

Telehealth Services Reimbursements in Minnesota December 2007

Type of service	Medicare		Medicaid/Minnesota Care		Health Plans		Comments
	Originating site	Provider site	Originating site	Provider site	Originating site	Provider site	
Telemedicine – primary and specialty medicine (via live videoconferencing)	Pays \$20 <u>site fee per event</u> ; facility fee charge = \$26. Facility absorbs remaining cost.	Same as <u>face-to-face visit</u> . Same CPT codes with modifier.	Pays 40% of facility fee charge (\$10.40 per \$26 charge)	Same as <u>face-to-face visit</u> . Same CPT codes with modifier.	Some pay up to 80% fee; facility absorbs remainder.	Generally, <u>same as in-office visit</u> . For provider time only.	Lack of provider facility fee is a perceived barrier for some clinic administrators. Physician providers in favor. Helps identify and treat patients needing services. Rural hospitals/communities keep patient, also benefit with labs, supporting procedures, follow-up.
Store-and-forward (provider reviews images and patient data and responds via Web)	No	No, except for radiology	No	Pays	No	No	MN one of few states that Medicaid pays store-and-forward.
Mental/behavioral health services	Pays \$23 <u>site fee per event</u> , only in HPSA or non-MSA (rural setting).	Same as <u>face-to-face</u> . Same CPT codes with modifier.	<u>No payment</u> , site provides staff oversight and room. Typically, agreement with provider to split reimb.	Same as <u>face-to-face</u> - for dual eligible only.	Some cover (incl. BCBS, Medica, others?)	Some cover (incl. BCBS, Medica, others?)	With no Medicaid reimbursement, originating sites do not capture ROI on investment in equipment, room, and staff time. High patient acceptance, lower appointment fail rate with TM visits.
Tele-home care (face-to-face via video connection)	No direct reimbursement for telehealth services. Does not count toward minimum visits under lump sum PPS 60 day 5-visit minimum. <u>Reportable</u> but not reimbursable. Must be included in care plan, but provider absorbs costs.		<u>Same as face-to-face</u> ; fee for service. Must be in conjunction with in-home services. Coded same, with modifier showing TH delivery.		<u>Recognized as a visit for public patients only</u> , generally following Medicare and Medicaid. <u>Not recognized for private patients</u> .		Medicare: Providers see benefit to staff and patients of adding additional TH visits. Patient healthier, less hospitalizations. Medicaid: Home care provider must negotiate Medicaid reimbursement at county level. Some counties more open than others.
Remote home monitoring	None. Does not recognize.		<u>Pays \$5-\$15/day for monitoring units</u> –ie. scale, pulse oximeter, blood pressure. Bills as equipment rental. No direct payment for nurse monitoring; built into fee.		<u>None currently</u> . BCBS, Prime West <u>considering reimbursing</u> for both equip. rental (as DME) and nurse time for dual eligibles and waiver only. <u>No reimbursement for private pay patients</u> with chronic conditions needing home monitoring.		Patient admits to hospital significantly reduced, as well as associated nursing home placements (Medicaid savings). Patients are healthier and happier, and system costs reduced.



Minnesota Telehealth Update

December 2007

Telehealth Inventory In Spring, 2007, the Institute for Health Informatics of the University of Minnesota, on behalf of the Minnesota Department of Health Office of Rural Health and Primary Care, conducted a survey of health providers to determine the extent of telehealth offerings in the state. 626 (43.1%) responded to the survey. Selected findings:

- As many as 600 facilities and organizations may be offering telehealth services in the state based on the sampling process in this survey. Survey respondents included hospitals, clinics, elder care organizations and others.
- Radiology was the most common telehealth-enabled service type, reported by one-third of all sites. Most of the other common service types are reflective of the video-centric nature of traditional telehealth and teleconsultation: training, mental health and psychiatry, home care, and dermatology.
- 208 (33.2%) reported they had considered or were considering, but were not currently offering telehealth services.
- Of the 208, 115 (55.3% of 208) indicated that cost was a significant barrier. Connectivity was consistently reported to be the item of highest direct cost.
- 315 (50.3%) respondents reported that they were not currently considering the provision or use of telehealth services.

Minnesota Telehealth Registry

107 health care organizations have voluntarily registered as telehealth providers on the searchable Minnesota Telehealth Registry at <http://www.mti.umn.edu/>. The registry was established by MDH and the University of Minnesota in 2007.

Remaining Telehealth Development Issues

- State level strategies and leadership
- Mechanisms for collaboration, coordination
- Resources for networking, support, training
- Integration with HIT initiatives
- Sustainability models
- Consistent coverage policies
- Cost issues: equipment, “last mile,” bandwidth