
TELEMEDICINE MEDICAL SERVICES IN TEXAS MEDICAID

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Executive Summary

Pursuant to S.B. 789, 77th Legislature, Regular Session, 2001, the Texas 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, including:

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

In 2010, HHSC conducted an analysis of telemedicine services to evaluate the effects of telemedicine in Texas Medicaid. HHSC found that the total number of distant and patient site providers using telemedicine services increased by 84 percent from fiscal year 2007 to fiscal year 2009. The number of clients receiving telemedicine services increased by 233 percent from fiscal year 2007 to fiscal year 2009, while expenditures for telemedicine services increased by 246 percent. It is assumed that these increases are the direct result of expanded coverage of telemedicine services, improved tracking of telemedicine services, and other telemedicine network expansion initiatives aimed at improving access to specialty and sub-specialty care in Medicaid.

Since Texas Medicaid began providing telemedicine medical services in 1998, services have been modified and expanded, with the goal of providing better access to health services for individuals in medically underserved areas. Legislation was passed each legislative session from 2001 to 2007 to improve the provision of telemedicine services in the state by expanding the eligible providers and locations and creating pilot projects.

On April 1, 2009, HHSC made changes to the telemedicine medical policy, pursuant to S.B. 24 and S.B. 760, 80th Legislature, Regular Session, 2007. These changes increased the types of medical services that may be reimbursed through telemedicine, expanded allowable sites where telemedicine services can be provided, and added reimbursement for facility fees.

In January 2010, HHSC further modified the telemedicine medical policy by adding inpatient telehealth consultation codes developed by the Centers for Medicare & Medicaid Services (CMS) to bill for telemedicine services. Prior to the addition of these codes, specific telehealth consultant codes did not exist, and telemedicine services had to be self-reported. This policy change has resulted in increased visibility of services and has also increased HHSC's ability to track telemedicine utilization and distinguish between distant and patient sites.

History and Background

Defining Telemedicine

Telemedicine is defined in Texas Administrative Code §354.1430 as the practice of health-care delivery, by a provider who is located at a site other than the site where the patient is located, for the purposes of evaluation, diagnosis, consultation, or treatment that requires the use of advanced telecommunications technology.

The provision of telemedicine services involves: (1) a patient site presenter responsible for presenting the patient for services; and (2) a distant site provider rendering consultation or evaluation for the purposes of diagnosis or treatment of the patient. The patient site presenters and distant site providers are restricted to certain provider types and locations as specified in the state's rules for Medicaid telemedicine services.

Terms and Definitions

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

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

Distant Site Provider – The distant site provider who uses telemedicine to provide health-care services to the patient. The distant site provider must be a physician who is licensed to practice medicine in Texas under Subtitle B, Title 3, Occupations Code.

Patient Site – The site where the patient is located.

Patient Site Presenter - The patient site presenter is the individual at the patient site who introduces the patient to the distant site provider for examination, and to whom the distant site provider may delegate tasks and activities in accordance with 22 TAC §174.6 (relating to Delegation to and Supervision of Patient Site Presenters). The patient site presenter must be: licensed or certified in this state to perform health-care services and must present and/or be delegated tasks and activities only within the scope of the individual's licensure or certification; and/or a qualified mental health professional (QMHP) as defined in 25 TAC §412.303(48) (relating to Definitions).

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.

Adoption of the Telemedicine Services Benefit in Texas Medicaid

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 consultations, interpretations, and interactive video visits when provided via telemedicine technology. Medicaid started reimbursing providers for these services in August 1998.

Legislative Changes Affecting Telemedicine Services

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.

Federal Legislation

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, including state Medicaid, 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.

State Legislation

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.

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.

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 instructed 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 directed HHSC to encourage the use of telemedicine.

General Telemedicine Policy Today

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 state hospital, state school, or in a rural or underserved area.

Medicaid rules currently limit telemedicine sites to rural or underserved areas, consistent with the formal designations established by the U.S. Census Bureau and U.S. Department of Health and Human Services (DHHS). The U.S. Census Bureau generally defines a rural area as a county with a population of 50,000 or less. DHHS defines an underserved area as an area that meets the current definition of a medically underserved area (MUA) or medically underserved population (MUP).

Table A in the Appendix shows the services that may be reimbursable when provided via telemedicine technology, the types of providers that may provide the services, and the locations at which services may be provided.

Use of Telemedicine Services in Texas Medicaid

Telemedicine technology is used to increase access to care in rural and underserved areas in Texas. For the most part, 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 underserved areas. From 1998 to early 2009 the Texas Medicaid program reimbursed distant site providers for consultations and patient site providers for office visits. In addition, beginning in September 2006, distant site providers were reimbursed for certain mental health services under the telemedicine mental health pilot. These services included medication management, psychiatric diagnostic interviews, and psychotherapy.

On April 1, 2009, Texas Medicaid removed limitations on distant site providers and began reimbursing distant site providers for office visits and psychiatric services that had previously been limited to the telemedicine mental health pilot. In addition, Texas Medicaid began reimbursing the patient sites a facility fee for presenting a client for telemedicine services, expanded the allowable patient site presenters to include any licensed or certified provider or qualified mental health professional (QMHP) as defined in state rule (25 TAC §412.303 (31)), and added local health departments as an additional location where patients may receive telemedicine services. Finally, in January 2010, as part of routine annual procedure code updates, Texas Medicaid added inpatient telehealth consultation codes developed by CMS. Prior to the addition of these codes specific telehealth consultation did not exist.

HHSC continues to evaluate the use of telemedicine in Medicaid, and encourage expansion through the adoption of pilot programs. With use of *Frew* Strategic Medical and Dental appropriations, in August 2009, the Pediatric Telemedicine Specialty Network began providing funds to expand the telemedicine networks in rural and medically underserved areas of the state. The initiative will be evaluating the impact to clients, providers, and cost of expanding the telemedicine network. The goals of the project are to: 1) increase access to specialty services for

children enrolled in Medicaid and decrease travel time and time away from work and school; and 2) promote increased coordination between primary care providers and subspecialists.

As part of the *Frew* initiative, HHSC entered into interagency contracts with two institutions with established telemedicine programs: The Texas Tech University Health Sciences Center (Texas Tech), and The University of Texas Medical Branch (UTMB).

- Texas Tech rolled out Project CHART (Children's Healthcare Access for Rural Texas) on August 31, 2009. Access to 16 pediatric sub-specialties is currently offered through this project. When fully implemented, Texas Tech will operate 25 patient sites.
- UTMB established the UTMB/HHSC TeleHealth Network for Children (UTNC) to offer pediatric psychiatry services. The project began operations the first week of August 2009. When fully implemented, UTMB will operate 18 patient sites.

Measuring the Effects of Telemedicine in Texas Medicaid

Data show an increase in the number of providers using telemedicine services and the number of services being provided via telemedicine technology. It is assumed that this increase is the direct result of expanded coverage of telemedicine services, improved tracking of telemedicine services, and other telemedicine network expansion initiatives aimed at improving access to specialty and sub-specialty care in Medicaid.

A telemedicine service is reported by including the GT (telemedicine) modifier on a claim. 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. However, because providers self-report telemedicine services and historically have been reimbursed for them the same as in-person services, it is likely that more providers are using telemedicine technology than is reported.

Reimbursement changes in the past two years resulted in increased visibility of telemedicine services and also increased HHSC's ability to track telemedicine utilization and distinguish between distant and patient sites. In April 2009, Texas Medicaid began reimbursing the patient sites a unique telemedicine facility fee for presenting a client for telemedicine services. In January 2010, HHSC further modified the Texas Medicaid telemedicine policy by adding inpatient telehealth consultation codes developed by the Centers for Medicare & Medicaid Services. Prior to the addition of these codes, specific telehealth consultant codes did not exist.

- The number of physicians and health professionals using telemedicine medical services.
 - From fiscal year 2007 to fiscal year 2009 the number of unique telemedicine providers in the state increased by 84 percent.
- The number of patients receiving telemedicine medical services.
 - There were 1,281 clients receiving telemedicine services in fiscal year 2007. By fiscal year 2009, that number increased to 4,269, representing a 233 percent increase.

- The types of services being provided.
 - From fiscal years 2007 through 2009, the most commonly billed telemedicine procedure was medication management. From fiscal years 2008 through 2009, the second most commonly billed telemedicine procedure was the telehealth facility fee. Prior to 2008, the second most commonly billed telemedicine procedure was a physician outpatient office visit.
- The expenditure of telemedicine medical services to the program.
 - In fiscal year 2007, Medicaid telemedicine expenditures were \$146,250, in fiscal year 2008, they were \$184,510.62, and in fiscal year 2009, they were \$506,136.82. Over the three-year period from fiscal years 2007 through 2009, Medicaid expenditures for telemedicine services increased by 246 percent.

Conclusion

HHSC conducted an analysis of telemedicine services to evaluate the effects of telemedicine in Texas Medicaid. HHSC found an increase in the number of providers using telemedicine from fiscal year 2007 to fiscal year 2009. From fiscal year 2007 to fiscal year 2009, the number of providers using telemedicine increased by 84 percent. The number of clients receiving telemedicine services increased by 233 percent from fiscal year 2007 to fiscal year 2009, while the expenditure of telemedicine services increased by 246 percent. It is assumed that this increase is the direct result of expanded telemedicine services, improved tracking of telemedicine, and other telemedicine network expansion initiatives aimed at improving access to specialty and sub-specialty care in Medicaid.

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
<ul style="list-style-type: none"> • Consultations • Medication management* • Psychiatric diagnostic interviews • Psychotherapy • Office or other outpatient visits • Inpatient telehealth consultations 	<ul style="list-style-type: none"> • No Limitation 	<ul style="list-style-type: none"> • Physicians 	<ul style="list-style-type: none"> • State hospital • State school • One of the following settings located in a rural or medically underserved area: <ol style="list-style-type: none"> 1. Physician office 2. Hospital 3. Rural health clinic (RHC) 4. Federally qualified health center (FQHC) 5. Intermediate care facility for persons with mental retardation (ICF/MR) 6. CMHC or associated outreach site 7. Local Health Department 	<ul style="list-style-type: none"> • Texas Licensed or Certified Healthcare Professionals • Qualified Mental Health Professional – community services (QMHP-CS)

Appendix B

Telemedicine Client Utilization, Provider Participation, and Expenditures

Fiscal Year 2005 - Fiscal Year 2009

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
2008	2,341	43	6,598	\$184,511
2009	4,269	46	14,767	\$506,137

Source : HHSC claims data.

Note: The number of unique providers includes both distant and patient site providers.

Appendix C

Telemedicine Services Provided

Fiscal Year 2005 - Fiscal Year 2009

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
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
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
Fiscal Year 2008	Procedure Codes	Number	Percent
90862	Medication Management	3,233	49.0
Q3014	Telehealth Facility Fee	1,800	27.3
99211-99215	Office/Outpatient Visit-Established Client	658	10.0
90805	Psychiatric Treatment, Office, 20-30 minute	437	6.6

90801-99802	Psychiatric Diagnostic Interview	378	5.7
99201-99205	Office/Outpatient Visit-New Client	50	0.8
99241-99244	Office Consultation	42	0.6

Total Fiscal Year 2008 **6,598** **100**

Fiscal Year 2009	Procedure Codes	Number	Percent
90862	Medication Management	7,873	53.4
Q3014	Telehealth Facility Fee	4,937	33.5
90801-99802	Psychiatric Diagnostic Interview	1,162	7.9
99211-99215	Office/Outpatient Visit-Established Client	437	3.0
90805	Psychiatric Treatment, Office, 20-30 minute	316	2.1
99241-99244	Office Consultation	21	0.1
99201-99205	Office/Outpatient Visit-New Client	6	0.0
Total Fiscal Year 2009		14,761	100

Source: HHSC claims data

Appendix D

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

Fiscal Year 2005 - Fiscal Year 2009

Fiscal Year	MSA	Number of Unique Clients	Number of Visits	Amount Paid
	Metro	76	130	\$4,170
	Micro	97	404	11,316
	Rural	159	488	13,630
2005	Total	332	1,022	\$29,117
	Metro	148	384	\$10,464
	Micro	82	357	10,126
	Rural	213	703	20,725
2006	Total	443	1,444	\$41,315
	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
	Metro	815	2,047	\$59,727
	Micro	539	1,824	47,180
	Rural	945	2,522	77,377
	Missing	117	205	227
2008	Total	2,416	6,598	\$184,511
	Metro	1,600	3,334	\$146,317
	Micro	1,008	4,693	152,782
	Rural	1,620	6,392	205,931
	Missing	199	348	1,106
2009	Total	4,427	14,767	\$506,137

* 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 claims data