

Telemedicine and Fair Market Value – What You Need to Know ***March 20, 2020***

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Telemedicine Demand Increases – COVID19 Crisis

With staffing shortages around the country, many healthcare facilities are calling on retired physicians and mid-levels to take telehealth shifts. In addition, many ER physicians and other specialists are being asked to work additional hours and take telehealth call. Needless to say, the demands of healthcare workers are increasing and the correct **fair market value** of their time and services is being called into question.

Health systems and telehealth companies are quickly ramping up telemedicine arrangements. Many questions and concern are being raised, some of which include:

- What is the FMV daily on-call rate for a telehealth provider?
- Will the physician take call from their home or a designated site (at a hospital)?
- How long is a typical telehealth patient encounter?
- What type of specialists will be needed?
- How many calls per hour will the physician take?
- What is the fair market value compensation for a retired physician?
- Who bills and collects and what is the payer mix?
- Who pays for the technology (i.e. terminal, phone line, software, device, data, etc.)?

While you are ensuring the proper compliance of your telehealth arrangement, it's important to provide your FMV appraiser with as much details as possible. Telemedicine physician fair market value compensation is rapidly expanding space where little historical data exists. Therefore, its paramount for health systems to keep good records and track data such as number of calls, length of calls, follow-up, specialists needed among other metrics.

Each telehealth arrangement is unique and the appraiser will need to know as many details as possible.

Overview of Telehealth Environment



Telemedicine (also known as telehealth) is a rapidly-evolving trend in the healthcare delivery space today. As the availability of medical providers decline and patient demand increases, many healthcare systems are searching for alternative solutions to traditional care models. Multiple studies have found that telemedicine can:

1. Provide access to care in underserved communities
2. Improve quality of care
3. Provide needed health education
4. Lower costs

The American Telemedicine Association (ATA) defines telemedicine as “the use of medical information exchanged from one site to another via electronic communication to improve a patient’s clinical health status.”¹ Simply stated, telemedicine allows patients to connect remotely with physicians via phone or video conference to address healthcare concerns. This treatment method has been used for several years to conduct specialty consultations in rural areas with patients who have limited access to doctors.

Telemedicine services are typically divided into three categories: a) store and forward b) video conferencing and d) remote patient monitoring

Store and Forward

Store and forward technologies allow sensitive medical information, such as digital images, documents, and pre-recorded videos to be transmitted securely via email. This information can include X-rays, MRIs, photos, patient data, and even video-exam clips. Store and forward communications primarily take place among medical professionals to aid in diagnoses and medical consultations when live video or face-to-face contact is not necessary. Because telemedicine consultations do not require the specialist, primary care provider, or the patient to be available simultaneously, the treatment process is streamlined for the patient and the provider.

Video Conferencing

Video conferencing uses two-way interactive audio-video technology to connect users when a live, face-to-face interaction is necessary. Video devices can include video conferencing units, peripheral cameras, video scopes, or web cameras. Display devices include computer monitors,

¹ <http://thesource.americantelemed.org/resources/telemedicine-glossary>

LED TVs, LCD projectors, and even tablet computers. Video conferencing provides a cost-effective way for patients to receive care.

Video conferencing is the most common form of telemedicine practiced today. It is an effective tool for a variety of applications, including emergency room and intensive care unit support.

Remote Patient Monitoring



Remote patient monitoring (RPM) uses digital technologies to collect various forms of health-related data. Patients electronically transmit medical information securely to healthcare providers in a different location for assessment and recommendations. Monitoring programs collect a wide range of health data from the point of care, such as vital signs, weight, blood pressure, blood sugar, blood oxygen levels, heart rate, and electrocardiograms. Data is then relayed to monitoring centers in primary care settings, hospitals, intensive care units, skilled nursing facilities, and centralized off-site case management programs. Healthcare professionals monitor these patients remotely to provide care as part of their treatment plan.

Demand for Telemedicine

30% of Medicare payments are now tied to alternative payment models (APMs). The Department of Health and Human Services (HHS) plans to raise the percentage by 50% by the end of 2018. Many healthcare providers are looking for ways to increase quality of care and patient access while keeping costs down. The Medicare Shared Savings Program (MSSP) is an alternative payment model that recognizes telemedicine services as a clinical practice improvement activity, which is one of four components required for incentive payments. Physicians who provide patients with free equipment for remote monitoring are now eligible for fraud and abuse waivers under recent changes to the MSSP program.

With today's technology, a physician or midlevel provider can perform primary care consultation, psychiatric evaluations, emergency care, and other medical services remotely. At the same time, these new technologies create a cost-effective alternative to full-time physician employment. Telemedicine is especially attractive to rural health systems due to specialized physician access that is typically unavailable in these areas. Specialties, such as mental health, radiology, and dermatology are a few types of practices that are well-suited for telemedicine.

Telemedicine Reimbursement

Medicare

Medicare first began to reimburse telemedicine services after the Balanced Budget Act of 1997 was passed. As of January 2017, Medicare reimbursement only includes video conferencing services under very specific circumstances. Store and forward, or asynchronous services, are not permitted for reimbursement (except for federal telemedicine demonstration programs in Alaska or Hawaii, as stated by the Center for Medicaid and Medicare Services).² Medicare claims for telemedicine services are billed using Current Procedural Terminology (CPT®) codes, along with the appropriate telemedicine modifier code “GT.”

Medicare reimburses live-video conferencing telehealth services according to a model which includes an “originating site” and “distant site practitioner.” The patient in need of care is located at the original site and the healthcare provider is located at the distant site.

In order to be reimbursed for video conferencing telemedicine, the patient must be located outside of a Metropolitan Statistical Area (MSA) or a rural Health Professional Shortage Area (HPSA). Additionally, Medicare limits the originating sites eligible to receive services through telemedicine to the following facilities:

- Provider offices
- Hospitals
- Critical access hospitals (CAHs)
- Rural health clinics
- Federally qualified health centers
- Hospital-based or CAH-based renal dialysis centers (including satellites)³
- Skilled nursing facilities
- Community mental health centers

These sites are also eligible to receive a facility fee from Medicare to compensate for the use of their facility. A patient’s home doesn’t qualify as an originating site, in most cases.

The following list of distant site providers qualify to deliver services via telemedicine through Medicare:

- Physicians
- Nurse Practitioners
- Physician Assistants

² “Telehealth Services.” Center for Medicaid and Medicare Services. Medicare Learning Network. December 2015. < <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctshst.pdf>>

³ “Telehealth Services.” Center for Medicaid and Medicare Services. Medicare Learning Network. December 2015. < <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctshst.pdf>>

- Nurse midwives
- Clinical Nurse specialists
- Clinical Psychologists and clinical social workers
- Registered Dietitians or nutrition professionals

However, there is no limitation to the site where the healthcare provider chooses to practice telemedicine.

For telemedicine services provided in approved settings, healthcare professionals are reimbursed at 100% of the current non-facility fee schedule for the eligible service. Additionally, the originating site is eligible to receive a facility fee. The facility fee is billed under Healthcare Common Procedure Coding System (HCPCS) code Q3014 as a separately billable Part B payment.

Medicaid

Coverage of telemedicine services under Medicaid is determined on a state-by-state basis.⁴ The official policy indicates that states may reimburse for telemedicine under Medicaid as long as the service satisfies federal requirements of “efficiency, economy, and quality of care.” This policy enables states to have unique standards for what services they deem appropriate for reimbursement, which causes gaps in the system due to a massive lack of uniformity. This results in differing reimbursement policies for each state. Recently, the Center for Medicaid and Medicare Services granted states flexibility to define their own telemedicine policy.

Similar to Medicare, video conferencing is the most common telemedicine modality that is reimbursed. As of January 2017, 48 states and DC were reimbursing for some form of live video telemedicine. However, there are often several restrictions on the type of provider, facility, service, or geographic location that can be reimbursed.



Reimbursement for the other two categories of telemedicine is less common. Store and forward is only reimbursed in nine states while remote patient monitoring is reimbursed in 16 states. There are often restrictions related to certain specialties and specific circumstances.

⁴ www.medicicaid.gov/Medicaid/benefits/telemed/index.html

In addition to reimbursement to the healthcare provider, many state Medicaid programs provide a facility payment and in some cases, a transmission payment to cover the cost of connecting the patient to the distant site provider.

Private Payers

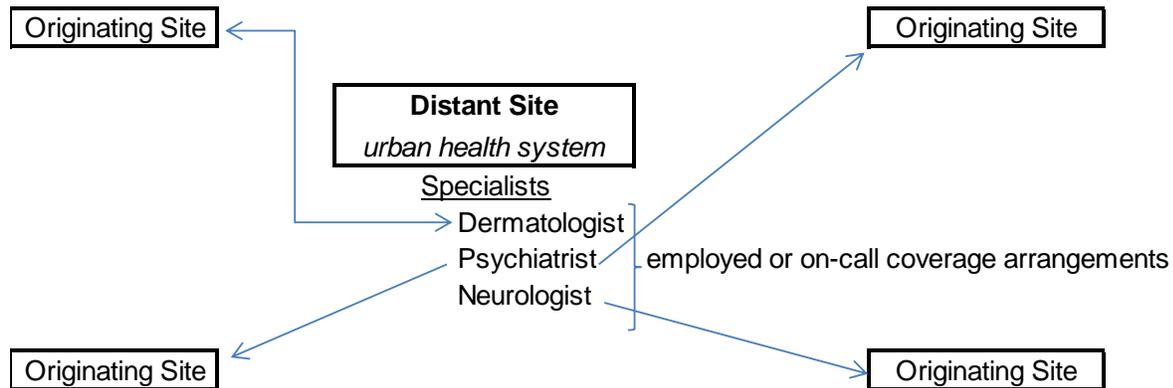
Private payers, such as Blue Cross Blue Shield, Aetna and Cigna are not required under federal law to provide coverage for any type of telemedicine service. For private payers that do reimburse for telemedicine services, there are no unique set of standards pertaining to insurance companies throughout the country. As of January 2017, 34 jurisdictions (including DC) have enacted (or will enact at a later date) laws that govern private payer telemedicine reimbursement. Some states mandate some sort of reimbursement, while others mandate reimbursement at the same level as in-person care under certain conditions. The existence of a state private payer law does not guarantee that all types of telehealth will be covered.

These laws often have restrictions, caveats, and limited applicability. These qualifying clauses may set up certain conditions where an insurer has the flexibility to restrict telemedicine reimbursement within their contract. For example, many states limit their coverage requirement to live video real-time interactions. Others include limitations on the location, facility type, condition treated, and eligible providers. Many private payer laws also often contain the caveat that telemedicine services must be covered, but make it subject to the terms and conditions of the contract between the enrollee and payer. This may set up certain conditions and situations providers and consumers should be aware of.

In the absence of a state law requiring telemedicine coverage, providers must carefully read the policies of each insurance company in order to determine whether or not they can be reimbursed for services delivered through telemedicine. Even when there is not a private payer law, some insurance companies still may pay for service.

Basic Model

As telemedicine continues to evolve, more health systems will begin forming remote care arrangements. A basic arrangement involves an originating site (usually a rural hospital) with patients in need of care and a distant site (usually a larger health system) employing or contracting with specialists who deliver treatment. This is a basic hub-and-spoke model that is illustrated like this:



Under this model, the originating site refers their patients to the distant site for the specialized care they need. This model can be structured in two different ways:

- 1) The distant site would employ the physician on a full-time or part-time basis and the distant site hospital would bill and collect.
- 2) The distant site would enter into independent contractor arrangements with specialists to be on-call and provide certain telemedicine services when needed. The on-call physicians would provide the needed consult or service via the approved technology and subsequently bill and collect the professional fee. The distant site would collect a facility fee and possibly an additional data transmission fee to cover the telecommunication costs.

Fair Market Value (FMV) Concerns

Under scenario 1, the distant site facility simply employs the physician on a fulltime or part-time basis at a fair market value (FMV) rate.

Under scenario 2, the dynamics get a little tricky. At first, the on-call arrangement appears to be very similar to a typical call arrangement for an emergency department. However, utilizing per diems reported in benchmark surveys to determine a telemedicine on-call rate is not exactly appropriate. It is important to remember that published call coverage data generally represents emergency department call coverage and will likely need to be adjusted when used for a telemedicine stipend calculation. Emergency department call coverage benchmarks typically consider the burden of responding in person to the emergency department to perform a consultation, surgery, or other procedure. In a telemedicine arrangement, the on-call physician can likely deliver the consult or examination at his home, office or over the telephone, which is much less burdensome than having to come into the emergency department. In this case, the per diem rates published in the compensation surveys should be discounted to account for the diminished burden.

In addition to the coverage stipend for availability, the on-call physician may be compensated a flat rate per consultation, exam, or an hourly rate. It's important to consider this component when analyzing the entire payment arrangement. For example, if a physician is going to be paid an hourly rate for his clinical time in addition to the per diem stipend, then the stipend may be a little lower. Or, if the physician is able to bill and collect for his professional services in a facility with a very favorable payer mix, then the daily stipend might be lower. However, if the physician does assume the risk of billing and collecting and the facility has a poor payer mix, then this factor would cause the daily stipend to be higher. Finally, the distant site would typically lease all the required hardware and terminals to the originating site at a fair market value (FMV) equipment lease rate.

Although the services offered under telemedicine arrangements may be similar to traditional on-call arrangements, determining the fair market value (FMV) of compensation for telemedicine requires a firm grasp of the legal and regulatory landscape surrounding these services. A provider's ability to bill and collect for telemedicine services must be taken into account to be properly compensated.

Contact Chris David at 303-918-3607 for further questions.