“State of Payor Network and Reimbursement for Telehealth Services”

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Introduction

- Reimbursement for services delivered via telehealth varies greatly from payor to payor and state to state.
  - Medicare, state Medicaid programs, and private payors maintain very different coverage policies.
- Services not covered by the payor are not covered when delivered via telehealth.
  - Ex: Routine eye care is not covered by Medicare, and so routine eye care delivered by telehealth is not covered.
- Nationally, telehealth coverage is expanding to include more services and more public and private payors.
State Telehealth Reimbursement Policies

- 43 states and the District of Columbia now provide some form of Medicaid reimbursement for telehealth services.
- Nineteen states and the District of Columbia require private health insurance plans to cover telehealth services.
  - Note: This requirement does not apply to self-funded employer health benefit plans, as states may not regulate these entities due to the requirements of Section 514 of the Employee Retirement Income Security Act of 1974 (ERISA).
Ohio Telehealth Reimbursement Policies

• HB 123 has been signed into law and requires the Department of Medicaid to “establish standards for Medicaid payments for health care services the Department determines are appropriate to be covered by the Medicaid program when provided as telehealth services.” See http://www.legislature.state.oh.us/bills.cfm?ID=130_HB_123.

• Proposed rule, Rule 5160-1-18, Telemedicine, was created to establish policy related to the coverage of services delivered via telemedicine.

• The rule would allow coverage for evaluation and management and psychiatric services through the use of telemedicine. However, it does not allow for hospitals and nursing facilities to be reimbursed as originating sites.

• Ohio does not require private insurers to reimburse for telemedicine.
Kentucky Telehealth Reimbursement Policies

• The Cabinet for Health and Family Services and any regional managed care partnership or other entity under contract with the Cabinet for the administration or provision of the Medicaid program must provide Medicaid reimbursement for a telehealth consultation that is provided by a Medicaid-participating practitioner who is licensed in Kentucky and that is provided in the telehealth network established in KRS 194A.125(3)(b).
• Kentucky requires private insurers to reimburse for telehealth.
Indiana Telehealth Reimbursement Policies

- Telemedicine is covered by Indiana Medicaid.
- Indiana does not require private insurers to reimburse for telehealth.
Medicare

- Medicare pays for specified Part B services furnished by a physician or practitioner to an eligible beneficiary via a telecommunications system.
- Asynchronous “store and forward” telehealth services are available only in Alaska and Hawaii.
- Reimbursement to the provider delivering the service is the same as the current fee schedule amount for the service provided.
The Medicare telehealth regulation is available at 42 CFR § 410.78.

*General rule.* Medicare Part B pays for:
- office or other outpatient visits,
- subsequent hospital care services (with the limitation of one telehealth visit every three days by the patient's admitting physician or practitioner),
- subsequent nursing facility care services (not including the Federally-mandated periodic visits under §483.40(c) of this chapter and with the limitation of one telehealth visit every 30 days by the patient's admitting physician or nonphysician practitioner),
- professional consultations,
- psychiatric diagnostic interview examination,
- neurobehavioral status exam,
- individual psychotherapy, pharmacologic management,
- end-stage renal disease-related services included in the monthly capitation payment (except for one “hands on” visit per month to examine the access site),
Medicare

• General rule. Medicare Part B pays for:
  • individual and group medical nutrition therapy services,
  • individual and group kidney disease education services,
  • individual and group diabetes self-management training services (except for one hour of “hands on” services to be furnished in the initial year training period to ensure effective injection training),
  • individual and group health and behavior assessment and intervention services,
  • smoking cessation services,
  • alcohol and/or substance abuse and brief intervention services,
  • screening and behavioral counseling interventions in primary care to reduce alcohol misuse,
  • screening for depression in adults,
  • screening for sexually transmitted infections (STIs) and high intensity behavioral counseling (HIBC) to prevent STIs,
  • intensive behavioral therapy for cardiovascular disease,
  • behavioral counseling for obesity,
  • and transitional care management services furnished by an interactive telecommunications system
Medicare

- 42 CFR § 410.78 lists the following conditions for payment:
  - The physician or practitioner at the distant site must be licensed to furnish the service under State law.
  - The practitioner at the distant site is one of practitioner types listed in 42 CFR § 410.78(b)(2).
  - The services are furnished to a beneficiary at an originating site, which is one of the following: the office of a physician or practitioner, a critical access hospital, a rural health clinic, a federally qualified health center, a hospital, a hospital-based or critical access hospital-based renal dialysis center (including satellites), a skilled nursing facility, or a community mental health center.
  - Originating sites must be located in a health professional shortage area or located in a county that is not included in a Metropolitan Statistical Area or an entity participating in a Federal telemedicine demonstration project that has been approved by, or receive funding from, the Secretary of HHS.
Private Payors - Humana

- Humana
  - Allows “eVisits” to enable doctor visits for certain, non-emergency care. In the near future, Humana sees this type of visit to become more common.
  - eVisits services can include, but are not limited to: triaging, diagnosis, acute non-emergent treatment, patient education and doctor (Primary Care Physician) to Specialist consultations. eVisits enable the care for certain conditions like: Upper respiratory infections like cold, cough, flu, sore throat, sinus infection, allergies and asthma, headaches, ear and eye problems, and skin conditions.
  - eVisits availability will vary depending on location and contract. Not available for all markets or plans. Humana does not currently provide a direct to consumer eVisits services at this time.
  - See https://www.humana.com/individual-and-family-support/benefits/health-resources/telemedicine
United Healthcare

- United Healthcare will reimburse for telehealth services which are recognized by CMS when reported with modifier GT (Interactive Telecommunications).
- United Healthcare will not reimburse telehealth services submitted with modifier GQ (Asynchronous Telecommunications) because these services do not include direct, in-person patient contact.
- See https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesHtml/ReimbursementPolicies/Telemed_v2014A.pdf
Private Payors - Aetna

• Aetna
  • First participated in telehealth in 2006.
  • Testing a pilot program, Teladoc, in several states. It offers a telehealth medical consultation for issues such as respiratory infections, ear infections, urinary tract infections, allergies, colds and flu, sore throat, and pink eye.
Private Payors - Anthem

• Anthem
  • In Ohio, Anthem Blue Cross and Blue Shield recently began a virtual doctor appointment service for non-emergency problems such as sore throats, allergies and minor infections.
  • Long-range goal is to make it available to all of the insurer’s nearly 29 million members. See http://www.managedcaremag.com/archives/1303/1303.telemedicine.html.
Telehealth Coding - Medicare

- Medicare
  - Telehealth facility fee is paid to the originating site. Claims for the facility fee are submitted using HCPCS code Q3014: "Telehealth originating site facility fee."
    - The CY 2014 Medicare Part B payment for Q3014 is $24.63.
  - GT modifier - Medicare providers at the distant site submit claims using the appropriate CPT or HCPCS code along with the GT modifier, “via interactive audio and video telecommunications system.”
    - The rate paid to the provider delivering the service at the distant site is the current Medicare fee schedule rate.
  - GQ modifier – In Alaska and Hawaii, “store and forward” technology may be used to substitute for an interactive telecommunications system.
    - The distant site practitioner reviews the medical information at a later time.
    - Medicare providers in these states may submit the CPT or HCPCS code for the professional service along with the GQ modifier, “via asynchronous telecommunications system.”
Telehealth Coding - Medicaid

- Medicaid
  - State Medicaid programs may select from a variety of HCPCS codes (T1014 and Q3014), CPT codes and modifiers (GT, U1-UD) in order to identify, track and reimburse for telemedicine services. See http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html
Costs

• Most peer-reviewed research is relatively new, but some research indicates that telehealth saves money for patients, providers, and payors.

  • A study of a program treating individuals with chronic illness that found spending reductions of approximately 7.7–13.3 percent ($312–$542) per person per quarter.
  • A study of a program that reduced transfers between emergency departments and found potential cost savings of $537 million a year.
Costs

- If further research and experience continue to strengthen the evidence for the cost-effectiveness of telehealth, in risk-based contracting the risk-bearing entity (payor or provider) will have a financial incentive to reimburse or provide telehealth services.
  - The risk-bearing entity would likely work within the current legal framework to the extent possible to minimize requirements, like in-state licensure, that could create barriers to accessing telehealth services.
- In shared savings payment arrangements, like an Accountable Care Organization (ACO) or certain bundled payment methodologies, in which the provider is rewarded for providing care at a lower cost, there will be an incentive for the provider to utilize telehealth to the extent the provider believes it will be cost-effective.
Telehealth is very likely to continue to expand to more payors and more services.  

2014 brought incremental changes to Medicare policy, including the addition of two services and an allowance for originating sites in health professional shortage areas (HPSAs) located in rural census tracts of metropolitan statistical areas. 

Law makers in Connecticut, Iowa, Illinois and West Virginia have recently introduced telehealth parity legislation, and fifteen states are reconsidering telemedicine legislation that was introduced in 2013, according to http://www.americantelemed.org/news-landing/2014/01/14/state-legislators-reconvene-to-consider-telemedicine-bills.
The Future of Telehealth Reimbursement

- Most states mandate that the provider be licensed in the state of the originating site, but some efforts, such as the TELE-MED Act of 2013, are under weigh to allow providers who are licensed in one state deliver telehealth services to patients in other states.  
- The long-term trend is that CMS is expanding Medicare coverage, and state Medicaid programs and private payors are often doing the same.
Sources/Resources

- American Telemedicine Association
  - http://www.americantelemed.org/
- Telehealth Resource Centers
  - http://www.telehealthresourcecenter.org/
- Center for Telehealth and e-Health Law
  - http://ctel.org/expertise/reimbursement/
- CMS – Medicare Teleheath Fact Sheet
- National Conference of State Legislators