National Rural Health Association Policy Brief

Telemedicine Reimbursement

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I. Executive Summary

Background: Many rural patients and communities have long faced challenges related to health care access and cost. These persistent problems for communities and rural health care facilities have been exacerbated by the current economic downturn. The negative impacts trickle down and affect patients most severely. The National Rural Health Research and Policy Analysis Center conducted a study that illustrated substantial health care access barriers and difficult financial circumstances.[1] The access barriers are even more pronounced in the specialty-care arena as rural sites lack a specialty-care system that meets residents' needs.

Issue: n Reimbursement limitations prevent widespread adoption of telehealth. The current telehealth reimbursement policy outlined by the Department of Health and Human Services in November 2009 applies associated geographical constraints as well as professional and application restrictions for providers. These pose significant barriers in the efforts to increase health care access for patients.[2]

Recommendation: Telehealth eliminates barriers to accessing quality care by using audio-video technology to connect patient with providers hundreds of miles away.

1. Lift the geographical patient requirements of receiving care in Health Professional Shortage Areas (HPSAs) and non-Metropolitan Statistical Areas (MSAs).
2. Eliminate separate billing procedures for telemedicine.
3. Reimburse care provided by physical therapists, respiratory therapists, occupational therapists, speech therapists, licensed professional counselors and therapists, and social workers.
4. Increase reimbursement for the originating telemedicine sites.
5. Provide reimbursement for store-and-forward applications.

II. Background

Telehealth provides patients and rural facilities access to primary and specialty care. The care delivered over videoconferencing equipment, aided by special stethoscopes, otoscopes and examination cameras, allows physicians and nurses to see patients almost as if they were directly in the room. Telehealth is considered to be a cost-effective alternative to the more traditional face-to-face way of providing medical care.[3] Telehealth lowers the cost of care by providing early and timely diagnosis, improving triage, reducing unnecessary transfers and improving management of chronic diseases.

More than 85 percent of patients seen via telemedicine remain in the local community, resulting in lower costs of care, and further enhancing the financial viability of the community hospital.[4]

III. Issue

There are five reimbursement challenges that prevent widespread adoption of telehealth:

- Geographic restrictions
- Coding limitations
- Provider eligibility limitations
- Inequitable originating site fees
- Ineligibility of store-and-forward applications

Geographical Restrictions: Telehealth was originally identified as a solution exclusively for rural patients, and reimbursement has been limited to patients in the most underserved communities. The Benefits Improvement and National Rural Health Association Policy Brief Telehealth Reimbursement Protection Act of 2000 included amendments to the Social Security Act and removed some of the prior constraints, yet maintained substantial limitations related to geographic location, originating sites and eligible telehealth services.[5] Barriers to health care exist independently and regardless of geographical criteria.

The current reimbursement policy outlined by the Centers for Medicare & Medicaid Services (CMS) requires the telehealth encounter to meet the following criteria: The Medicare beneficiary resides in, or utilizes the telehealth system in a federally designated rural health professional shortage area (HPSA) in a county that is not included in a metropolitan statistical area (MSA); or from an entity that participates in a federal telemedicine demonstration project that has been approved by the Secretary of Health and Human Services as of Dec. 31, 2000.[6]

A MSA contains a core urban area of 50,000 people or more and includes the counties containing the core urban area, as well as any adjacent counties that have a high degree of social and economic integration (as measured by commuting to work).[7] There are two key problems with limiting eligibility to MSAs. The first is that the definition of MSAs by county line may result in rural communities more than an hour outside of the city limits being defined as metropolitan. Additionally, there may be many instances where patients living within MSAs lack access to specialists because their sub-specialty is not available locally or the specialist does not have capacity to take new patients. In many areas of the country there are not enough health professions to provide certain in-person visits. Telehealth allows patients in need of services to reach providers with capacity and should not be restricted based on rurality.

HPSAs are designated by the Health Resources and Services Administration as having shortages of primary-medical care, dental or mental-health providers and may be geographic (a county or service area) demographic (low income population) or institutional (comprehensive health center, federally qualified health center or other public facility). Because of limits to eligibility based on HPSAs, residents who have access to primary care, dentistry, and mental health but no other key specialties are penalized.

Code Limitations: The current reimbursement policy requires the telehealth encounter to include specific professional CPT codes. The following is a breakdown of codes that are currently reimbursed and codes that should be reimbursed.

Telehealth Reimbursed Codes	
CPT/HCPCS Codes	**Telehealth Services**
99201-99215	Initial outpatient visits
99211-99215	Follow-up outpatient visits
G0425-G0427	Initial telehealth inpatient visits
G0406-G0408	Follow-up inpatient visits
90801	Psychiatrist diagnostic interview examinations
90804-90809	Individual psychotherapies
96150-96152	Individual health and behavioral assessment interventions
90862	Pharmacologic management
G0270, 97802, 97803	Individual medical nutrition therapies
90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961	End-stage-renal-disease-related services
96116	Neurobehavioral status exams

Codes NOT Reimbursed if Provided by Telehealth	
CPT/HCPCS Codes	**Telehealth Services**
96118-96119	Neuropsychological testing
99231-99233	Subsequent hospital care for behavioral health
99238-99239	Discharge-day service for behavioral health
99291-99292	Critical care
99307-99310	Subsequent nursing facility care per day
99315-99316	Discharge services for nursing facility services
99318	Other nursing facility services
96153	Health and behavior intervention, group
96154	Health and behavior intervention, family-with-patient

Provider Eligibility Limitations: Medicare reimbursement for telehealth services is limited to certain providers, specifically, the telehealth encounter must be performed by a:

- Physician
- Nurse practitioner
- Physician assistant
- Nurse midwife
- Clinical nurse specialist
- Clinical psychologist
- Clinical social worker with master's degree
- Registered dietitian
- Nutrition professional

However, there is a shortage of several types of professionals who are not included on the reimbursement eligible list. These providers include:

- Physical therapists
- Speech therapists
- Respiratory therapists
- Occupational therapists
- Social workers

The services of these providers are in high demand and often not available in rural communities. With assistance from health care technicians at the rural site, these services can be provided over telehealth.

Inequitable Facility Fee:

CMS provides reimbursement to the telehealth provider and the originating site. The originating site is defined as the physical location of the patient. This location provides a nurse to facilitate the provider consultation with the patient. The nurse completes a nursing assessment on the patient, presents the patient to the physician and assists as needed throughout the consultation via the telehealth equipment.

For this service, the originating site can charge a telehealth site facility fee. The payment amount for HCPCS Level II code Q3014 Telehealth originating site facility fee is 80 percent of the lesser of the actual charge or $24 – up from $23.72 in 2009, an increase of 1.2 percent. Patients are responsible for any unmet deductible amount or coinsurance.

As of October 1, 2001, coverage and payment for Medicare telehealth includes consultation, office visits, individual psychotherapy, and pharmacologic management delivered via a telecommunications system.

Costs to the originating sites (where patient is located) for telemedicine consultations is insufficient to cover costs of 4 providing the services. The current site fee a telehealth originating site is $24, which is only a $4 increase in the amount established in 2001.Beginning October 1, 2001 CMS initiated coverage of and payment of a site fee for Medicare telehealth services including office visits, individual psychotherapy, and pharmacologic management delivered via an interactive telecommunications system. In 2001 the fee was set at $20.8 Because rural providers do not receive equitable compensation for their provision of services provided via telehealth, they are concerned about maintaining the support staff that is required to facilitate telehealth visits. If the originating site is not fairly compensated, telehealth is doomed to remain a fringe service.

Ineligibility of Store-and-Forward Applications:

Store-and-forward is the transmission of medical information to be reviewed at a later time by a physician or practitioner at a distant site. Medical information may include still images, X-rays, MRIs, EKGs, laboratory results, audio clips and text. The physician at the distant site reviews the case without the patient being present. Certain store-and-forward technologies such as X-rays, diagnostic ultrasound, EKG, EEG and cardiac pacemaker analysis, are covered as they are services that do not normally require in-person interaction between provider and patient. Others, such as digital images for diabetic retinopathy or skin lesions and pathology slides that are captured, sent and read without direct patient interaction, are not reimbursable outside of demonstration projects.

Several respected health care providers, payers and professional groups, including the VA, Aetna, the National Institutes of Standards and Technology and the American Academy of Dermatology, have recognized the efficacy of these telehealth applications. For many years, regional store-and-forward programs have been providing consultation to VHA sites in need of specialty expertise. VHAs first national store-and-forward program is a primary-care based model that screens veterans with diabetes for retinopathy using teleretinal imaging, which expedites referral for treatment and provides health information. Numerous other studies also support the use of store-and-forward technologies.9 Limiting these technologies with a requirement for in-person interaction unnecessarily restricts access to care for underserved patients.

IV. Recommendations

1. Lift the geographical patient requirements of receiving care in a health professional shortage area (HPSA) and non-metropolitan statistical areas (MSA).

2. Eliminate separate billing procedures for telemedicine,

3. Reimburse care provided by a physical therapist, respiratory therapist, occupational therapist, speech therapist and social worker.

4. Implement fair-market reimbursement for the originating site.

5. Provide reimbursement for store-and-forward applications.

Bibliography

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