Telehealth Programs
Rural Opportunities

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What we're gonna do…

- Describe the evolution and future of CMS rules related to telemedicine
- Describe how the use of telehealth benefits rural ambulance services
- Discuss the new technology and networks that make rural access to wireless broadband possible
- Discuss the financial considerations of telehealth for rural ambulance services when there isn't (direct) reimbursement for it
- Relate telehealth implementation tips for rural ambulance services
- Recognize support available to rural ambulance services interested in utilizing telehealth

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Telehealth: Defined

Telehealth, **telemedicine**, and related terms generally refer to the exchange of medical information from one site to another through electronic communication to improve a patient's health.

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Prior to the Public Health Emergency

- **Generally, in a Healthcare Setting**
  - Or in a designated rural area
- **Audio + Video**
- **HIPAA Compliance platform**
  - Encrypted at source
  - Encrypted at destination
  - Encrypted ***in transit***

Pandemic Waivers

EXPANSION OF TELEHEALTH WITH 1135 WAIVER:
Under this new waiver, ***Medicare can pay for office, hospital, and other visits furnished via telehealth across the country and including in patient's places of residence*** starting March 6, 2020. A range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to their patients. Additionally, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

Prior to this waiver Medicare could only pay for telehealth on a limited basis: when the person receiving the service is in a designated rural area and when they leave their home and go to a clinic, hospital, or certain other types of medical facilities for the service.

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Pandemic Waivers

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA): Effective immediately, the HHS Office for Civil Rights (OCR) will exercise ***enforcement discretion*** and ***waive penalties for HIPAA violations*** against health care providers that serve patients in good faith through everyday communications technologies, such as ***FaceTime or Skype***, during the COVID-19 nationwide public health emergency.

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

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TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	Patient Relationship with Provider
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: • 99201-99215 (Office or other outpatient visits) • G0425–G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406–G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency
VIRTUAL CHECK-IN	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	• HCPCS code G2012 • HCPCS code G2010	For established patients.
E-VISITS	A communication between a patient and their provider through an online patient portal.	• 99421 • 99422 • 99423 • G2061 • G2062 • G2063	For established patients.

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

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Flexibility for Medicare Telehealth Services

- Eligible Practitioners. Pursuant to authority granted under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) that broadens the waiver authority under section 1135 of the Social Security Act, the Secretary has authorized additional telehealth waivers. CMS is waiving the requirements of section 1834(m)(4)(E) of the Act and 42 CFR § 410.78 (b)(2) which specify the types of practitioners that may bill for their services when furnished as Medicare telehealth services from the distant site. *The waiver of these requirements expands the types of health care professionals that can furnish distant site telehealth services to include all those that are eligible to bill Medicare for their professional services*. *This allows health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services.*

Audio-Only Telehealth for Certain Services.

- Pursuant to authority granted under the CARES Act, CMS is waiving the requirements of section 1834(m)(1) of the ACT and 42 CFR § 410.78(a)(3) for use of interactive telecommunications systems to furnish telehealth services, to the extent they require use of video technology, for certain services. This waiver allows the use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services (see designated codes https://www.cms.gov/Medicare/MedicareGeneral-Information/Telehealth/Telehealth-Codes).
    - Unless provided otherwise, other services included on the Medicare telehealth services list must be furnished using, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner.

- *Medicare Physician Supervision and Auxiliary Personnel:* The physician can enter into a contractual arrangement that meets the definition of auxiliary personnel at 42 CFR 410.26, including with staff of another provider/supplier type, such as a home health agency (defined under § 1861(o) of the Act) or a qualified home infusion therapy supplier (defined under § 1861(iii)(3)(D)), or entities that furnish ambulance services, that can provide the staff and technology necessary to provide care that would ordinarily be provided incident to a physicians' service (including services that are allowed to be performed via telehealth). In such instances, the provider/supplier would seek payment for any services provided by auxiliary personnel from the billing practitioner and would not submit claims to Medicare for such services.

https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf

Proposed 2021 Medicare Physician Fee Schedule Telehealth Highlights

Following on the heels of a presidential executive order focused on "Improving Rural Health and Telehealth Access," the proposed 2021 Medicare Physician Fee Schedule includes a number of important telehealth policy proposals. Highlights include:

- Proposed policy changes to maintain certain elements of the various telehealth flexibilities authorized on a temporary basis during the COVID-19 public health emergency (PHE), with some proposals lasting until Dec. 31, 2021, or the end of the calendar year in which the public health emergency ends, whichever is later. Among the services the Centers for Medicare and Medicaid Services (CMS) is proposing to add to the Medicare telehealth list:
  - GPC1X - Visit Complexity Associated with Certain Office/Outpatient E/Ms
  - 99XXX - Prolonged Services
  - 99334, 99335 - Domiciliary, Rest Home, or Custodial Care Services
  - 99347, 99248 - Home Visits

- A proposal to create a temporary category of criteria for adding services to the list of Medicare telehealth services. The below are intended to be used during the COVID-19 PHE and will remain on the list through the calendar year in which the PHE ends.
  - 99336, 99337 - Domiciliary, Rest Home, or Custodial Care Services
  - 99349, 99350 - Home Visits, Established Patient
  - 99281, 99282, 99283 - Emergency Department Visits
  - 99315, 99316 - Nursing Facilities Discharge Day Management
  - 96130, 96131, 96132, 96133 - Psychological and Neuropsychological Testing

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Telehealth

Last Updated: 07-20-2022

Generally, telehealth is the remote or virtual delivery of health care services. Patients can receive a wide range of telehealth services, including check-ins with their primary care providers, mental health care, and specialty services. Similarly, telehealth can be provided through a wide range of technologies, including video chats, remote patient monitoring devices, and phone calls. Read more about the types of telehealth.

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The Department of Health and Human Services (HHS) has significant influence on how telehealth services are delivered and paid. For example, the Centers for Medicare & Medicaid Services (CMS) establishes payment and coverage requirements for telehealth services in the Medicare and Medicaid programs, and the Office for Civil Rights establishes privacy and security requirements that affect how telehealth services can be delivered.

https://oig.hhs.gov/reports-and-publications/featured-topics/telehealth/

Rural EMS Telehealth Benefits

- **Reduce ambulance out of service time from 9-1-1 calls**
  - 9-1-1 redirection/alternate dispositions
    - Treatment in Place
    - Alternate destinations
- **Reduce ambulance responses**
  - Support Preventive Services
  - Community Paramedicine

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ET3 Program Summary

April 5, 2021 through: 7/10/2022

Overall Emergency Response Volume (No Card 33 or 37)		
Documented Medicare Patient Contacts	38,893	
≥ 65	28,192	72.5%
< 65	10,640	27.4%
Not Documented	61	
Transported	33,096	85.1%
AMA (incl. Refused All Care & Refusal w/o Capacity)	3,746	9.6%
ET3 Intervention Offered	5,987	15.4%
ET3 Intervention Accepted	789	13.2%
IES	783	
MHMR	5	
Outcomes		
Transported	62	7.9%
Hospital ED	57	
Other	5	
TIP	727	92.8%
Dispatch Health Referral	346	47.6%
MCOT Referral	4	

Rural EMS Telehealth Benefits

- **Enhance Community Health**
  - Bring telehealth to the patient
    - "EMS" On-Demand"?
- **Enhance revenue**
  - Payment for non-transports
    - TIP & "AMA"
  - MD Partnership
    - Pay for facilitating telehealth visits
  - Bring greater value to the community

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https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf

Ancillary Services Agreement

This Ancillary Services Agreement (“Agreement”) is between XXX HealthCare of Texas, Inc. (“Cigna”) and Metropolitan Area EMS Authority (“Provider”) and is effective upon Cigna’s execution and implementation of the Agreement into its administrative systems. Provider will be notified of the Effective Date via XXX’s return of the signed contract to Provider, and will be indicated in the space below.

Effective Date: March 1, 2022

II. Reimbursement Rates

Coding	Description	Reimbursement
HCPCS Code: A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS 1)	$675.80 One Way
HCPCS Code: A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 – emergency)	$1,126.75 One Way
HCPCS Code: A0428	Ambulance service, basic life support, non-emergency transport (BLS)	$640.17 One Way
HCPCS Code: A0429	Ambulance service, basic life support, emergency transport (BLS-emergency)	$1,094.97 One Way
HCPCS Code: A0431	Ambulance service, conventional air services, transport, one way (rotary wing)	Services not available as of effective date. If service becomes available, Provider will contact Cigna to amend contract.
HCPCS Code: A0433	Advance life support, level 2 (ALS 2)	$1,159.60 One Way
HCPCS Code: A0434	Specialty care transport	$1,939.12 One Way
HCPCS Code: A0425	Ground mileage, per statute mile	$13.74 Per Mile
HCPCS Code: A0998	Ambulance response and treatment, no transport	$1126.75 Per Visit

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Health and Human Services Commission, Article II

Proposed Rider

Emergency Triage, Treat, and Transport Demonstration Payment Model

Prepared by LBB Staff, 03/09/2021

Overview

Add a rider directing the Health and Human Services Commission to implement an Emergency Triage, Treat, and Transport payment model in Medicaid. Decrease appropriations in Goal A, Medicaid Client Services, by $1,667,479 in General Revenue Match for Medicaid Account No. 758 and $2,586,293 in Federal Funds in fiscal year 2023 due to assumed savings relating to implementing the program.

XX. **Emergency Triage, Treat, and Transport Demonstration Payment Model.**

(a) For the purposes of this provision, ET3 Program means an Emergency Triage, Treat, and Transport Model or a substantially similar program approved by the federal Centers for Medicare and Medicaid Services that is designed to improve quality of care and lower costs by reducing avoidable emergency transports and unnecessary hospitalizations.

(b) Out of funds appropriated above in Goal A, Medicaid Client Services, and not later than September 1, 2022, the Health and Human Services Commission (HHSC) shall implement the ET3 Program in Medicaid to reimburse Medicaid-enrolled emergency medical services providers for:

(1) transporting Medicaid clients to alternative destinations, other than an emergency department, as approved by HHSC;

(2) facilitating appropriate treatment in place at the scene; and

(3) facilitating appropriate treatment via telehealth.

This drafted policy is open for a two-week public comment period. This box is not part of the drafted policy language itself and is intended for use only during the comment period to provide readers with a summary of what has changed.

As mandated by Rider 42, 87th Legislature, Regular Session, 2021, HHSC is performing a comprehensive review of the Medicaid Ambulance Services policy for Medicaid clients to add Emergency Triage, Treat and Transport (ET3) services. HHSC is publishing a draft of the updated policy as a result of this review.

The following is a summary of changes in scope for this policy review:

- Explained scope and requirements for ET3 services.
- Updated the 'Reimbursement' section of the policy to include guidelines related to ET3 services.
- Added five CMS approved destination modifiers to allow emergency ambulance transport reimbursement for transport to an alternative destination other than an emergency department, and for treatment in place (TIP).
- Added code Q3014 to be used as an indicator of TIP with telehealth or telemonitoring services - informational only and not reimbursable to ambulance providers.
- Added code G2022 to the policy to be used on a claim as informational - not reimbursable to ambulance providers.

Transport to an Alternative Destination

12. An ambulance provider **may** transport a client to an **alternative destination** (such as an urgent care clinic, behavioral health clinic, FQHC, etc.) when upon evaluation the following requirements apply:
    - 12.1 The client's condition is determined to be non-emergent but requires medical attention.
    - 12.2 An alternative destination will meet the client's level of care more appropriately than an emergency department.
    - 12.3 There is no other appropriate transportation available.
13. The alternative destination must be within or near the responding emergency transportation provider's service area.

Treatment in Place

16. Upon the emergency response team's arrival to the scene and their evaluation of the client, if the services required at that time are determined to be medically necessary, but not emergent, the emergency transportation provider **may** provide treatment to the client *in accordance with the provider's scope of practice, their emergency transport service's medical direction and established protocols*.

17. Treatment on scene **may** also be performed, when medically necessary, via a telemedicine or telehealth visit performed in accordance with telemedicine and telehealth services requirements outlined in the Telecommunication Services Handbook (Vol. 2, Provider Handbooks).

United in response and communication

The FirstNet mission is to deploy, operate, maintain, and improve the first high-speed, nationwide wireless broadband network dedicated to public safety. This reliable, highly secure, interoperable, and innovative public safety communications platform will bring 21st century tools to public safety agencies and first responders, allowing them to get more information quickly and helping them to make faster and better decisions.

https://www.firstnet.com/

FIRSTNET.
Built with AT&T

BY THE NUMBERS

The **only** dedicated communications platform in the country that brings first responders:

- ***Always-on, 24x7*** *priority and preemption across voice and data communications*
- *A physically separate network core* ***fully dedicated*** *to public safety*
- *Government oversight and accountability from the* ***FirstNet Authority***

Updated: 7/21/2022

3.7M
FirstNet connections

21.8K+
Public safety agencies and organizations subscribed

200+
apps in the FirstNet App Catalog

450+
FirstNet Ready® devices

AMERICA'S PUBLIC SAFETY NETWORK

2.81M+
Square miles of coverage

50K+
Square miles more than commercial networks

150+
Dedicated assets in the FirstNet fleet

30+
ROG the Dog therapy animals

95%+
Band 14 coverage completion; well ahead of schedule

450+
Solutions deployed for public safety this year

https://about.att.com/story/2021/fn_expands.html

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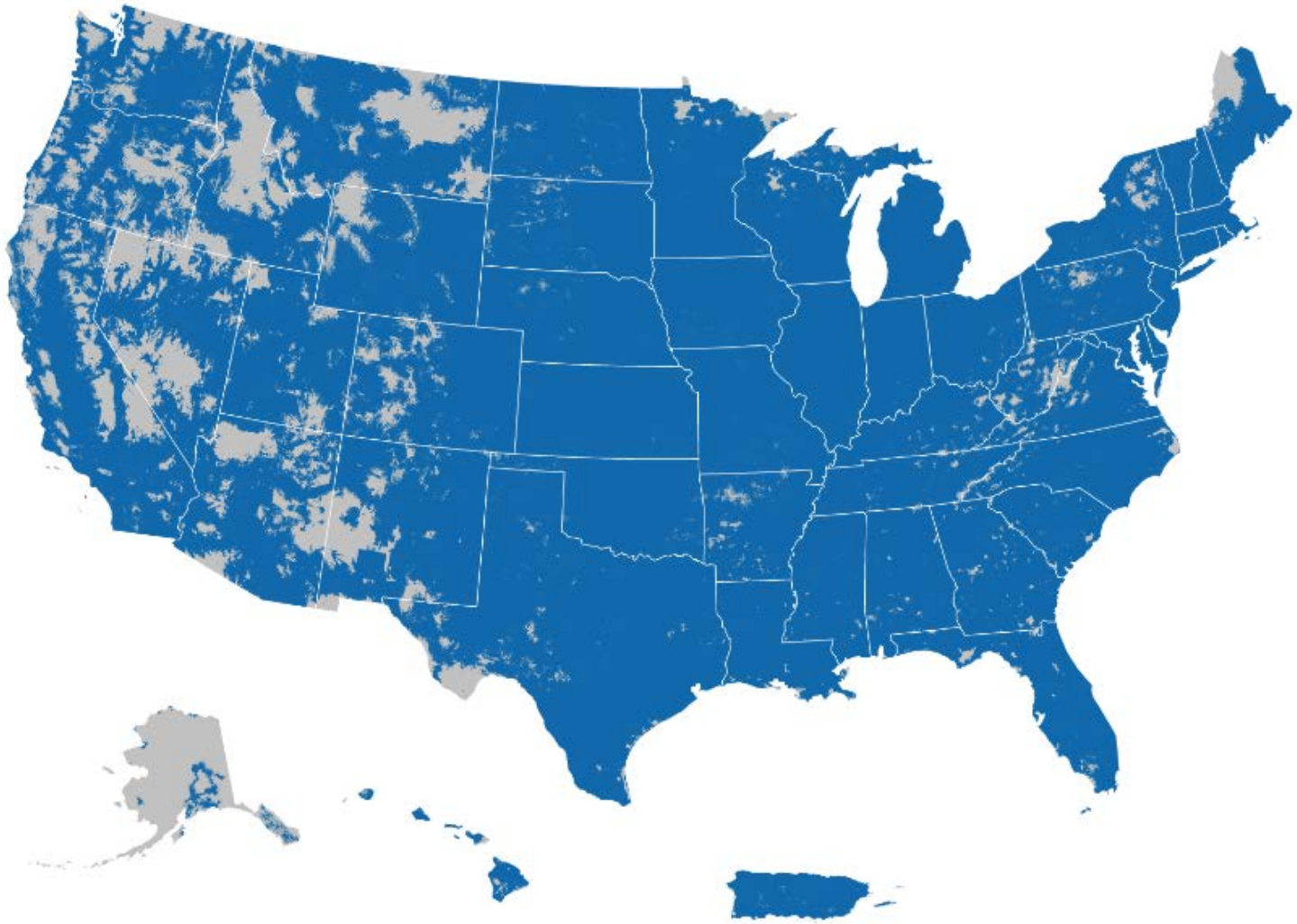
FIRSTNET
Built with AT&T

Expanding to Serve:

FirstNet Surpasses 2.71 Million Square Miles, Covering Tens of Thousands of Cities & Towns



https://about.att.com/story/2021/fn_expands.html

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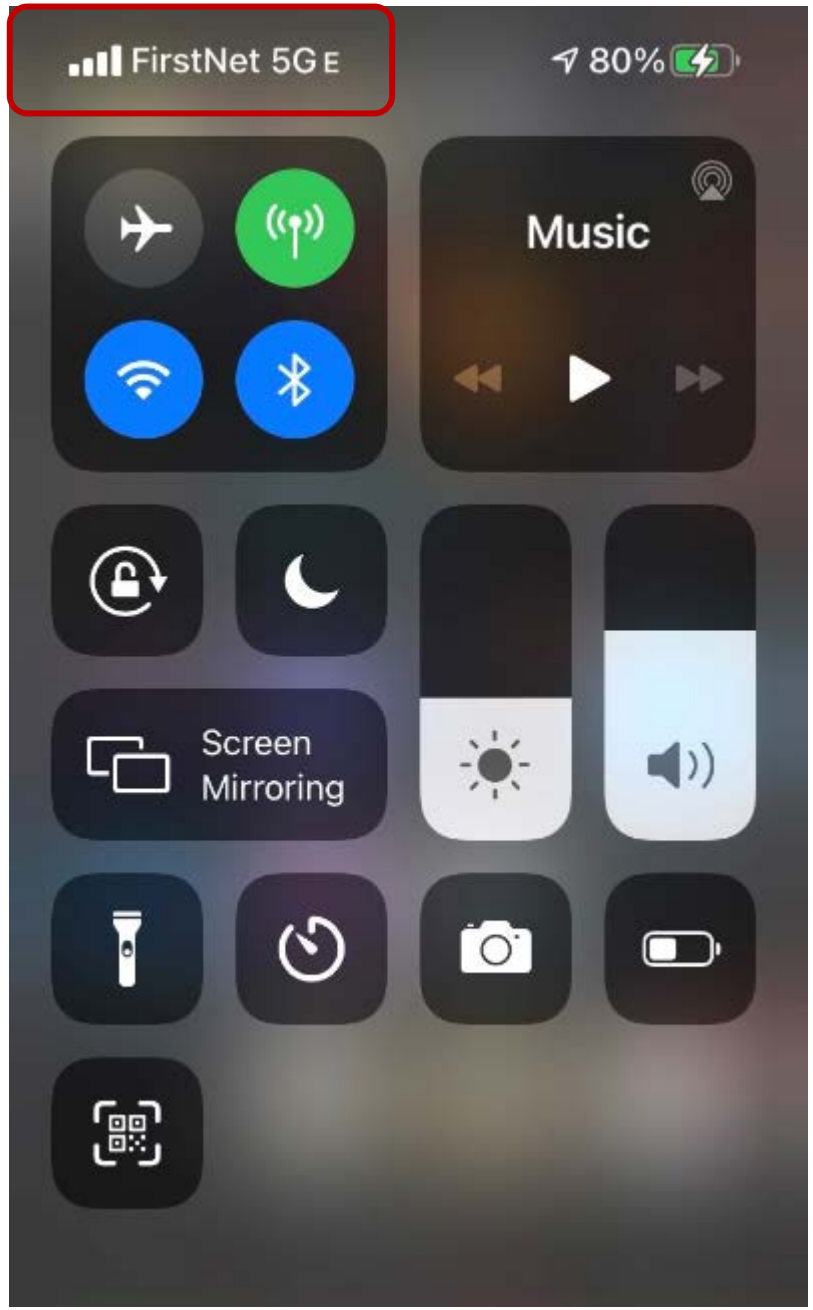
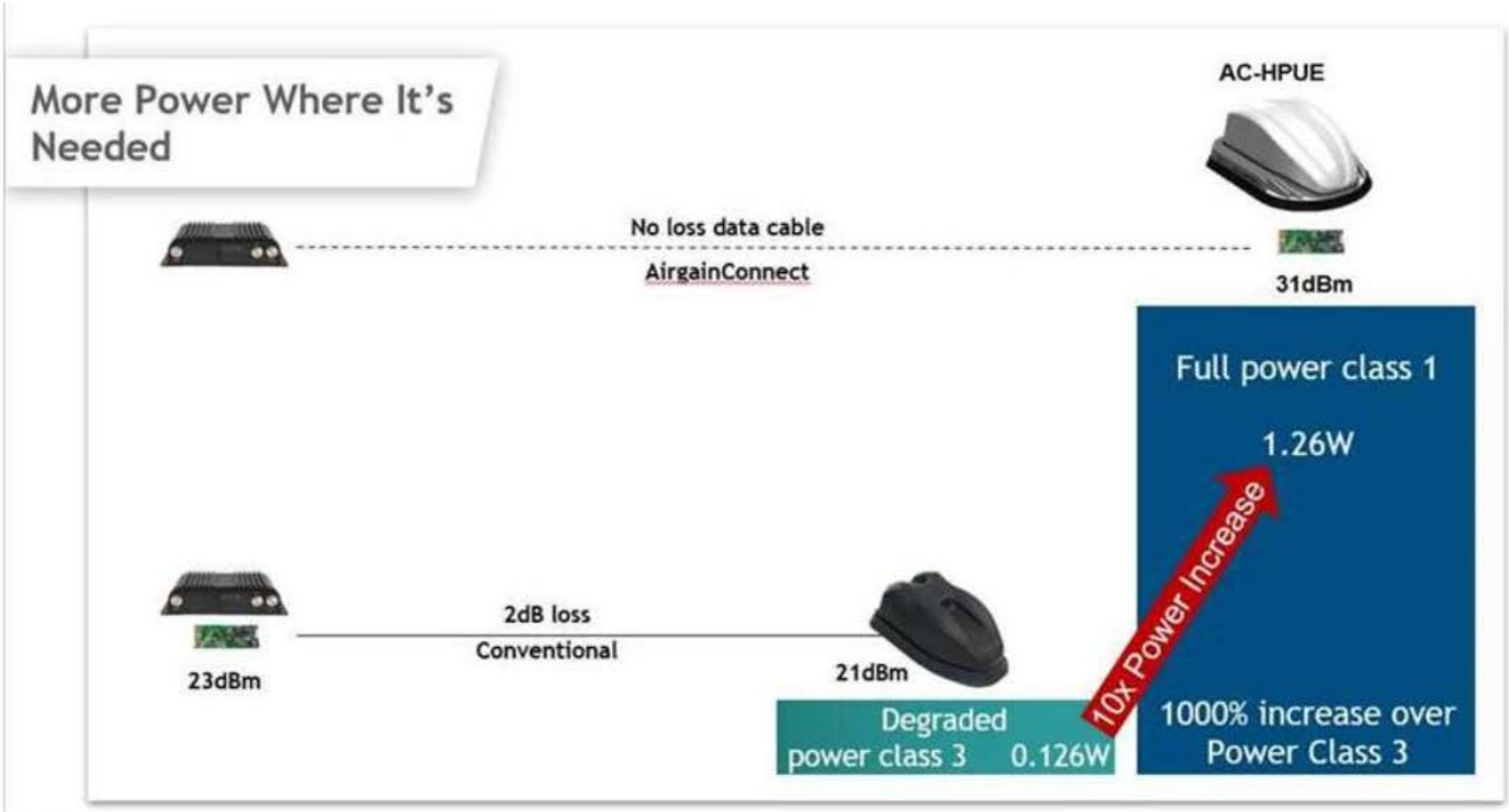

FirstNet 5G E
80%
Music
Screen
Mirroring

High-power user equipment (HPUE) can help bridge Band 14 coverage gaps in rural, in-building locations

FIRSTNET™
Built with AT&T



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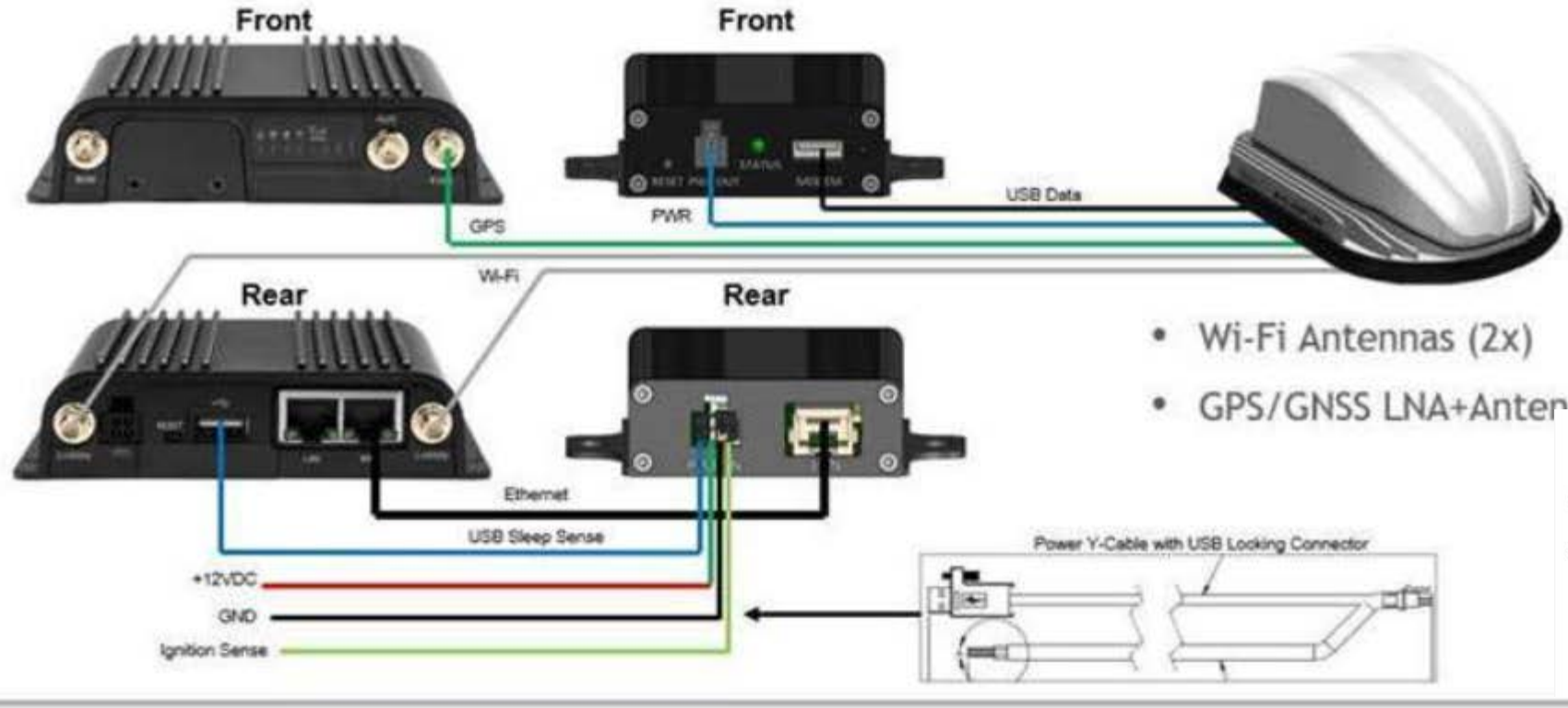
Power Conditioner to Router

- Power conditioning per ISO 7637-2
- Activates on ignition on
- Deactivates on router sleep



- Wi-Fi Antennas (2x)
- GPS/GNSS LNA+Antenna

MEDSTAR MOBILE HEALTHCARE

Evidence-based improvement in emergency communications for public safety using high-power user equipment

ABSTRACT: "Power Class 1" or High-Power User Equipment (HPUE), has been available to public safety users for about 1 year. This technology increases the power transmitted by cellular user devices from 0.2 Watts up to 1.25 Watts. This increase in power has shown improved connectivity and performance for emergency responders, particularly in rural areas.

THE PROBLEM:

Public safety needs reliable communications however coverage decreases in certain conditions:

- Remote and Rural locations
- Challenging terrain
- Longer distances to cell towers
- Heavy forest and foliage
- Large building shadows coverage

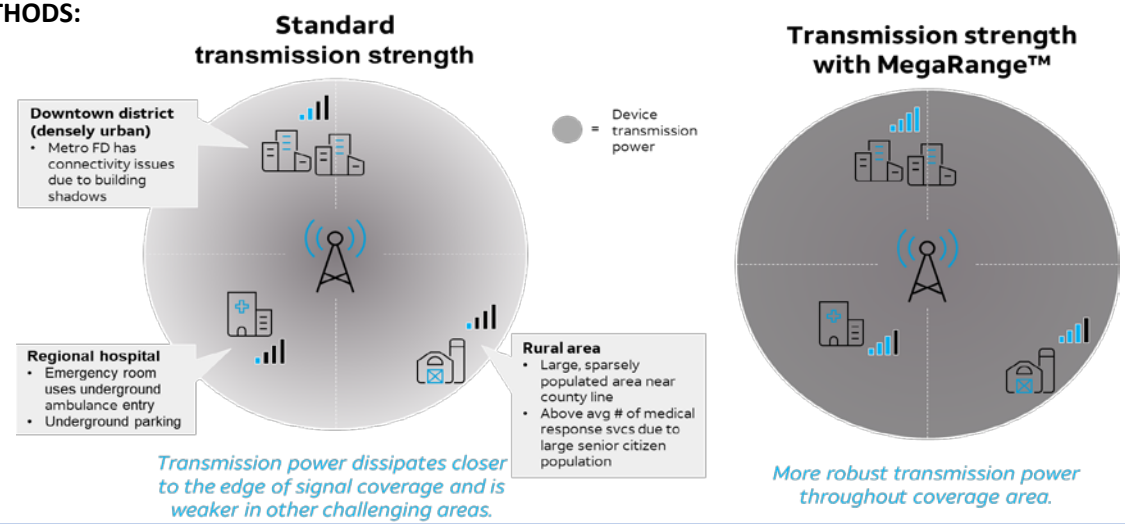
OBJECTIVE:

Close the Coverage Gap with High Power User Equipment (HPUE)

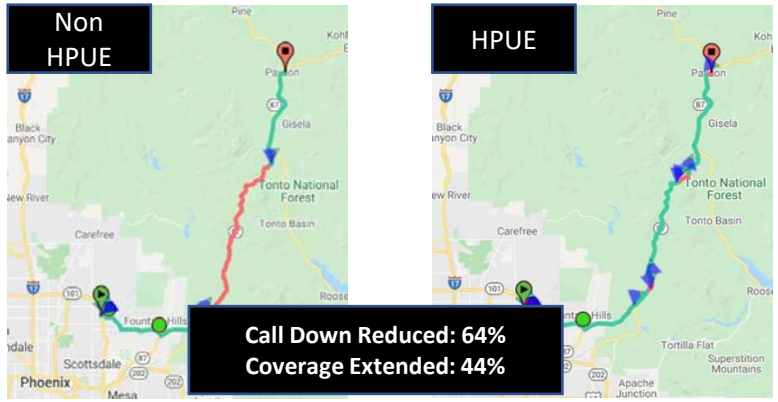
CONCLUSION:

Use FirstNet® MegaRange™ to enable the highest LTE communications availability to meet first responder needs with a stronger more reliable connection as first responders reach the edge of signal coverage.

METHODS:

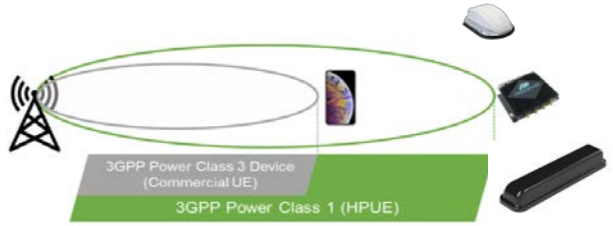


RESULTS: AirGain side by side tests: Scottdale - Payson AZ



RECOMMENDATIONS: IMPLEMENT MEGARANGE™

- FirstNet is the only network in the U.S. that makes Power Class 1 (PC1) HPUE available to public safety
- Exclusively available on Band 14
- 62% to 100% improvement (mid-to far-cell)
- MegaRange™ on PC1 transmits up to 1 watt higher than regular PC3 device
- FCC & 3GPP industry standards allow MegaRange to transmit up to 1.25 Watts. 'Standard' devices are limited to 0.2 Watts.



OUTCOMES:

- Overcome failed connections
- Increase connection speeds
- Increase uplink speeds in normal cell coverage areas
- Improve performance in building shadows
- Minimize downed tower coverage holes
- Improved data transmission

See how Bangs Ambulance expanded coverage

Program Development

- **Community Support**
  - Medical Director/Regional EMS Authority/State
  - Staff
  - Local government officials
  - Medical groups
  - Hospitals
  - Payers
- **Cell coverage**
  - Propagation studies
  - FirstNet?
  - Bandwidth
  - HPUE

Program Operations

- **Selecting the Telehealth partner**
  - Coverage
  - Platform
  - Billing/Economics
- **Protocols**
  - Eligibility
  - Alternate dispositions
    - Treat in place
    - Alternate destination
- **Economics**
  - Payment for treatment in place?

Program Eligibility

Inclusion:

- *Medicare patient*

AND

Vitals within range:

- *Systolic blood pressure > 90 mmHg (or age-specific)*
- *Heart rate 50-110 beats per minute*
- *Respiratory rate 8-20 breaths per minute*
- *Pulse* oximetry > 94% on room air

AND

- Provider suspicion of low-acuity medical or traumatic illness

Exclusion:

- Patients in a healthcare facility
  - *(i.e.: SNF, MD office, Urgent Care Center (UCC))*
- Age < 1-year old
- OB/Pregnancy complaints
- Provider suspicion of moderate or high-acuity illness
- Refusals without demonstration of capacity (Contact OLPG)
- Patients in custody
- Refusal of telemedicine consent (Follow AMA Protocol)
- Ambulance ***NOT*** on scene (no BERT/SRU units)

Procedure

- **Standard EMS Response**
- **If the patient meets eligibility for telehealth:**
  - Offer patient opportunity for telehealth intervention (TI)

'You have a medical condition that may be benefit from a secondary assessment by a telehealth provider selected by MedStar who has specific knowledge of emergency medical care and potential follow-up care options for your condition.

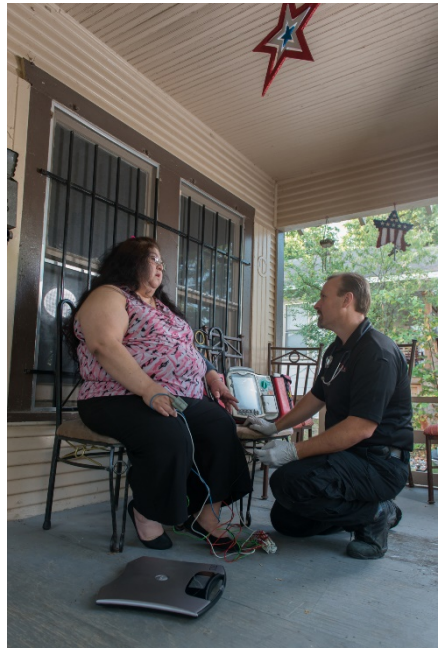
The telehealth provider may encourage you to seek care at an emergency department, or may recommend other appropriate follow-up care, including the recommendation that we transport you to an alternate destination, such as an urgent care, or other location.

Would you like us to initiate a telehealth consultation for you using our telehealth platform here in my hand?'

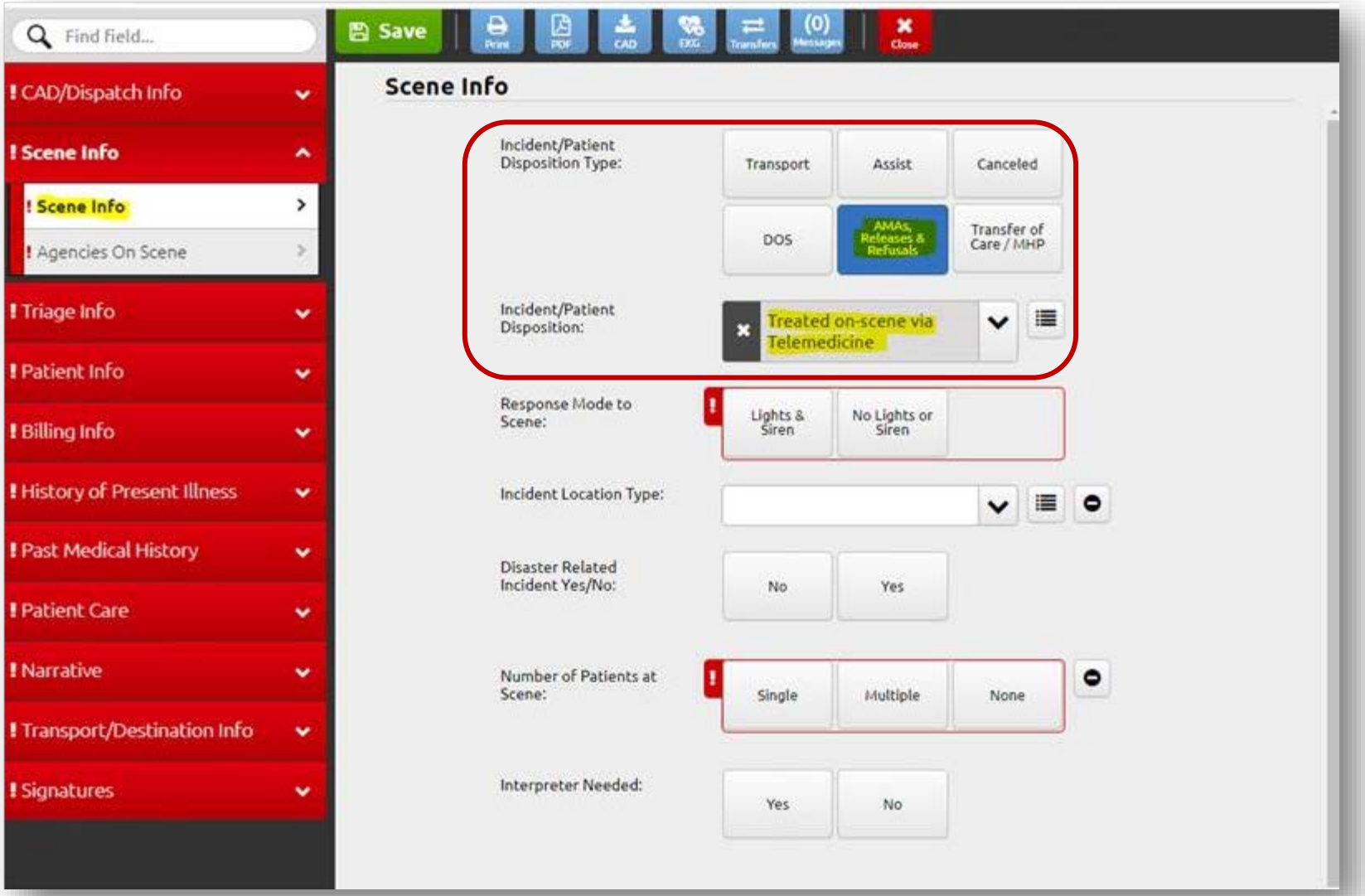
Does not have to be word for word!

Procedure

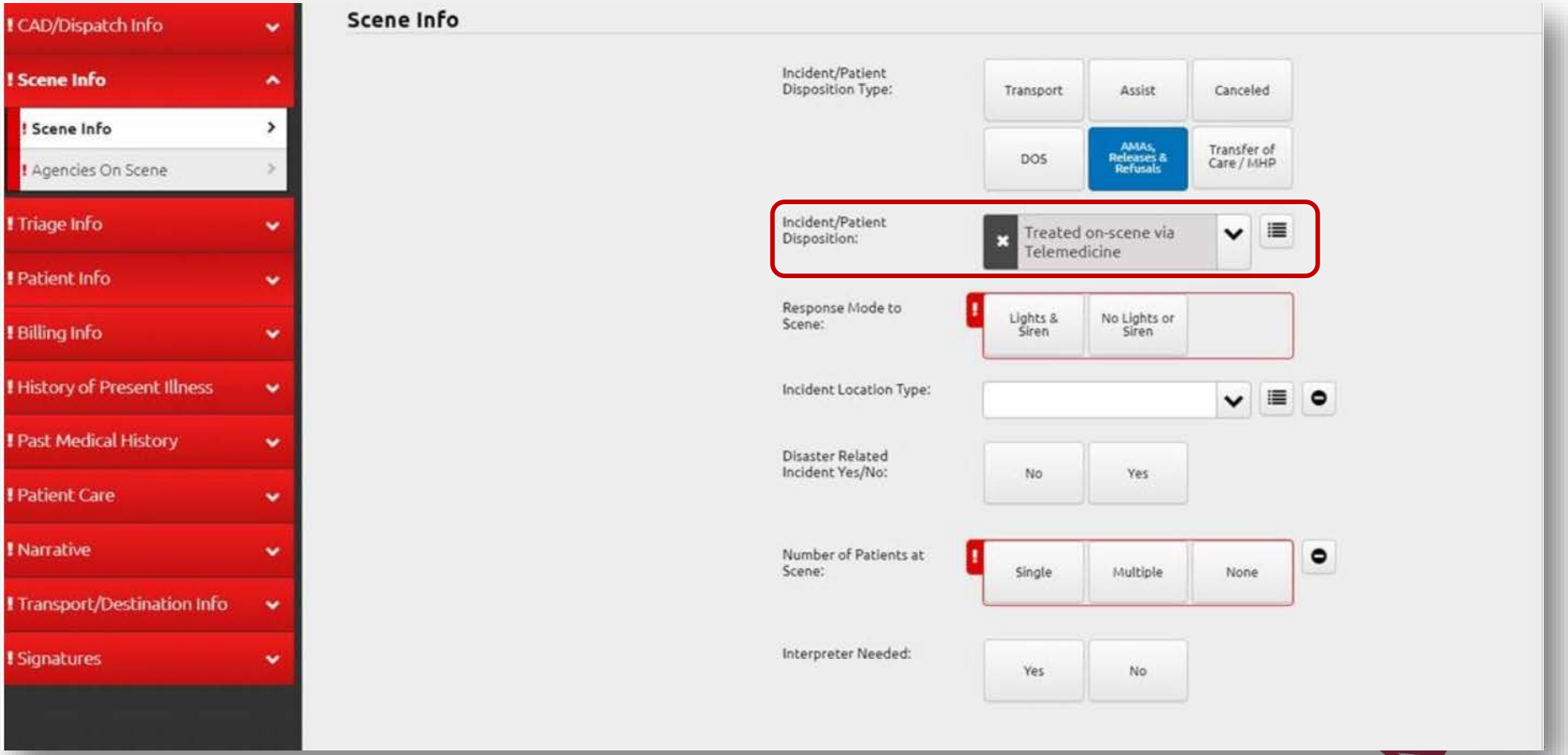
- **If the patient asks about a fee for the TI:**
  - Explain that like hospital EDs, MedStar, or other healthcare providers, there will be a fee for the TI
    - Fee for ambulance and ED as well
    - Billing processes for these services have multiple options for reducing the financial impact of medical care, up to and including ***charity care*** for patients who qualify



ePCR documentation: TI Engaged



ePCR documentation – Treatment in Place



Quality Assurance

- **Quality Improvement:**
  - % of patients with ADT/TIP disposition, who ***didn't*** have Telemedicine consulted (e.g. inappropriate disposition)
  - % of patients who were referred to telemedicine who ***didn't*** meet directive criteria (e.g. inappropriate referrals)
- **Opportunity for Improvement:**
  - % of patients referred to telemedicine who IES recommended ED transport
  - % of patients who met criteria, but did not undergo telemedicine evaluation

MEDSTAR MOBILE HEALTHCARE

Support for System Development

Page Refresh (seconds): Manual | 30 | **60**

Event ID	Type	Purchasing Entity	Description	Posted Date	Published Date	Opening Date	Status
2832	Project	South Dakota State Government	EMS Regional Service Designation Consultant (22-0903006-019#2832)	6/01/2022 10:24 AM	6/01/2022 10:23 AM	9/01/2022 4:00 PM	Open For Responses
	Attachments:						
	Regional Service Designation Consultant: Open						
	Summary Event Information: Open						
2805	Project	South Dakota State Government	EMS Telehealth Consultant (22-0903006-016#2805)	5/04/2022 8:03 AM	5/04/2022 8:00 AM	5/20/2022 4:00 PM	Responses Under Review
	Attachments:						
	EMS Telehealth Consultant-1: Open						
	Q & A : Open						
	Summary Event Information: Open						

https://www.mercurycommerce.com/App/SourcingEventPostingBoard/SourcingEventPostingBoardView.aspx

3.0 SCOPE OF WORK

The Department of Health Office of Rural Health is seeking a vendor to provide telehealth services to Emergency Medical Services (EMS) in South Dakota including hardware, software, implementation, training, and professional services.

3.1 Analysis of current and future needs to provide telehealth services for up to 124 licensed ground ambulance services to include:

- **3.1.1** Hardware to support telehealth in dynamic changing environments associated with an ambulance response.
- **3.1.2** Software to support connectivity with professional healthcare services including vendors current infrastructure, SD Critical Access Hospitals (CAHs), and other allied healthcare facilities.
- **3.1.3** Information Technology support services to troubleshoot connectivity issues.

3.2 Provide professional medical consulting services to include:

- **3.2.1** Professional service and support to provide emergent and non-emergent consulting services during an ambulance response including access to paramedic, registered nurse, Advanced Practice Provider, and physician availability.

3.3 Provide post-event evaluation services to ambulance services to include:

- **3.3.1** Post event survey for EMS personnel
- **3.3.2** Post event survey for CAH associated in a response
- **3.3.3** Evaluation metrics reportable to the DOH

MEDSTAR MOBILE HEALTHCARE

Support for System Development

- **National Rural Health Resource Center**
- **National Association of EMTs**

NAEMT is pleased to offer FREE CE webinars to its members. In addition, recordings of these educational webinars are available to NAEMT members in the Member Portal.

NAEMT members can click ***HERE*** to login and access the webinars and podcasts.

To learn more about sponsoring an NAEMT-hosted webinar, view the NAEMT Corporate Partner **opportunities** brochure section on Webinars.

Past webinars include:

- Pediatric Medical Emergencies – Assessing the Critically Ill Child, sponsored by ReelDx
- Building a Financial Framework for Your Telehealth Program, sponsored by Amazon Business and ZOLL Data Systems
- Enhancing Patient Care Through Telehealth, sponsored by ZOLL Data Systems

Support for System Development

- **Telehealth Providers**

Summary

- New opportunities
- Could be a very viable solution for rural health challenges
- Moves “EMS” further into the healthcare space
- Understand the limitations
- Try it!

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Thank you !

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