

Staying Connected

A Progress Report: Reimbursement under the Telemedicine Development Act of 1996

California has been a national leader in developing telehealth¹ technologies to improve health care access and quality, particularly for medically underserved populations. California's telemedicine coverage law, the Telemedicine Development Act of 1996 (TDA),² was a ground-breaking statute and became a model law for other states.

This issue brief summarizes the key findings and recommendations of a Center for Connected Health Policy review of telemedicine reimbursement under the TDA, based on analysis of the statute, programs in other states, previous studies and reports, and interviews with key stakeholders. The full report can be found online at www.ConnectedHealthCA.org.

The TDA

The TDA defines “telemedicine” as *the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications*. It defines “interactive” as *an audio, video, or data communication involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information*. The TDA explicitly excludes provider-patient contact by telephone or e-mail from this definition.

The TDA prohibits health plans and health insurers, as well as Medi-Cal, from requiring face-to-face contact between patient and provider for services appropriately provided through telemedicine, subject to all other contract or policy terms. The TDA specifically requires Medi-Cal to cover teleophthalmology and teledermatology services via store-and-forward technology.

According to analyses of the original bill, proponents supported the TDA with the expectation that health plans would be required to develop telemedicine reimbursement policies. However, the TDA simply requires health plans and insurers to apply internal claims payment and appeal standards to telemedicine.

Progress Report on Reimbursement under the TDA

Enactment of the TDA relatively early in the evolution of telemedicine established California as a national policy leader. Though telemedicine has been available for years—and despite its success in rural pockets of California—its use throughout the state is not widespread. Interviewees for this study identified multiple barriers to expansion of telemedicine—overall low reimbursement levels in health care; limited provider knowledge on how to deliver and bill for telemedicine; restrictions on the telemedicine sites, providers, and services that will be paid for; and reluctance among many health plans, medical groups, and providers to invest in the infrastructure needed for telemedicine.

What are Telehealth and Telemedicine?

Telehealth is the use of telecommunications technology to deliver medical care, health education, and public health services. Telehealth encompasses a broad range of technology-enabled health care services that connect multiple users in separate locations. It includes **telemedicine**, the diagnosis and direct treatment of illness.

Telehealth services are delivered in three main ways:

- Video conferencing, for real-time patient exams, provider-patient consults, and provider-to-provider discussions;
- Patient monitoring, in which electronic measurement devices connect patients with health care providers; and,
- Store-and-forward technologies for the electronic transmission of digital images between primary care providers and specialists.



The TDA has improved the chance for reimbursement and coverage of telemedicine in both public and private health care programs, but implementation has been uneven. The findings that follow highlight the status of telemedicine reimbursement under the TDA.

- ***The TDA is not as comprehensive as many proponents anticipated.*** The TDA established a somewhat indirect mandate for coverage by prohibiting a requirement of face-to-face contact for reimbursement.

There is little evidence of health plans or insurers violating this face-to-face prohibition. The TDA does not, however, directly require health plans or insurers to cover specific telemedicine applications or to adopt specific telemedicine reimbursement policies. In addition, it fails to define what constitutes services “appropriately provided by telemedicine.”

- ***Services provided via telemedicine are being reimbursed, but often providers must pursue appeals or educate payers.*** There is some difference of opinion as to whether health plans and insurers are consistently reimbursing for telemedicine under the TDA. Early telemedicine adopters invested significant time and resources working with all payers to clear up billing system glitches and confusing policies. Long-established telemedicine providers now report that reimbursement is common for those who know and follow the rules, but some providers and advocates contend that they continue to experience reimbursement denials and administrative barriers to payment for telemedicine.
- ***Health plan benefit materials and coverage guidelines, though technically in compliance with the TDA, often are silent or vague regarding telemedicine.*** Evidence of coverage (EOC) documents are the mandatory disclosure documents provided to purchasers and consumers of a health coverage contract or insurance policy. Most EOCs are silent on

telemedicine and telemedicine coverage, and most exclude coverage for any services provided by phone, e-mail, or the Internet. Several national insurers doing business in California exclude telemedicine coverage entirely in company-wide guidelines, “except as required by state law or policy.” Generic or vague policies complicate tracking of TDA compliance and effective enforcement of its requirements.

- ***Inconsistent payer policies increase administrative costs for providers.*** Payer policies related to telemedicine are often unclear, inconsistent, and complicated. In addition to the policies applicable to public programs, each private health plan must be approached individually to obtain coverage and billing requirements. Some plans cover both live, interactive and store-and-forward services, while some cover only live interactions. Some provide a facility fee to the originating site, while some do not. Some have no distinct billing or payment system for telemedicine. The wide variations complicate claims and payment processing for telemedicine providers, increasing the costs of participation.
- ***Awareness of the TDA is limited.*** Health plans, providers, medical groups, and their representative organizations have limited knowledge of the TDA. While a few health plans have staff assigned to work on telemedicine for public programs, telemedicine coverage does not appear to have high visibility or be well understood beyond the providers and health plans that have been the most active in pioneering telemedicine programs.
- ***Telemedicine is used most often by safety net providers in public programs.*** Most telemedicine innovation and investment in California has focused on improving health care access and overcoming geographic barriers to care for safety net populations, predominantly through community clinics and small hospitals in rural and remote areas. As a result, public payers dominate reimbursement for telemedicine.
- ***Payment policies may not recognize that telemedicine can overcome multiple access challenges beyond geography.*** Telemedicine can be used to alleviate cultural and linguistic barriers, specialty provider short-

Telemedicine Laws in Other States

Ten other states have some form of health insurance coverage mandate for telemedicine. Five states (CO, HI, KY, OK, and TX) have adopted telemedicine statutes similar to California’s that in some way prohibit the requirement of face-to-face contact for reimbursement. Five states (GA, LA, ME, NH, and OR) have stronger requirements, including three (LA, NH, and OR) that mandate coverage for telemedicine for any service that would be covered in person.

Thirty-six states, including California, have adopted telemedicine statutes or policies for coverage of telemedicine in Medicaid, five other states are considering doing so, and Florida covers telemedicine under the terms of a federal Medicaid waiver.

ages, and poor health care literacy. As one example, submitting a diabetic patient's retinal scan from the primary care site to an ophthalmologist via store-and-forward technology improves the likelihood that the consult will occur. For patients with transportation or other socio-economic challenges to seeking follow-up care, the opportunity to receive a service on-site during a primary care visit can improve outcomes. Yet many policies only cover telemedicine when it is used to address geographic isolation and distance.

- **Existing reimbursement methods limit data.** Most interviewees agree that telemedicine use is underreported. One of the few data sources available on telemedicine use is the Anthem Blue Cross Telemedicine Network, which receives self-reported usage and payer information from the presenting sites. Anthem estimates the data received may be underreported by as much as 25%. Health plans that treat telemedicine just like in-person services, a positive strategy for integration of telemedicine, generate no usage data. When providers choose not to use telemedicine codes because of complexity or fears of delayed reimbursement, telemedicine services are not captured as such in the database. Telemedicine programs funded via grants may not yield encounter or service data. These data challenges complicate monitoring, analysis of costs and benefits, and data-driven policy and business decisions.
- **The TDA and current reimbursement practices may be too restrictive to promote telemedicine expansion.** In general, telemedicine is currently reimbursed for specific authorized services and providers, for specific types of patients (often limited to remote or rural communities), or for specific barriers to in-person care. At the same time, improvements in technology have made possible new models of remote consultation among providers, transfers of medical imaging, and clinician-patient interaction. Emerging technologies such as remote monitoring of intensive care units and home monitoring of patients have already radically changed care delivery. The TDA may need updating to ensure that public and private reimbursement policies keep up with proven innovations and developments in care improvements.

Recommendations for Improving Reimbursement under the TDA

Implementation of the following recommendations would improve the effectiveness of the TDA and ensure that California law and policy keep pace with technological advances.

- **Recommendation 1. Strengthen the TDA.** Ideally, the TDA should be amended to clearly require reimbursement for any medically necessary service covered under the terms of a contract or policy, whether it is provided in person or through telemedicine. In addition, the TDA should be amended to extend to private health plans Medi-Cal's store-and-forward coverage mandate. At a minimum, the Department of Managed Health Care and California Department of Insurance should require all health plans and insurers to demonstrate how they comply with the TDA, including describing telemedicine in the EOC as a coverage option.
- **Recommendation 2. Streamline and modernize Medi-Cal coverage.** Medi-Cal coverage policies should be updated with the following changes: 1) Eliminate the requirement that a specific barrier be identified before telemedicine is covered, or at a minimum simplify documentation; 2) Extend Medi-Cal's store-and-forward coverage to any specialty; 3) Expand originating sites to include all approved Medi-Cal providers, or at least the sites added by Medicare in 2009 (skilled nursing facilities, hospital-based dialysis centers, and community health centers); and 4) Revise Medi-Cal managed care plan contracts to incorporate telemedicine coverage.
- **Recommendation 3. Promote telemedicine as a tool for addressing broad goals of quality, efficiency, and access.** As a starting point, payers should eliminate restrictions on the geographic locations, provider sites, or medical specialties where telemedicine will be covered. This would bring policies in line with the growing recognition that telemedicine can overcome numerous barriers to care beyond geographic or physical limitations.

- **Recommendation 4. Standardize billing and coverage procedures.** Experts and stakeholders should develop and disseminate common utilization and reimbursement guidelines by building on the best elements of provider manuals already developed for Medicare, Medi-Cal, the County Medical Services Program, and county mental health managed care plans. To encourage adoption of the common guidelines, the TDA could be amended so that use of the guidelines would be considered compliance for regulatory purposes.
- **Recommendation 5. Increase awareness of the TDA.** Many health plans and insurers, providers, and consumers are unaware of the TDA requirements or the availability of telemedicine technologies. State agencies, policy organizations, and provider groups should engage in education and outreach to increase awareness and facilitate expanded use and coverage of telemedicine.
- **Recommendation 6. Acknowledge and establish telemedicine as the standard of care.** Telemedicine has proven it can be an effective tool in the pursuit of improved access, reduced costs, and quality outcomes. The current momentum to expand and enhance the use of technology in health care presents an opportunity to more fully integrate telemedicine into standard health care delivery. For example, new reimbursement methods that reward performance rather than numbers of visits might encourage greater use of telemedicine to meet quality standards. Telemedicine should be actively promoted as part of any health care reform effort.

The Future of Telemedicine and Telehealth Policy

California has been a leader in telehealth and telemedicine adoption and policy. The TDA was a landmark piece of legislation; it legitimized the use of telemedicine as an appropriate form of health care. California law reflects policymakers' recognition that telemedicine and telehealth are tools to transform and improve the care delivery system and the health status of the population. Policymakers can further encourage these improvements by ensuring that California law keeps pace with developments in telehealth technologies.

There is significant momentum now—and new funding—to modernize and strengthen technology and information technology in health care. Technology is only as powerful as the uses to which it is deployed. Telehealth and telemedicine are two uses of technology that serve policymakers' goals of delivery system

and health status improvement. Telemedicine changes the way health care is delivered, the way it is paid for, and the way the health care system is held to account. Policymakers have the opportunity to align California's statutory and regulatory framework for telemedicine to advance these goals.

Author

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1. The mission of CCHP is premised on the promotion of telehealth technologies, which include but are not limited to telemedicine. This issue brief generally uses the term telemedicine, to be consistent with the terminology in the TDA.
2. SB 1665 (Thompson, M.), Chapter 864, Statutes of 1996.

Center for Connected Health Policy

The Center for Connected Health Policy (CCHP) is a nonprofit planning and strategy organization working to remove policy barriers that prevent the integration of telehealth technologies into California's health care system.

Telehealth technologies are tools for improving health outcomes and access to care, particularly among uninsured and low-income Californians, and for making the state's health care system more efficient and cost-effective. CCHP advocates for policies that expand telehealth services in pursuit of these goals.

CCHP conducts objective policy analysis and research, develops nonpartisan policy recommendations, and operates telehealth demonstration projects.

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