

Tele-Dermatology in Medi-Cal

Findings from the Field and Challenges for the Future

Overview

Access to specialty care is a major concern in medically underserved communities, both urban and rural. Concerns about access to specialty care are anticipated to grow, as significant numbers of uninsured persons obtain health coverage through implementation of national health reform. Telehealth technologies can serve as tools to improve access to timely, cost-effective care.

One of the specialty services frequently identified as high need for safety net patients is dermatology. Skin diseases

Telehealth technologies can serve as tools to improve access to timely, cost-effective care.

affect a large percentage of Americans and can result in markedly decreased quality of life. Nearly 25 percent of all physician office visits are

for skin complaints. The majority of visits for skin complaints occur with primary care providers (PCPs), and only about one third of these visits occur with dermatologists.¹ Non-dermatologists often have difficulty recognizing skin diseases, which can lead to diagnostic errors and reduced quality of care.

Dermatologists specialize in diseases and disorders of the skin. Practices include treatment of conditions such as skin cancers, inflammatory and blistering skin diseases, skin infections, and hair and nail disorders. There are 10,600 dermatologists in the United States, or 3.6 per 100,000 population.² The shortage of dermatologists to serve safety-net populations is compounded by a lack of dermatologists in certain geographic areas, and the fact that increasing numbers of dermatologists are focusing their practices on cosmetic services.³



Key Findings

- **Access to specialty care is a major concern** in medically underserved communities. Demand for care is projected to grow with national health reform. Telehealth technologies can serve as tools to improve access to timely, cost-effective care.
- **Dermatology is a high-need specialty for safety net patients.** Store and forward tele-dermatology (S&F) became an approved Medi-Cal benefit in 2007. Proponents argued that this new payment mechanism would spur providers to take up telehealth.
- It appears that a **gap exists between the anticipated benefits of tele-dermatology in Medi-Cal and its unexpectedly slow adoption.** State data indicates fewer than 300 total tele-dermatology claims in 2007-09.
- A survey of tele-dermatologists who provide S&F consults to Medi-Cal, primary care providers who refer to tele-dermatologists, and dermatologists who do not employ telehealth, **found both benefits to the technology and barriers to its use.**
- For tele-dermatologists, **positive impacts** include improvements in practice efficiency; patient access, satisfaction, and quality of care; cost savings to the state's health care delivery system; and knowledge of dermatology and satisfaction among referring primary care providers.
- All dermatologists in the survey—those who practice tele-dermatology in Medi-Cal and those who do not—indicate **challenges to adoption.** These include low reimbursement rates and a cumbersome reimbursement system in Medi-Cal; lower revenues in tele-dermatology because of fewer follow-up procedures; liability fears; and increased paperwork and telehealth training issues.
- This issue brief contains **policy recommendations** (see p. 6) to improve uptake of tele-dermatology. These include educating specialists on Medi-Cal reimbursement; easing Medi-Cal administrative burdens; increasing dermatologist training in telehealth; and clarifying private payors' tele-dermatology reimbursement policies.

According to 2010 American Medical Association figures, California has 1,594 board-certified and licensed dermatologists. No published literature exists on the number of dermatologists practicing tele-dermatology, or on the number of dermatologists providing services to patients in Medi-Cal, California's Medicaid program. A national study in 2005 found that Medicaid and uninsured patients made up a significantly smaller fraction of dermatologists' practices, 5 percent, than would be expected by the size of this patient population in the United States overall, about 27 percent.⁴

One potential solution to the lack of access to dermatologists is tele-dermatology. Tele-dermatology is the practice of delivering dermatological care via communications technologies. The two primary forms of tele-dermatology are live, interactive video (LI), and store and forward (S&F). In an LI consult, dermatologist and patient are connected in real time through audio/video technologies. In S&F, PCPs electronically transmit medical information, such as digital images and patient histories, to tele-dermatologists, via a secure, encrypted system that is akin to email with attachments. Tele-dermatologists make diagnoses and treatment recommendations via electronic responses to the PCPs.

Medi-Cal provides reimbursement for both S&F and LI tele-dermatology consultations. S&F dermatology became an approved benefit of the Medi-Cal fee-for-service program in 2007. Medi-Cal requires clinicians to include a special "modifier" code, and documentation of an in-person access barrier, when submitting claims for telehealth services.

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Services (DHCS), tele-dermatologists submitted fewer than 300 LI and S&F fee-for-service claims

in 2007-09. Two thirds of these claims were for LI services, and one third for S&F. The top five primary diagnoses were eczema, dermatitis, acne, warts, and psoriasis. These modest results call into question the broadly held assumption that when reimbursement is provided for a new service, providers will change their practices to take advantage of the new payment mechanism.

This issue brief explores the low uptake of tele-dermatology in Medi-Cal, and provides a set of policy recommendations to streamline the delivery of tele-dermatology in Medi-Cal, and speed wider adoption overall. It includes the results of extensive one-on-one interviews with tele-dermatologists and PCPs who use these technologies, as well as interviews with traditional, office-based dermatologists, who do not employ tele-dermatology in their practices.⁵

Policy Recommendations for Telehealth Adoption

1. The California Department of Health Care Services (DHCS) should educate dermatologists, ophthalmologists, and optometrists on Medi-Cal telehealth reimbursement policies.
2. DHCS should ease administrative burdens for telehealth providers by eliminating separate reimbursement coding requirements for tele-dermatology.
3. Increase dermatologist training in telehealth by a) incorporating telehealth training into federal and state student loan programs; and b) facilitating standardized tele-dermatology training for dermatologists and referral sites.
4. Work with insurers to clarify tele-dermatology in policies.

Tele-Dermatology in California: Findings from the Field

The information in this issue brief is derived from interviews with 17 tele-dermatologists and 10 PCPs who refer to tele-dermatologists, and interviews with 26 traditional, office-based dermatologists, who do not employ tele-dermatology in their practices. To differentiate the two groups of dermatologists, all answers from dermatologists who use telehealth technologies in their practice are identified as tele-dermatologists, and those who do not use telehealth technologies are identified as dermatologists.

Positive Impacts of Tele-Dermatology in Medi-Cal

Tele-dermatologists who provide S&F consults to Medi-Cal patients cited a number of positive impacts from its use. These include:

- Increased efficiency of dermatologists' practice—consultations can be performed whenever the dermatologist has time, and more patients can be treated with fewer exam rooms and support staff;
- Increased access for patients;
- Increased patient satisfaction;
- Higher quality of care, from more timely specialist recommendations, which results in improved patient outcomes;
- Reduced costs associated with reductions in misdiagnoses and delays in diagnoses, trials of ineffective treatments, patient travel time, and costs for face-to-face physician visits;
- Enhanced satisfaction from referring PCPs, due to increased patient access, and satisfactory resolution of complex diagnoses.

Challenges to Tele-Dermatology Adoption

All dermatologists in this survey—those who practice tele-dermatology in Medi-Cal and those who do not—indicate a number of challenges to broad adoption of these technologies.

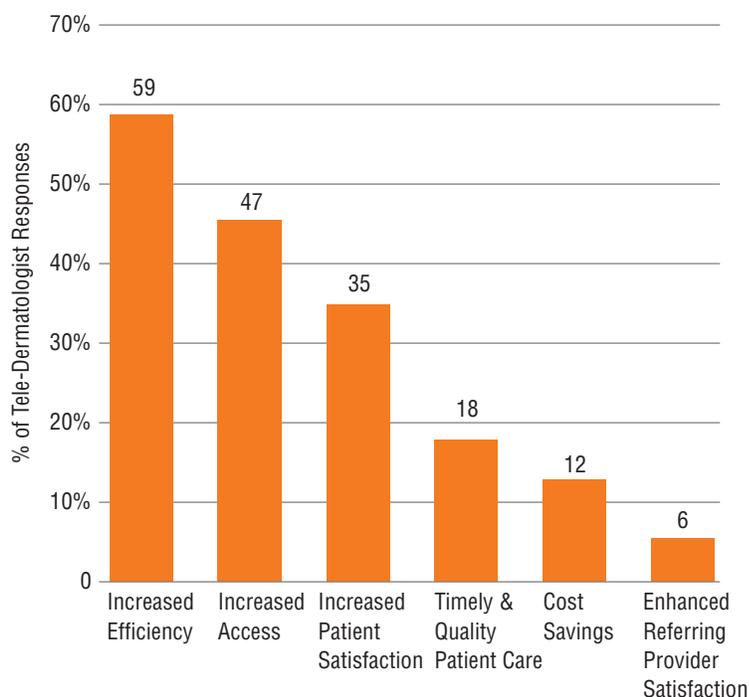
Uncertainty Regarding Medi-Cal Reimbursement

Tele-dermatologists familiar with their organization's reimbursement processes indicated that their reimbursement success rate for Medi-Cal telehealth consults was only about 41 percent. Reasons for denial of claims included delays in claims processing, which triggered rejections of legitimate tele-dermatology claims; tele-dermatologists billing for services conducted at home, which Medi-Cal prohibits; and inadequate documentation for tele-dermatology services.

Other problems identified in the interviews include:

- Uncertainty on how to bill Medi-Cal, and use of telehealth-specific code modifiers for tele-dermatology;
- Medi-Cal's prohibition on the physician's home as a site of care. Because S&F services are done by computer, and do not require the patient or the dermatologist to be in an office for the consult, respondents questioned this restriction on site of care.
- The belief among tele-dermatologists that telehealth dermatology services are reimbursed at a lower rate than in-person consults. Some respondents stated that Medi-Cal reimburses S&F at rates below those of in-person visits; in fact, reimbursement rates are identical.

Figure 1: Positive Impacts of Tele-Dermatology in Medi-Cal



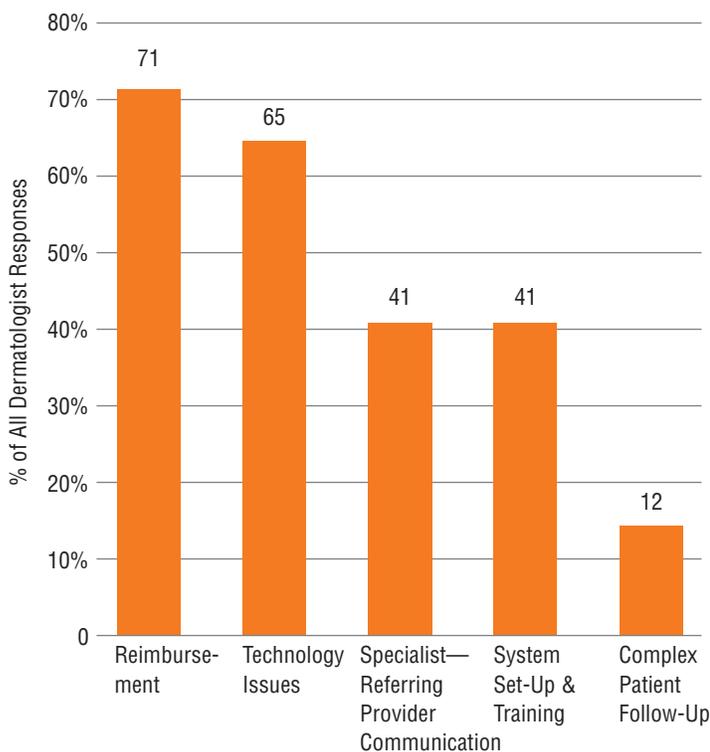
Fewer Follow-Up Procedures Means Lower Revenues

Respondents reported that clinic administrators favor in-person care, because related follow-up procedures—which cannot be provided via tele-dermatology—generate higher revenues for the practice. Procedures such as biopsies and sample collection for lab work cannot be provided remotely, which results in lower overall per-patient revenues.

Low Medi-Cal Reimbursement Rates Discourage Participation

Dermatologists reported high demand for their services. This fact, combined with low Medi-Cal reimbursement rates for specialty care—\$24 to \$83 for an office visit⁶—was cited as a barrier to dermatologists’ participation in Medi-Cal. For commercially insured patients, reimbursement for similar levels of care ranges from approximately \$119 to \$260. Tele-dermatologists who participate in Medi-Cal indicated they do so largely out of a sense of community service and that their participation is limited to a small portion of their overall practice.

Figure 2: Tele-Dermatology Practice Challenges



Tele-Dermatologists Perceive Medi-Cal Reimbursement System as Cumbersome

Medi-Cal requires the use of modifier codes for tele-dermatology claims. While the modifiers are useful for tracking telehealth utilization, dermatologists cited the additional coding as an impediment to program participation.

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Prior to payment of a claim for tele-dermatology services, Medi-Cal requires the submission of documentation that a barrier to in-person care exists. Tele-

dermatologists reported this requirement as an impediment to broad-scale adoption.

In addition, in the initial year of implementation of S&F dermatology, tele-dermatologists reported that Medi-Cal’s automated processing system rejected the new codes, which required a manual adjustment process, and resulted in payment delays and claim denials. This discouraged dermatologists who were early adopters of tele-dermatology. The processing of telehealth claims has since been automated, but the delays of the first year continue to be cited as a barrier.

Liability Fears

Dermatologists reported uncertainty as to whether there is a higher risk associated with providing telehealth services over in-person consults, and whether their malpractice insurance will cover claims. This is consistent with other research that indicates clinicians are unclear about the legal ramifications of telehealth service delivery.⁷

Tele-Dermatology Training Issues

Many tele-dermatologists indicated that they received no formal training in telehealth, and cited the need for standardized training; in addition, dermatologists indicated that a lack of telehealth training during residency contributed to their discomfort with the technology. Further, some dermatologists indicated a general discomfort with telehealth and cited a preference for in-person patient contact.

Telehealth Requires More Paperwork

Respondents indicated a preference for template-based documentation (example: automated prompts for information) in patient medical records, and indicated that S&F technology requires more extensive documentation from the specialist than in-person consults. Additional written documentation by the specialist is needed when using S&F to assure that communication with the PCP is clear and understood.

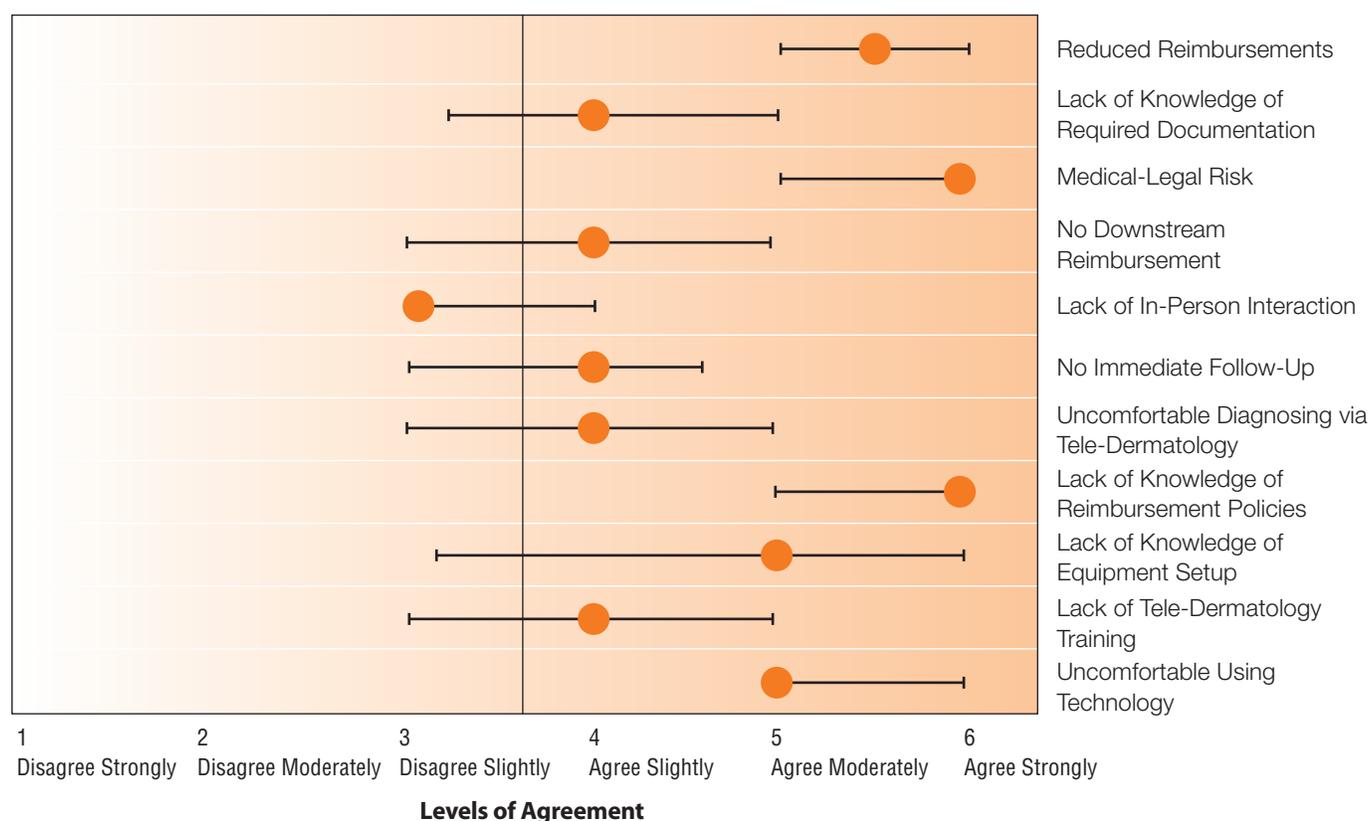
Tele-Dermatology's Partners: Interviews with Primary Care Providers

Telehealth proponents have argued that one of its benefits will be an increase in PCP skill levels, as a result of the closer interaction between PCPs and specialists. All of the PCPs interviewed for this issue brief said their **knowledge of dermatological problems had improved through the use of tele-dermatology, and this reduced the number of patients they refer to specialists.**

PCPs indicated that as a result of their interactions with tele-dermatologists, they are able to handle less complicated, more frequently seen conditions themselves. The virtual creation of a team approach to care has enhanced the ability of PCPs to make more effective use of specialists' time.

The flip side of the increased training of PCPs is that tele-dermatology results in a workload shift to primary care settings. For example, with S&F technology, the primary care site has responsibility for communicating the specialist's findings and recommendations to patients.

Figure 3: Dermatologists' Reasons for Not Practicing Telehealth



Strengthening Tele-Dermatology in Medi-Cal

When state policy makers established S&F tele-dermatology as a means of delivering necessary health care services to Medi-Cal beneficiaries, it was thought that clinical practice patterns would follow reimbursement policy. This has not occurred.

Safety net providers continue to identify dermatology as a specialty with high levels of unmet demand. As the state prepares for implementation of the Patient Protection and Affordable Care Act (ACA) and the resulting projected increase of at least 2 million new Medi-Cal enrollees, the need for specialty care will increase. This issue brief identified a number of policy and medical practice recommendations to improve the uptake and use of tele-dermatology in California.

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Policy Recommendations

1. DHCS Should Educate Dermatologists, Ophthalmologists, and Optometrists on Medi-Cal Telehealth Reimbursement Policies

This issue brief revealed pervasive misunderstandings of Medi-Cal tele-dermatology policy. Many dermatologists believe that Medi-Cal provides lower fees for tele-dermatology than for in-person consults. A targeted outreach effort to dermatologists, as well as ophthalmologists and optometrists, the two other specialties currently covered for S&F services, could enhance program participation.

2. DHCS Should Ease Administrative Burdens for Telehealth Providers by Eliminating Separate Reimbursement Coding Requirements for Telehealth

DHCS telehealth billing code modifiers were intended to give the state a means of tracking telehealth utilization.

In each of the first three years of S&F tele-dermatology implementation, fewer than 100 claims were submitted, indicating possible widespread under-use of the codes. Anecdotal evidence from research conducted for this issue brief indicates that tele-dermatologists do not uniformly use the modifiers—sometimes because the dermatologist wrongly believed the modifiers would result in manual adjudication of the claim, with attendant payment delays and possible claim rejection. Elimination of the code modifiers would simplify billing processes..

3. Increase Dermatologist Training in Telehealth

a) Incorporate Telehealth Training into Federal and State Student Loan Programs

State and federal loan repayment programs have been in use since the early 1970s, to help attract newly trained providers to where they are most needed. The state Office of Statewide Health Planning and Development, with support of federal matching funds, operates loan repayment programs for health professionals who agree to a two- to four-year post-training service commitment in medically underserved areas.

Given the promise of telehealth for forming virtual multidisciplinary teams, and providing access to vast resources for consults and other services, California should use its loan repayment programs to encourage the use of telehealth. For example, partial credit on loans could be offered to dermatologists who spend a percentage of their time providing telehealth services to underserved areas.

The state currently requires that sites hosting health professionals offer a “comprehensive system of care.” To be considered comprehensive, sites should be encouraged to implement telehealth to the greatest extent possible, to help support providers in expanding health care services into underserved areas.

By assuring that sites and providers are equipped and trained to use telehealth, the loan program would increase the likelihood that specialists, such as dermatologists, continue to partner with clinicians serving the underserved.

3. Increase Dermatologist Training in Telehealth

b) Facilitate Standardized Tele-Dermatology Training for Dermatologists and Referral Sites

Clinical education and training programs should include curricula on telehealth in dermatology.

Dermatologists who wish to perform LI or S&F tele-dermatology consultations need to have ready access to standardized and up-to-date training materials for tele-dermatology consult operations, coding and billing procedures, and ways of improving communication with referral sites and patients.

To ensure success of tele-dermatology programs, referral site physicians and tele-dermatology coordinators also will need to receive standardized tele-dermatology training. This should include proper use of telemedicine equipment, capturing optimal video images or still images of skin lesions, optimizing operational flow of the referral encounter, and implementation of dermatologists' recommendations. During the training process, the referral site's resources such as the ability to perform skin biopsies, must be properly identified, in order to ensure that the dermatologist's recommendation can be carried out locally, or if further technical training of the referral providers is necessary.

4. Work with Insurers to Clarify Tele-Dermatology in Policies

Telehealth malpractice coverage is available through commercial carriers. There is no documentation of actual barriers to coverage for clinicians, or increased liability with regard to services delivered using telehealth. However, the interviews in this issue brief and extensive anecdotal evidence all point to a disconnect between what providers believe is covered, and what malpractice insurers cover.

Conclusions

With the passage of national health care reform—and the commensurate increase in public and private coverage—California has an opportunity to assure that adequate clinician capacity exists to serve the needs of Medi-Cal enrollees. Telehealth is an effective tool to help increase access to specialty health care, improve quality of care, and make the health care delivery system work more efficiently.

California's policy makers established dermatology as one of the first specialties to receive reimbursement from the state's largest public insurance program. This was a bold first step. However, adoption of new models for delivery of care requires more than a new billing code.

The recommendations in this report will help California make use of telehealth in service to underserved populations, and to once again serve as a model for the nation.

Endnotes

1. Fleischer AB, Jr., Feldman SR, Rapp SR. Introduction. The magnitude of skin disease in the United States. *Dermatol Clin* 2000;18:xv-xxi.

Ramsay DL, Weary PE. Primary care in dermatology: whose role should it be? *J Am Acad Dermatol* 1996;35:1005-8.

Federman D, Hogan D, Taylor JR, Caralis P, Kirsner RS. A comparison of diagnosis, evaluation, and treatment of patients with dermatologic disorders. *J Am Acad Dermatol* 1995;32:726-9.
2. Smart DR. Physician characteristics and distribution in the US. Chicago: *AMA Press*; 2007.
3. Resneck J Jr. The influence of controllable lifestyle on medical student specialty choice: a dermatologist's perspective. *Virtual Mentor, AMA J Ethics* 2006;8:529-32.
4. Resneck JS, Jr., Isenstein A, Kimball AB. Few Medicaid and uninsured patients are accessing dermatologists. *J Am Acad Dermatol* 2006;55:1084-8.
5. A multi-pronged approach was used to identify tele-dermatology use in California's Medi-Cal program. The American Telemedicine Association Teledermatology Special Interest Group and the Telemedicine Task Force of the American Academy of Dermatology were contacted to identify practicing dermatologists in California. A Public Records Act request was submitted to the Department of Health Care Services (DHCS) to obtain Medi-Cal records to identify dermatologists who submitted claims for tele-dermatology services from January 1, 2007 through December 31, 2009. Existing relationships with practicing tele-dermatologists were leveraged to identify other practicing tele-dermatologists not captured from the above efforts. Seventeen California-based dermatologists who practice tele-dermatology were identified. One-on-one, one-hour interviews were conducted with these tele-dermatologists to learn about their tele-dermatology practices, their perceived challenges, and suggestions for improvement.

To understand the perspectives of dermatologists in California who are not currently practicing tele-dermatology surveys were distributed at professional meetings and were sent to randomly selected dermatologists' offices in California. Of the 120 surveys that were distributed, 26 surveys were returned, which yielded a response rate of 21.6%.

To assess the referring providers' perspective on how the needs of the Medi-Cal populations are served through tele-dermatology one-hour, one-on-one interviews were conducted with 10 primary care providers (PCPs) to explore their perspective on the impact of tele-dermatology on the Medi-Cal population.
6. California Department of Health Care Services. Medi-Cal Rates as of June 15, 2011. http://files.medi-cal.ca.gov/pubsdoco/Rates/rates_download.asp.

7. Center for Connected Health Policy. *Advancing California's Leadership in Telehealth Policy: A Telehealth Model Statute & Other Policy Recommendations*. February 2011. <http://www.connected-healthca.org/sites/default/files/TelehealthModelStatuteReport-Feb2011.pdf>.

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Authors: Dr. April Armstrong, MD, MPH, Mei Wa Kwong, JD, Lynda Ledo

Contributors: Amber Harrison, Shane Trimmer

Editor: Stephen Robitaille

Reviewers: Sandra Shewry, MPH, MSW, CCHP CEO; Thomas S. Nesbitt, MD, MPH, CCHP Executive Director for Telehealth Services, and Associate Vice Chancellor for Strategic Technologies and Alliances of the University of California Davis School Of Medicine.

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About CCHP

Established in 2008 by the California HealthCare Foundation, the Center for Connected Health Policy (CCHP) is a non-profit planning and strategy organization working to remove policy barriers that prevent the integration of telehealth technologies into California's health care system. CCHP conducts objective policy analysis and research, develops non-partisan policy recommendations, and manages innovative telehealth demonstration projects.

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