TELEMEDICINE MEDICAL SERVICES

Biennial Report to the Texas Legislature

As Required by Texas Government Code Section 531.0216

Health and Human Services Commission

December 2008

Table of Contents

Executive Summary 1

Telemedicine in Texas Medicaid/History and Background 2

Adoption of the Telemedicine Services Benefit 2

Changes Affecting the Telemedicine Services Benefit 2

Telemedicine in Texas Medicaid 3

Telemedicine Medical Policy 3

Terms and Definitions 3

General Telemedicine Policy 4

Effects of Telemedicine in Texas Medicaid 5

Conclusion 5

Appendix A A-1

Appendix B B-1

Appendix C C-1

Appendix D D-1

Executive Summary

Pursuant to S.B. 789, 77th Legislature, Regular Session, 2001, Health and Human Services Commission (HHSC) is required to submit a report to the Legislature by December 1 of each even-numbered year, on the effects of telemedicine medical services on the Medicaid program. The stated goals of the report, as articulated in S.B. 789, are to report on the effects of telemedicine services on the Medicaid program in the state including:

- the number of physicians and health professionals using telemedicine medical services;
- the geographic and demographic disposition of the physicians and health care professionals;
- the number of patients receiving telemedicine medical services;
- the types of services being provided; and
- the cost of telemedicine medical services to the program.

HHSC conducted an analysis of telemedicine services to evaluate the effects of telemedicine in Texas Medicaid. HHSC found that only a small number of physicians utilized telemedicine services. This finding, however, could be due to the way providers report the use of telemedicine services. Providers report telemedicine services by using a GT (telemedicine) modifier. A physician will modify the billable procedure code they submit for reimbursement by attaching a "GT" on to the end of that code. This enables HHSC to track the use of telemedicine services. Because providers self-report telemedicine services and there are no mechanisms to enforce the use of the GT modifier, it is likely that more providers are using telemedicine technology than is reported.

HHSC continues to encourage the use of telemedicine to increase access to care in medically underserved areas of the state. HHSC is also making changes to improve the use of these services. These changes will increase the types of medical services that may be reimbursed through telemedicine, expand allowable patient site presenters, remove limitations on distant site providers, add reimbursement of a facility fee payable to the patient site, and add local health departments as an additional location where patients may receive telemedicine services. In conjunction with these changes, HHSC is also increasing its ability to track telemedicine utilization and distinguish between patient and distant sites, thereby increasing the ability to further analyze the use of telemedicine in Texas Medicaid.

Telemedicine in Texas Medicaid/History and Background

Adoption of the Telemedicine Services Benefit

H.B. 2386 and H.B. 2017, 75th Legislature, Regular Session, 1997, directed HHSC to reimburse providers for services performed using telemedicine. Pursuant to this legislative direction, HHSC adopted a rule that was published in the Texas Administrative Code, which set forth definitions for telemedicine and established Medicaid reimbursement for distant and patient site providers. The original adopted rule allowed providers to be reimbursed for the following services when provided via telemedicine technology: consultations; interpretations; and interactive video visits.

Medicaid started reimbursing providers for these services in August 1998.

Changes Affecting the Telemedicine Services Benefit

Since the adoption of the telemedicine benefit in 1998, changes in state and federal laws have affected telemedicine reimbursement and expanded the use of telemedicine services in Texas Medicaid.

S.B. 789, 77th Legislature, Regular Session, 2001, authorized HHSC to establish procedures to determine which telemedicine medical services should be reimbursed, reimburse services at the same rate as face-to-face medical services, and submit a report to the Legislature by December 1 of each even-numbered year, on the effects of telemedicine medical services on the Medicaid program.

The Health Insurance Portability and Accountability Act was enacted by the U.S. Congress in 1996. The Act required that by October 2003 health insurance payors use universal transaction and code standards for claims payment. Up until this point, payors could use their own standards, which is how HHSC reimbursed providers. Because of this new requirement, HHSC had to change the telemedicine policy. Instead of using a local reimbursement code, HHSC was required to adopt national codes for reimbursement of its telemedicine services.

S.B. 691, 78th Legislature, Regular Session, 2003, required HHSC to periodically review policies regarding the reimbursement of telemedicine services under the Medicaid program. Specifically, HHSC was directed to identify variations between Medicaid and Medicare reimbursement and was also authorized to modify rules and procedures as appropriate.

S.B. 1340, 79th Legislature, Regular Session, 2005, authorized HHSC to develop, and the Texas Department of State Health Services (DSHS) to implement, a pilot program enabling Medicaid recipients in need of mental health care to receive these services via telemedicine.

Most recently, S.B. 24 and S.B. 760, 80th Legislature, Regular Session, 2007, directed HHSC to make additional policy changes to the Medicaid telemedicine program. S.B. 24 instructs HHSC to add office visits as an additional telemedicine service for which distant site providers may receive reimbursement and to establish a mechanism to reimburse services provided at the patient site by either: (1) allocating reimbursement between the distant and patient site; or (2) establishing a facility fee and extending the telemedicine mental health pilot through

September 1, 2009. S.B. 760 changes the telemedicine terminology and directs HHSC to encourage the use of telemedicine.

Telemedicine in Texas Medicaid

The Texas Administrative Code, §354.1430, defines telemedicine as a method of health care service delivery used to facilitate medical consultations by physicians to health care providers in rural or underserved areas for purposes of client diagnosis or treatment that require advanced telecommunications technologies.

Telemedicine involves: (1) a patient site provider responsible for presenting the patient; and (2) a distant site provider rendering consultation for the purposes of diagnosis or treatment. The patient and distant site providers are restricted to certain provider types and locations as specified in rule.

Telemedicine technology is used to increase access to care in medically underserved areas in Texas. Generally, telemedicine services have been used to provide specialty care since there are shortages of specialists in many areas of the state, particularly in rural and medically underserved areas. To date, the Texas Medicaid program has reimbursed distant site providers for consultation and patient site providers for office visits when the presenter is a physician provider type. In addition, telemedicine is also reimbursed when mental health services are provided within the scope of the telemedicine mental health pilot. This includes reimbursement of medication management, diagnostic interviews, and psychotherapy.

HHSC is in the process of amending the telemedicine rules to adopt the mental health services available in the telemedicine pilot. The changes also include the expansion of telemedicine services to allow distant site providers to bill and be reimbursed for office visits, in addition to consultations, for the provision of follow-up and ongoing medical care. The proposed rules further expand who is allowed to present the patient to include licensed and certified health professionals or qualified mental health professionals, and will allow for reimbursement of a facility fee for presenting the patient.

Telemedicine Medical Policy

Terms and Definitions

Texas Medicaid uses the following words and terms to define telemedicine services, providers, and places of service.

Telemedicine – A method of health care service delivery used to facilitate medical consultations by a physician to health care providers for purposes of patient diagnosis or treatment that requires advanced telecommunications technologies.

Distant Site – The location where the consulting physician is physically located.

Distant Site Provider – A provider that is located at a distant site and uses telemedicine to provide health care services to a patient located at patient site.

Patient Site – The site where the patient is located.

Telepresenter – The provider at the patient site responsible for presenting the patient to the distant site provider.

Rural Area – A county that is not included in a metropolitan statistical area as defined by the U.S. Office of Management and Budget (OMB) according to the most recent U.S. Bureau of the Census population estimates.

Underserved Area – An area that meets the current definition of a medically underserved area or medically underserved population by the U.S. Department of Health and Human Services.

General Telemedicine Policy

Telemedicine is a benefit of Texas Medicaid only when provided under certain guidelines. For example, the services must be provided using a system that meets minimum technical specification standards, as identified by HHSC. In addition, the medical service must be provided by a distant site provider who diagnoses and treats a client in a rural or medically underserved area.

Medicaid rules currently limit telemedicine sites to rural or medically underserved areas, consistent with the formal designations established by the U.S. Census Bureau. The U.S. Census Bureau generally defines rural areas as counties with a population of 50,000 or less.

Table A in the Appendix shows the allowable services, locations, and provider types that may be reimbursable when provided via telemedicine technology and billed with the GT modifier. The GT modifier is used to indicate that the service was provided via telemedicine. The chart also specifies which services, site locations, and providers are specific to the telemedicine mental health pilot, and indicates which aspects are included in the proposed changes to the telemedicine rules.

The proposed telemedicine rule changes will allow for the reimbursement of a facility fee at the patient site, thereby providing reimbursement for services provided by tele-presenters under the delegation of the distant site provider. The proposed rules also remove the restriction on distant site locations, thereby expanding the options for distant site providers. Currently, distant site providers are limited to providing services in medical schools and entities affiliated through a written agreement with medical schools or a governmental agency. These changes meet the directive in S.B. 24 and S.B. 760 and serve to further promote the use of telemedicine services in Texas Medicaid.

Effects of Telemedicine in Texas Medicaid

Limited data exists to demonstrate the effects telemedicine has on the Texas Medicaid program. Available data show a slow increase in the use of telemedicine services; however, the analysis was found to be inconclusive because of limited claims data.

Telemedicine services are reported by providers using the GT (telemedicine) modifier. A physician will modify the billable procedure code to be submitted for reimbursement by attaching a "GT" onto the end of that code. This enables HHSC to track the use of telemedicine services. Because providers self-report using telemedicine services, and there are no mechanisms to enforce the use of the GT modifier, it is likely more providers are using telemedicine technology than is reported.

While limited data exists, available information demonstrates a slow increase in the use of telemedicine services, the number of clients receiving services, the cost of telemedicine to the Medicaid program, and the types of services being provided via telemedicine. Tables B and C in the Appendix provide more detail on these data.

Geographic designations for rural or medically underserved counties classify 211 of Texas' 254 counties as eligible for patient site services. An additional 37 counties contain specific eligible census tracts that make them partially eligible for the medically underserved designation. Only six counties in Texas are neither rural nor medically underserved and, therefore, are not allowable locations for telemedicine patient site services. Table D in the Appendix demonstrates client utilization and amount of funds expended on telemedicine services by metropolitan statistical area.

Lastly, DSHS' evaluation of the telemedicine mental health pilot shows that the use of telemedicine increased access to services. In addition, the clinical outcomes of clients were not significantly different between telemedicine and face-to-face service delivery methods.(1)

Conclusion

Provider billing practices and limitations in the claims data impede our ability to comprehensively evaluate the effects of telemedicine in the Medicaid program at this time. However, the proposed rule changes will help to address this issue, encourage the use of telemedicine, and allow for easier tracking of telemedicine services and providers. Further, as HHSC continues to develop and deploy telemedicine pilots, the state expects to gain a better understanding of the effects of telemedicine on the access to care, quality, utilization, and provider base.

Reference:

1. Mental Health Telemedicine Service Pilot Report, Prepared by the Department of State Health Services for the Health and Human Services Commission, September 2008. (A copy of the report can be found on the HHSC website at: http://www.hhsc.state.tx.us/about_hhsc/reports/search/Search_Reports.asp).

Appendix A

Texas Medicaid Telemedicine Benefits

Medicaid Reimbursable Distant Site Services	Allowable Distant Site Locations	Allowable Distant Site Providers	Allowable Patient Site Locations	Allowable Patient Site Providers and Tele-presenters
• Consultation • ***Medication Management*** • ***Psychiatric Evaluation Psychotherapy with Evaluation and Management*** • *Office Visits*	• Medical School • Osteopathic School • One of the following entities affiliated through a written contract or agreement with a government agency, medical or osteopathic school: 1. Hospital 2. Tertiary Center 3. Health Clinic 4. Community Mental Health Center (CMHC) 5. Rural Health Facility • *No Limitation*	• MDs	• State hospital • State school • One of the following settings located in a rural or medically underserved area: 1. Physician office 2. Hospital 3. RHC 4. FQHC 5. ICFs/MR, **CMHCs, and Associated Outreach Sites** 6. *Local Health Departments*	• MDs • APNs • PAs • **One of the following professionals contracted with or employed by a CMHC:** **1. Licensed Psychologist** **2. Licensed Professional Counselor (LPC)** **3. Licensed Clinical Social Worker (LCSW)** **4. Licensed Marriage and Family Therapist (LMFT)** ***5. Qualified Mental Health Professional – Community Services (QMHP-CS)*** • *Texas Licensed or Certified Health Care Professionals*

Note: *Italics*: Represents the proposed changes to the Texas Medicaid telemedicine rules.
Bolded: Represents benefits specific to the telemedicine mental health pilot.
Italics and Bolded**:** Represents items that are specific to the mental health pilot that are being adopted into the proposed rule changes.
Regular: Represents current benefits.

Source: HHSC Center for Strategic Decision Support.

Appendix B

Telemedicine Client Utilization, Provider Participation, and Funds Expended

Fiscal 2005 – Fiscal Year 2007

Fiscal Year	Number of Unique Clients	Number of Unique Providers	Number of Visits	Amount Paid
2005	332	14	1,022	$29,117
2006	443	16	1,444	$41,315
2007	1,281	25	4,408	$146,250

Source: HHSC Center for Strategic Decision Support.

Appendix C

Procedure Codes of Telemedicine Services Provided Fiscal Year 2005 - Fiscal Year 2007

Fiscal Year 2005	Procedure Codes	Number	Percent
90862	Medication Management	749	73.3
99211-99215	Office/Outpatient Visit-Established Client	170	16.6
99241-99244	Office Consultation	75	7.3
90801-99802	Psychiatric Diagnostic Interview	15	1.5
99201-99205	Office/Outpatient Visit-New Client	11	1.1
90805	Psychiatric Treatment, Office, 20-30 minute	2	0.2
	Total Fiscal Year 2005	**1,022**	**100.0**

Fiscal Year 2006	Procedure Codes	Number	Percent
90862	Medication Management	843	58.4
99211-99215	Office/Outpatient Visit-Established Client	375	26.0
90805	Psychiatric Treatment, Office, 20-30 minute	87	6.0
99241-99244	Office Consultation	67	4.6
90801-99802	Psychiatric Diagnostic Interview	56	3.9
99201-99205	Office/Outpatient Visit-New Client	16	1.1
	Total Fiscal Year 2006	**1,444**	**100.0**

Fiscal Year 2007	Procedure Codes	Number	Percent
90862	Medication Management	2,186	49.6
99211-99215	Office/Outpatient Visit-Established Client	1,572	35.7
90805	Psychiatric Treatment, Office, 20-30 minute	376	8.5
90801-99802	Psychiatric Diagnostic Interview	213	4.8
99241-99244	Office Consultation	37	0.8
99201-99205	Office/Outpatient Visit-New Client	24	0.5
	Total Fiscal Year 2007	**4,408**	**100.0**

Note: All codes except the office consultation can only be billed when providing telemedicine services through the DSHS mental health pilot.

Source: HHSC Center for Strategic Decision Support.

Appendix D

Client Utilization and Funds Expended for Telemedicine Services by Metropolitan Statistical Area (MSA)*

Fiscal Year 2005 - Fiscal Year 2007

Fiscal Year	MSA	Number of Unique Clients	Number of Visits	Amount Paid
2005	Metro	76	130	$ 4,170
	Micro	97	404	11,316
	Rural	159	488	13,630
2005 Total		**332**	**1,022**	**$ 29,117**
2006	Metro	148	384	$ 10,464
	Micro	82	357	10,126
	Rural	213	703	20,725
2006 Total		**443**	**1,444**	**$ 41,315**
2007	Metro	312	1,682	$ 42,615
	Micro	277	832	33,066
	Rural	689	1,888	70,311
	Missing	3	6	258
2007 Total		**1,281**	**4,408**	**$146,250**

Note: MSAs are geographic entities defined by the U.S. Office of Management and Budget (OMB) for use of federal statistics. In general terms, a metropolitan area contains a core urban area population of 50,000 or more, a micropolitan area contains an urban core population of 10,000 - 50,000 and a rural area is outside any urban area with a decennial census population of 2,500 or more. For more information, see: http://www.census.gov/geo/lv4help/cengeoglos.html.

Source: HHSC Center for Strategic Decision Support.