interest in the provider community about how Nebraska may be able to utilize Telehealth to positively impact the health care of its residents. Research shows that patients are accepting of the technology; the rapid growth seen in other states shows that once practi-

tioners try the technology they, too, find it to be useful. It has the potential to reduce medical and patient costs, enhance patient compliance with treatment, reduce hospital readmissions, increase access to mental health services, decrease unnecessary patient transfers, keep nursing home patients in their environment and reduce medication errors, among other benefits.

How do we in Nebraska make Telehealth part of our health care culture? We hope that you will review the articles in this magazine and follow-

up with your local Telehealth coordinator – at nearly any hospital or health department in Nebraska – for more information. As the State’s chief medical officer and director of public health for the Nebraska Department of Health and Human Services, I am invested in continually looking for better ways to improve access to health care for all Nebraskans and hope to help lead this conversation. I welcome your suggestions, questions and concerns.

Thank you for your consideration on this important topic. □



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# Telehealth 101:

## *Implementing Telehealth into Your Practice (continued)*

of the National Coordinator, CFDA No. 93.719; Grant Number 90HT0041/01 (covering 43 percent of mobile technology project costs).

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## Telepharmacy: *Helping to Enhance Medication Safety, Control Costs, Reduce Readmissions, Improve Outcomes* (continued)

discharge planning and follow-up. This improves patient medication compliance, reduces preventable readmissions and, potentially, unnecessary emergency department visits and resources, and improves patient outcomes. The pilot program is still in the very early stages of implementation, and optimal use of the video conferencing technology is evolving. Video conferencing is additionally supported with person-to-person telephone calls to provide

checks, double-checks verifying patient/family care giver understanding, compliance, and absence of undesired effects.

Our experience leads us to conclude that remote pharmaceutical care can be an important tool if used correctly to assure safe medication practices for patients in rural community hospitals. Technology has been effectively utilized to stretch scarce and difficult to recruit/retain pharmacist resources,

promote efficiency through cost-sharing models, provide important clinical resources to health care professionals in remote areas, and assure medication therapy is safe and appropriate for patients.

For more information about The Nebraska Medical Center's Telepharmacy program, please contact Lori Murante, PharmD at [lmurante@nebraskamed.com](mailto:lmurante@nebraskamed.com). ☐



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For additional resources and support in adopting certified EHR technology, visit the Office of the National Coordinator for Health Information Technology (ONC):

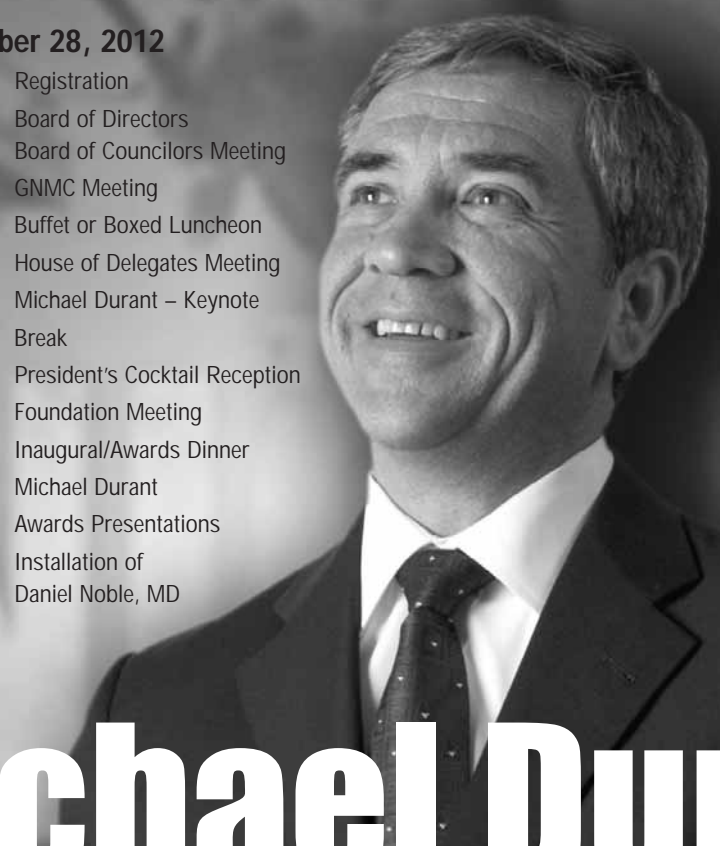
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# SAVE THE DATE: 9/28/12

## Friday, September 28, 2012

A black and white portrait of Michael Durant, a man with short, graying hair, wearing a dark suit, white shirt, and dark tie. He is smiling and looking slightly to the right.

9:00 am	Registration
10:00 am–12:00 pm	Board of Directors Board of Councilors Meeting
12:00 – 1:00 pm	GNMC Meeting
12:00 – 1:00 pm	Buffet or Boxed Luncheon
1:00 – 5:00 pm	House of Delegates Meeting
1:00 – 2:00 pm	Michael Durant – Keynote
3:00 – 3:15 pm	Break
5:30 – 6:00 pm	President's Cocktail Reception
5:30 pm	Foundation Meeting
6:30 – 8:30 pm	Inaugural/Awards Dinner
6:30 – 7:15 pm	Michael Durant
7:15 pm	Awards Presentations
8:00 pm	Installation of Daniel Noble, MD

## Michael Durant, master pilot and inspiration for the movie *Black Hawk Down*, featured speaker at the 2012 Annual Session & House of Delegates

**T**he NMA is excited to announce this year's speaker for our 2012 Annual Session and House of Delegates which will be held September 28 at the Strategic Air Command in Ashland, Nebraska.

Little did retired Chief Warrant Officer Four Michael J. Durant know when he entered the United States Army in 1979 that one day he would be the target of a Somali-fired grenade launcher, a prisoner of war, and the subject of an acclaimed book and major

motion picture. The story of *Black Hawk Down* is a tense one, and Durant, talks vividly about his experience as a soldier and as a hostage, and what it has taught him about being an American and a leader.

An inspirational speaker, Durant illustrates the power of teamwork, leadership, and change through awe-inspiring stories, captivating visuals, and heart-racing accounts of life in the line of fire.

Join us for this captivating speaker

and as we install Dan Noble, MD, of Lincoln as your 2012-13 president. We encourage you to bring your family to this year's meeting. In addition to the home football game vs. Wisconsin, there are many other activities in the area including the Strategic Air Command Museum and the many offerings of Eugene T. Mahoney State Park. Look for the registration brochure to mail this summer. Or you can visit our website [www.nebmed.org](http://www.nebmed.org) for more information.



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# What You Don't Know Will Hurt You

*by Ross Polking*

*Provided by the Foster Group*

“**M**y 401k doesn't cost me anything.” If you agree with that statement, I have some bad news. Nearly 71 percent of 401(k) participants assume they don't pay any fees for the operation and management of their employer's retirement plan. That means investors are in for a major shock, come mid-year.

Effective July 1, thanks to the Dodd-Frank financial reform legislation and other pressures on Wall Street to increase transparency for investors, all fees associated with a group retirement plan must be disclosed, in line item form, to the plan sponsor. Falling under section 408(b)(2) of the Employee Retirement & Income Security Act (ERISA), the goal is to provide employers with information that allows them to better perform their fiduciary due-diligence on the providers serving their 401(k) plan.

Originally set to roll out April 1, the implementation date was pushed back to allow service providers to make final preparations for delivering this information. Translation: most service providers are not being transparent with their fees today,

have no idea how they are going to deliver the data and are dreading what they'll say when employers call asking where in the world these fees came from. Insurance companies are pouring millions of dollars into lobbying the IRS, the SEC and other governmental bodies to hold off implementation as long as possible, hoping the requirement will just “go away.”

If you're a physician-owner offering a retirement plan to your staff, a trustee serving as a decision-maker for your medical organization's retirement plan or simply an investor in your health system retirement platform, pay close attention. Hopefully, those in the role of third-party administrator, custodian, investment advisor, and/or record-keeper for your plan have been clearly disclosing their fees all along. Even if you think they have, you should still pay attention. It's required of them to provide more detail than most ever have. Later in the year, section 404(a)(5) will come into effect, requiring that all fees withdrawn from individual participant accounts be disclosed to the participant on their statement.

Again, if you're in one of the aforementioned ownership or leadership

roles for your organization's plan – you are a FIDUCIARY. Thus get ready for questions - and plenty of them - from concerned/shocked/enraged employees (remember, most assume they are paying nothing!). It's not uncommon for “all-in” plan costs to be siphoning upwards of 2-3 percent from investors' accounts annually. Retirement preparedness and confidence has been rocked over the past few years. The physician community has acknowledged that nearly 70 percent of doctors have changed their retirement plans since 2008, mostly due to a lack of assets. Undisclosed - often excessive - fees do nothing to help the situation.

Foster Group has always provided full disclosure of the costs of our services and has operated in a FIDUCIARY capacity as long as we've served retirement plans. If you have questions or are interested in a second opinion on your retirement plan platform, please let us know. With declining reimbursements, increasing costs, malpractice worries and the uncertainty of health reform, the medical profession is under duress today. The last thing you need is any more complexity, liability, lack of fiduciary oversight or unsubstantiated costs. Pay attention. ☐



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A close-up photograph of a man with short brown hair, wearing a grey shirt, looking down at a newborn baby. The baby is wrapped in a white blanket and is looking up at the man. The background is softly blurred.

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