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an interview with Justin Lansford

U.S. Army Veteran
America's Fund Recipient,
and Gabe's pal

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by Max Reiboldt, CPA

Addressing compliance issues in reimbursement and licensing for telemedicine

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A growing number of hospitals and healthcare providers are now using telemedicine to deliver clinical services to patients located in hospitals, physician offices, and beyond. With telemedicine, healthcare facilities can aim to reduce hospital admissions, readmissions, and emergency room (ER) volume by treating patients with chronic conditions who may otherwise be unable to seek treatment or effectively manage their conditions without the availability of telemedicine. Patients with minor ailments or those needing follow-up visits can also use telemedicine in cases where an in-person visit is not necessary to address health needs. Additionally, telemedicine facilitates better patient care by connecting patients to specialists that they would be unable to access otherwise, such as in rural areas or locations experiencing a shortage of specialists.

Reiboldt

Although telemedicine promises to expand access and improve the quality of care for patients, current reimbursement and licensing policy is often viewed as a barrier to the adoption of telemedicine. Compliance-related regulations and requirements for telemedicine reimbursement vary among federal and private payers. No two states are alike when it comes to how telemedicine is covered and reimbursed. Licensing and credentialing also present a challenge, because providers are generally required to be licensed in every state where they work and in every facility in which they see patients. Fortunately, procedures have been enacted to facilitate the licensing and credentialing process for telemedicine providers. Providers should always be vigilant of new policies, regulations, and other changes that occur over time in the emerging field of telemedicine.

Medicare and telemedicine

Major Medicare regulations around telemedicine reimbursement include stipulations on the location of the patient and provider,

eligible types of providers, and method of telemedicine care delivery. First, to define some terms commonly used in telemedicine, the "originating site" refers to the patient's location at the time of service. The "distant site" refers to where the provider is located at the time of service.

For telemedicine services to be reimbursed by Medicare, patients must be in a county outside of a Metropolitan Statistical Area (MSA), which are determined by the Census Bureau, and in a recognized Health Professional Shortage Area (HPSA). Further, patients must also be located in an eligible originating site at the time of service. Under Medicare, eligible originating sites are physician offices, hospitals, critical access hospitals, federally qualified health centers (FQHCs), hospital-based dialysis centers, skilled nursing facilities (SNFs), and community mental health centers.[1]

However, Medicare patients and providers participating in a New Generation Accountable Care Organization (ACO) are eligible for the Telehealth Expansion Waiver from the Centers for Medicare & Medicaid Services (CMS). The waiver eliminates any geographic restrictions for telemedicine and also allows patients to be located in their own homes in addition to any of the previously mentioned eligible sites.

Medicare also specifies which types of providers are eligible to bill for and receive reimbursement. Currently, eligible practitioners are physicians, nurse practitioners, physician assistants, nurse-midwives, clinical nurse specialists, nurse anesthetists, clinical psychologists and social workers, registered dieticians, and nutritionists.[2] Finally, only telemedicine encounters rendered in a real-time interactive audio-video format are eligible for reimbursement (see Table 1). Store-and-forward encounters (i.e., where a patient records images, videos, and data, which are collected and forwarded electronically to a provider for evaluation) are only reimbursable in Alaska and Hawaii.

Billing codes

A "GT" modifier must be used in addition to the CPT code to bill for services. If located in Hawaii or Alaska and using a store-and-forward method of care, use the GQ modifier instead. To indicate that the billed service was furnished as a telehealth service from a distant site, also use the modifier Place of Service (POS) 02 for services furnished on or after January 1, 2017. Originating sites are also able to bill a separate facility fee that is intended to cover the cost of carrying out the telemedicine visit (e.g., use of technology, equipment, space) by using CPT code Q3014. For 2017, the CMS allowable telehealth originating site facility fee is $25.40. If all the requirements are met, Medicare will reimburse providers at the same

Table 1: A sample offering of Medicare Telehealth Services – Calendar Year 2017

Service	CPT Code
Advance Care Planning	99497 & 99496
Psychoanalysis of Family Psychotherapy	90845–90847
Prolonged service in the inpatient or outpatient setting	99354–99357
Individual and group medical nutrition therapy	97802–97804
Neurobehavioral status examination	96116
Smoking cessation services	99406 & 99407
Office and outpatient visits	99201–99215
Hospital care services, limit of 1 telehealth visit every 3 days	99307–99310
Individual and group health and behavior assessment	96150–96154
Individual psychotherapy	90832–90834 & 90836–90838
End-Stage Renal Disease (ESRD)-related services	90963–90970
Transitional care management services	99495 & 99496

rate for telemedicine services as comparable in-person services.[3]

Medicaid and telemedicine

Medicaid coverage for telemedicine is much more varied, because states have extensive control over how to structure and administer their Medicaid telemedicine policy. Medicaid regulations may not always reflect state laws and regulations on telemedicine. However, most regulations can be grouped into major areas, such as eligible modalities of telemedicine, eligible locations for service, eligible providers, obtaining consent for treatment, and online prescribing.

Currently, 48 states and the District of Columbia provide some form of reimbursement for live-video telemedicine services, 13 states will reimburse for store-and-forward telemedicine services, and 22 states reimburse for remote patient monitoring (RPM), limited to specific conditions (see Table 2). RPM is a form of telemedicine where health data (e.g., vital signs, weight, blood pressure) is consistently collected from a patient using digital technologies and transmitted to a provider to use in the management of health or disease. Finally, there are eight states whose Medicaid programs will reimburse for all three forms of service. They are Alaska, Arizona, Hawaii, Illinois, Minnesota, Mississippi, Missouri, and Washington.

Different restrictions and allowances for telemedicine exist among states' Medicaid programs regarding several major areas of policy and regulation. As with Medicare, states can determine eligible locations for both the originating and distant site. A specific geographic distance may also be required between the provider and patient, although states are generally trending away from location/geography restrictions. The types of providers who are eligible to bill and be reimbursed for telemedicine services also vary. Medicaid in 15 states presently covers any healthcare provider who practices telemedicine, while four states limit coverage to only physicians. Another highly varied requirement is the process for obtaining consent for treatment. States can require verbal or written consent from the patient prior to treatment. Some states take it a step further and require that a patient and provider have had a previous in-person encounter before allowing for telemedicine reimbursement. Finally, states will have different regulations on the prescribing of controlled substances through telecommunication.

Table 2: Medicaid reimbursement for telemedicine delivery methods

Live Video/Real Time	Store-and-Forward		Remote Patient Monitoring	
All states except Massachusetts and Rhode Island.	• Alaska • Arizona • Connecticut • Hawaii • Illinois • Minnesota	• Mississippi • Missouri • New Mexico • Nevada • Virginia • Washington	• Alabama • Alaska • Arizona • Colorado • Hawaii • Illinois • Indiana • Kansas • Kentucky • Louisiana • Maine	• Minnesota • Mississippi • Missouri • Nebraska • New York • South Carolina • Texas • Utah • Vermont • Virginia • Vermont
Reimburse for all Modalities: Alaska, Arizona, Hawaii, Illinois, Minnesota, Mississippi, Missouri, and Washington				

In general, reimbursement for Medicaid-covered telemedicine care must satisfy federal requirements for efficiency, economy, and quality of care, although clearly for Medicaid, there are many more compliance-related issues to be aware of connected to reimbursement. These rules and regulations are rapidly changing as states continue to pass legislation regarding telemedicine. Therefore, to qualify for maximum reimbursement, it is important to be vigilant of all potential and upcoming changes in the state(s) where one practices telemedicine.

Private payers and telemedicine

Commercial payers have perhaps been the most aggressive in reimbursing for telemedicine visits in recent years. Some are steadily broadening coverage through partnerships with telemedicine service companies. Twenty-nine states and the District of Columbia have enacted parity laws that mandate private payers to cover telemedicine services. A further eight states have proposed parity laws and are awaiting legislative action. Under parity laws, coverage and restrictions still vary by state, but live-video telemedicine care is always covered to some extent.

Many large private payers are conducting telemedicine pilot programs to test cost-saving benefits and care outcomes.

The top five commercial payers—Aetna, Cigna, Blue Cross Blue Shield, Humana, and UnitedHealthcare—all offer some form of coverage for telemedicine, even in states where coverage is not legally required (i.e., where there is no parity law). However, telemedicine coverage is dependent on policy. For example, a Blue Cross Gold Plan may cover telemedicine services while a Bronze Plan might not. Many large private payers are conducting telemedicine pilot programs to test cost-saving benefits and care outcomes.[4]

Reimbursement rates from private payers depend on state policy and negotiated rates with providers. Some states mandate private payers to reimburse for telemedicine at the same amount as in-person care, but most states leave the determination of rates up to the payers. That said, a majority of commercial payers will still reimburse at the same rate as in-person visits. As with Medicare billing, most commercial payers require the billing of telemedicine services with the GT modifier, along with the correct CPT codes. It is always important to verify with payers on their specifics regarding billing.

Licensing and credentialing

Physician licensing is usually not an issue when a physician provides telemedicine services to a patient within the same state. However, it becomes more complicated when physicians are required to treat out-of-state patients. The rule of thumb is that a physician must be licensed in the state where the patient is located at the time of service. Each state has the ability to determine what licensing out-of-state physicians must obtain to provide telemedicine within the state. Some states also issue special telemedicine licenses that allow out-of-state physicians to practice only telemedicine in the state. The Federation of State Medical Boards (FSMB) offers an expedited licensing process for physicians to practice across multiple states through the Interstate Medical Licensure Compact. Twenty-two states have currently enacted the compact, making it easier for physicians to obtain licenses to practice in multiple states, which

increases the number of physicians able to provide care to patients by telemedicine.[5]

Hospitals are responsible for credentialing all physicians who provide services at the hospital. But with telemedicine, the credentialing process is more labor intensive, because physicians need to be credentialed at the facility from which they provide services (the distant site) as well as the facility to which they provide telemedicine services, or where the patient is located (the originating site). In 2011, CMS enacted the process of credentialing by proxy, so that the originating site can use the credentialing completed at the distant site to establish privileges for physicians at the originating site. Credentialing by proxy allows hospitals to easily use specialists who are credentialed by another hospital for telemedicine services.[6]

Credentialing by proxy requires that the originating site hospital enters into an agreement with the distant site hospital stipulating that:

- both sites are Medicare-participating facilities,
- physicians will have privileges at the distant site,
- physicians are licensed in the originating site state, and
- the originating site will alert the distant site of all actions and complaints against their physicians.[7]

Conclusion

Telemedicine is an ever-growing area of healthcare that is expected to expand access to care, create more effective healthcare delivery, and realize cost savings over time. It has grown from 250,000 patient users in 2013 to an anticipated seven million patient users by 2018.[8] As health networks expand to encompass multiple states through clinically integrated networks and reimbursement shifts to value-based payments, health systems and providers are looking to telemedicine to improve the value of care and drive down costs. But a challenge with the adoption of telemedicine is that regulations, such as those related to reimbursement and licensing, are not yet standardized from state-to-state. Remaining aware of upcoming changes to policies and other compliance is important as this emerging method of care delivery evolves. To avoid risks and pitfalls, successful implementation of telemedicine programs start with and require understanding and compliance with all federal and state legal requirements and regulations.

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