



Telehealth Workgroup Minutes

Office of Health Information Technology
James R. Thompson Center, 100 W Randolph, 2-201
November 1st, 2011
877.402.9757 / PC 4269321

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Participants (in-person and via phone):

Name	Organization
Wesley Valdes	IL Office of Health Information Technology (OHIT)/UIC
Mary McGinnis	OHIT
Laura Zaremba	OHIT
Ian Bertorelli	OHIT
Deborah Seale	Community Member
Jim Anfield	BlueCross BlueShield – Illinois
Nancy Kaszak	University of Illinois
Bob Wesley	SIU School of Medicine

Wesley Valdes (Wes) took roll call and made a motion to approve the minutes of the previous meeting. **Nancy Kaszak (Nancy)** asked that the minutes reflect the correct spelling of her name. The minutes were then approved.

Mary McGinnis (Mary) gave an update on the statewide HIE. InterSystems has been selected as the ILHIE vendor. **Mary** explained that in the state procurement process, there is a protest period following vendor announcement that allows any questions or concerns to be registered with the Executive Ethics Committee; the InterSystems procurement passed the protest period and now OHIT is diligently working to complete contract negotiations and the statement of work by the end of the first week of November. **Wes** asked if the projected core services rollout date was still in April of 2012; both **Mary** and **Laura Zaremba (Laura)** confirmed. **Mary** said that OHIT would be looking for alpha and beta partners to test selected use cases such as Emergency Room linking, specialty referral, the Public Health Node (PHN), and quality reporting for the MU program. **Laura** clarified that while these use cases need to be tested to ensure their functionality, that does not mean they will be available for statewide use in April or rolled out in that order. The first service expected to come online in April is the PHN interface (a webinar detailing the PHN can be found on OHIT's website). **Wes** asked if a specialty referral use case would be helpful. **Laura** explained that the InterSystems' scope of work involved identifying alpha and beta testing partners for that use case. **Wes** encouraged the workgroup to think about how work group members could support this effort. **Laura** invited any members who were interested in participating as a testing partner to get in touch with Ivan Handler at OHIT, adding that testing would be going on for a year to 18 months.

Wes opened discussion on the Final Draft to the HIE Advisory Committee from the Telehealth Work Group. **Deborah Seale (Deborah)** noted that the draft did not list her as a member of the work group. Additionally, she expressed concern that she should be listed as "Telehealth Expert" rather than be listed as the position she recently accepted at St. Louis University in Missouri, commenting that having an out-of-state member in the work group might seem erroneous. **Mary** noted that large Medicaid and commercial populations move across that border for tertiary care in St. Louis, and foresaw ILHIE would be involved with Missouri in the future. **Wes** agreed that **Deborah's** relocation to Missouri would not affect her relevance to the work group or her membership. **Wes**

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then moved to approve the Final Draft, which passed. He said that he would be at the next Advisory Committee meeting on November 8 presenting the suggestions. **Laura** confirmed that **Wes** was on the agenda to deliver the recommendations, then thanked the work group for drafting a paper that she predicted would raise the profile of telehealth within the Advisory Committee.

Wes opened discussion on the Medicaid Clarification Document. **Bob Wesley (Bob)** expressed the opinion that, regardless of how exhaustive it is, the document should go forward right away because clarifying billing issues is imperative. **Deborah** identified two points she did not fully understand. First, she brought up item 3 under "Discussion regarding the originating site," saying that she did not see what the policy issue was regarding a home health nurse that "may not have the capacity to incorporate a telehealth visit in their documentation." **Wes** explained that it was an attempt to reconcile differences between billing rules and legal document of record rules. In a telehealth situation, where the provider is being virtually transported to the care site, the location of the original medical record as a legal document is unclear. Ideally, a telehealth provider documents their patient encounter into the medical record at the location of care, but there are instances where this is not possible. He also pointed out that in the Joint Committee on Administrative Rules' (JCAR) administrative code for Telehealth Services require that copies of the medical record be kept at both sites, but do not specify which record is the original. Using a hypothetical, **Wes** and **Deborah** demonstrated that if a provider visits a home health site then the original record of that encounter stays with the provider, but in the telehealth model the original stays with the home health nurse. **Wes** pointed out that this issue only comes up with the home because it is a less understood site of healthcare delivery. He acknowledged that the location of the original document becomes irrelevant if it can be accessed from anywhere, (so the advent of a statewide HIE may eliminate this problem), but reiterated his point that there needs to be clarification on how the existing rules for home care function in the telehealth model and that a clear guideline needs to be written for what to do in this situation. **Wes** thinks this is part of a larger question: in this electronic world, what constitutes the original, legal medical record? **Wes** suggested deferring to Nancy for clarification on this point. **Nancy** suggested bringing OHIT's Mark Chudzinski in to weigh in on these issues. **Deborah** posited that whoever held legal liability holds the original legal document, but **Wes** then raised the possibility that both of them have legal liability.

Deborah moved on to item 4 under "Discussion regarding the originating site," saying that the confusion could be avoided by recommending the words "present at all times" be changed to "available at all times." **Wes** agreed, but said it was an issue of carefully choosing the language. He brought up language in "Incident to" billing that requires the doctor to be available at the time of care, saying that while it is generally understood that the criteria requires the doctor to be in the same clinic, some interpret it more loosely to mean in the same geographical area (such as the same city). **Wes** stressed that the language has to be written in a way that results in the least abuse possible.

Deborah asked for clarification on item 2 under "Discussion regarding the distant site," saying that she did not understand the question it raised. **Wes** said that this issue was of particular importance for Federally Qualified Health Centers (FQHCs) and felt the best way to explain it was a hypothetical situation where an FQHC hires a telehealth dermatologist and is responsible for reimbursing the dermatologist for telehealth conferencing services. Historically, if a primary care provider (PCP) writes a referral to a dermatologist, the patient physically leaves the FQHC and it charges for that encounter. In the telehealth model, however, there is no registration event that starts the electronic

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process of creating a bill for the dermatology consult because the patient does not report back to the FQHC. For example, in the scenario where a PCP sends an asynchronous request to a telehealth dermatologist in the form of a photograph of a rash, it is unclear where the encounter with the PCP ends and where the telehealth consult starts. **Wes** asked whether the dermatologist was supposed to be reimbursed from the initial encounter fee or if the dermatologist's action was considered an independent interpretation of the photograph, (as "asynchronous" is currently defined in the JCAR code), and therefore considered a separate encounter for which the FQHC could bill for and then reimburse the dermatologist with. **Deborah** noted that telehealth consults would not be requested if the originating sites could not get paid. **Wes** agreed, adding that reimbursing the telehealth provider out of the first fee and not allowing the FQHC to bill for a second encounter fee is not an affordable model for an FQHC, yet HFS is under the impression that in this situation only one encounter fee will be billed. He solicited suggestions for clarifying the points that **Deborah** brought up, suggesting that he could make a table that presented two word flows, an encounter for the PCP and an encounter for the telehealth provider, and examine the financial results.

Bob asked if Healthcare and Family Services has received a systematic response such as the Medicaid Clarification Document before. **Wes** was not aware of them ever receiving such a document. **Bob** said that while it was important for the work group to make the document as clear as possible, submitting presently it would cause Healthcare and Family Services to clarify their language and request clarification on the document where it is necessary. He believed that the document in its current state would sufficiently guide HFS to places where the language is vague or unclear and he reiterated the importance of presenting the document as quickly as possible. **Wes** asked if the suggestions should be presented at the start of the document or embedded within it. **Bob** thought that best practice was to include them at the beginning. **Wes** then asked **Jim Anfield (Jim)** if he thought the document could be useful for third party payers and perhaps written with them in mind in an effort to avoid a situation where these payers have to develop methods to reimburse telehealth consults themselves. **Jim**, speaking only for his own organization, said that telehealth is being discussed but is not their top priority and predicted that if the Medicaid model made sense they would leverage it. **Wes** decided to keep the document geared towards the Healthcare and Family Services audience with the possibility of drafting a version for third party payers if a discussion is initiated.

Deborah confirmed that she will send **Wes** her edits on the Medicaid Clarification Document. **Wes** plans to turn them around by Friday for review and approval by work group members. He then ended discussion on the document.

Wes started open discussion. There were no items.

Wes then opened it up for public comments. There were no comments from the public.

Wes asked for the date of the next meeting. **Mary** said that it was tentatively December 6. **Wes** let the work group know that December 6 would be the day of the mHealth summit in Washington and invited them to have the meeting without him. The work group members suggested moving the meeting to December 13, determining that **Wes** would be able to tell them about both the summit and the telemedicine special interest group he would be chairing.

The meeting was adjourned 10:50 AM.