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Written by Marki Stewart – 3/27/18

The use of telemedicine has soared in recent years, as new technologies develop and consumer demand for instant access to healthcare increases. Indeed, the telemedicine market is expected to grow to $113.1 billion by 2025, at an estimated compound annual growth rate of 18.8%. It is expected that at least 7 million patients in the U.S. will access telemedicine services in 2018, a sharp increase from 2013, when the estimated number of telehealth patients was less than 350,000. Despite this momentous growth, reimbursement continues to be a key obstacle for telemedicine providers. However, reimbursement rules by various payors are slowly expanding to cover more telemedicine services.

Medicare remains one of the most restrictive payors for telemedicine services, with exceptionally limiting reimbursement rules. With some exceptions, Medicare will pay for a telemedicine encounter only when the patient is located in a rural area and present at an eligible originating site, the service must be delivered by one of 8 eligible professionals, and the modality must be real-time, interactive, and face-to-face (thus prohibiting "store and forward" telemedicine technologies), with a limited number of available codes. Notably, Medicare recently changed its coding for telemedicine services, eliminating use of the "GT" modifier traditionally used to indicate that the service was provided via telemedicine; in its place, Medicare has

created Place of Service Code 2, which should be used in the place of the former GT modifier. A list of Medicare's rules, restrictions, and codes for telemedicine encounters can be found here. Despite Medicare's reluctance to shed its restrictive reimbursement rules, several drafts of legislation have been proposed to expand Medicare payment for telemedicine services, typically targeted to particular conditions and disease states. Accordingly, Medicare payment restrictions may soon be eased, albeit gradually.

Contrary to Medicare, Medicaid plans are generally more liberal in reimbursing a variety of telemedicine services. According to www.medicaid.gov, Medicaid views telemedicine as a "cost-effective alternative to the more traditional face-to-face way of providing medical care . . . . As such, states have the option/flexibility to determine whether (or not) to cover telemedicine; what types of telemedicine to cover; where in the state it can be covered; how it is provided/covered; what types of telemedicine practitioners/providers may be covered/reimbursed, as long as such practitioners/providers are 'recognized' and qualified according to Medicaid state/regulation; and how much to reimburse for telemedicine services, as long as such payments do not exceed Federal Upper Limits." Currently, 48 state Medicaid programs offer some type of coverage for telehealth services. The Center for Connected Health Policy has compiled a survey of each state's Medicaid reimbursement rules for telemedicine, with hyperlinks to each Medicaid program's rules, available here. Michigan's Medicaid program currently reimburses for a variety of live video encounters, including inpatient consults, outpatient consults, psychiatric diagnostic procedures, training services, end stage renal disease-related services, behavioral health and substance use disorder treatment, and education

services. Although Michigan's Medicaid program typically requires the patient to be located at an eligible original site, which include physician or other provider offices, a patient may be treated from home for behavioral health therapies. Further details can be found in Michigan's Medicaid Provider Manual, available here.

Commercial payors vary with respect to payment for telemedicine services. State "parity" laws may require a health plan to pay for telehealth services, and a minority of states require health plans to pay the same amount for telehealth services as if the treatment had been provided in-person. However, many payor contracts omit specific terms relating to telemedicine payment, perhaps unintentionally. Physicians need not be passive in hoping that a private health plan will pay for telemedicine services. Providers can get ahead of a telehealth payment dispute by requesting key terms for telemedicine reimbursement when payor contracts are first negotiated and signed. Providers should make their contracting team aware of what telemedicine services are available to their patients, so that they can request specific terms for the telemedicine modalities used by that provider in their negotiations. Knowledge of your state's parity law can and should be used in negotiations with payors as well (although a parity statute is not required to negotiate reimbursement). Additionally, Medicare Advantage coverage for telehealth is a potential area for growth, as Medicare Advantage plans recognize the positive outcomes and lower costs for telemedicine services, and can benefit greatly from those cost savings.

Finally, telemedicine providers need not be restricted to the intricacies of Medicare, Medicaid, and private health plan reimbursement rules, which frequently conflict. Telehealth providers can find other ways of

generating revenue for its services, including providing services for a flat rate or an hourly rate charged directly to patients. Many patients are willing to pay a reasonable out of pocket amount for the convenience of telehealth services, provided the rate is fair market value and meets other state-specific rules.