

Medicaid Telehealth Reimbursement Research Project

III. Coverage and Reimbursement

Final Report

For

Alaska Telehealth Advisory Council

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Dear Friends and Colleagues:

I am pleased to announce my endorsement of the Alaska Telehealth Advisory Council (ATAC) Reimbursement Workgroup's recommendations for Medicaid reimbursement of Telehealth services.

The Reimbursement Workgroup was tasked with determining the scope of current coverage throughout the nation, analyzing the issues relevant to Alaska's unique geographic environment, and collecting information to support recommendations for coverage of Medicaid beneficiaries. The enclosed report will be the proposed framework for deployment and reimbursement of statewide Telehealth services in Alaska. These recommendations address the full range of provider categories eligible for Medicaid reimbursement as well as outlining statewide Telehealth practices.

The Department of Health and Social Services has a tremendous interest in supporting the development of Telehealth in Alaska. The work of the ATAC is important considering Alaska's vast cultural, geographic and economic differences. This determined effort will put Alaska in the forefront of this exciting and developing technology that will help to encourage appropriate and timely health care and help to diagnose and treat ailments of those who do not have adequate access.

Of course, more work lies ahead. Regulations which spell out the details of implementing these policies will have to be developed, a process that is likely to take nearly a year to complete. I have confidence that the leadership of the Division of Medical Assistance will follow through on this necessary task. I wish to thank Bob Labbe, Director, Division of Medical Assistance, Teri Keklak, Manager, Health Program and Policy, Vonne Mason, Health Program Manager, and Gwen Obermiller, Tribal Health Liaison for their commitment to this effort. Without their vision and hard work, Alaska would not be able to lead the nation in the policy area.

As co-chair of the ATAC, and as Commissioner of the Department of Health and Social Services, I also want to thank the Reimbursement Workgroup for its determination and effort while producing this document. Their work, as well as that of the entire ATAC, is the starting point of an improved health care delivery system within Alaska.

Sincerely,

Karen Perdue
Commissioner

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Executive Summary

Myers and Stauffer was engaged to recommend coverage and reimbursement policies for a planned Alaska Medicaid Telehealth delivery model. If the telehealth reimbursement model recommended in this report is adopted, Alaska Medicaid's telehealth policies will

1. Allow initial, follow-up, or confirming consultations; diagnostic and interpretative services via live telehealth media in all regions of the state.
2. Allow initial, follow-up, or confirming consultations; diagnostic and interpretative services via store-and-forward telehealth media in all regions of the state.
3. Allow providers currently reimbursed for HCPCS Evaluation and Management codes to be eligible to serve as referring/ presenting providers. See Table 1.3.
4. Allow any recognized practitioner, (1) eligible for Alaska Medicaid reimbursement, (2) rendering a Medicaid qualified consulting service, (3) to eligible Alaska Medicaid recipients to be a consulting provider. Exclusions should apply, including, for example transportation services. See Table 1.3.
5. Require that the referring and consulting practitioners be licensed in the state(s) in which each is located.
6. Require minimum technological standards, determined by Alaska Medicaid, for data transfer and imaging.
7. Prohibit direct reimbursement of practitioners' equipment/on-going technological costs.
8. Reimburse telehealth services at no less than the current fee schedule amount paid for the same service rendered in the traditional manner.
9. Reimburse both the consulting and referring practitioners separately at the full fee for services provided by each. Also reimburse the presenting practitioner a small fee for presenting the patient. These are defined later in this document.
10. Use HCPCS Level 1 and Level 2 codes with a "GT" modifier for billing and tracking telehealth services provided via interactive telecommunications. Assign a "GQ" modifier for the appropriate Level 1 or Level 2 code for billing and tracking telehealth services provided via store-and-forward technology.

The cost of technology will have an impact on the success of Alaska's telehealth model. Practitioners who use the more expensive, interactive, technologies (reimbursed by Medicare) will likely serve Medicaid to supplement Medicare and/or commercial practices. New entrants to telehealth practice, with a predominantly Medicaid patient panel, may opt for less-costly technological applications. Service coverage and fee scale development should consider how Medicare's current and anticipated policies might influence practitioner technology acquisition. Several telehealth and related initiatives are being undertaken in Alaska concurrent to ATAC's efforts. Each offers infrastructure, funding ideas, awareness, experience and information. Collaboration between any or all of the initiatives should continue to be encouraged.

III: Coverage and Reimbursement

The Alaska Telehealth Advisory Council

The Alaska Telehealth Advisory Council (ATAC) is a group of private and public stakeholders (e.g., hospitals, professional practitioner groups, utility companies, and government agencies) that all have an interest in promoting telehealth in the state of Alaska. ATAC's primary goals are to accomplish the following:

- Explore/ document the potential for and challenges to telehealth in Alaska.
- Propose a framework for development/ deployment of statewide capacity for telehealth systems.
- Establish core principals to ensure a coordinated, cost-effective, and integrated approach to telehealth in Alaska.
- Consider ways to assess effectiveness, efficiency, and whether or not telehealth is improving equity of access to health services for all Alaskans.
- Recommend a long-term process for addressing issues as they emerge with changing technologies and practice patterns.
- Add quality to healthcare.
- Deliver health services to individuals living in areas where geographic location or weather conditions may limit access to care.

Subcommittees or “workgroups” have been formed to deal with certain telehealth issues. In 1999, ATAC created a Reimbursement Workgroup to (1) investigate general reimbursement policy, (2) determine how other Medicaid programs across the country cover and reimburse telehealth applications, (3) analyze issues relevant to Alaska's unique geographic environment, (4) assist in collecting information to support recommendations for future telehealth coverage for Medicaid beneficiaries, and (5) develop an implementation plan for recommendations. Teri Keklak is the Alaska Department of Health and Social Services/Division of Medical Assistance (the Medicaid office) Designated Representative to the ATAC Reimbursement Workgroup for this project.

Project Overview

The Alaska Telehealth Advisory Council agreed to fund a contract with a private consultant to assist the Reimbursement Workgroup with the development of policies. Accordingly, Alaska's Native Tribal Health Consortium engaged Myers and Stauffer LC to develop a recommendation plan for reimbursing Medicaid telehealth services. Myers and Stauffer's workplan for this project contains four components:

1. a report summarizing other states' telehealth initiatives;
2. a report outlining Alaska's telehealth issues;
3. a report recommending coverage and reimbursement policies; and
4. a final report recommending an implementation and evaluation plan.

Introduction

Alaska is the largest state in the country in landmass, contributing approximately 16% of the United States' total size. Conversely, the state is the 48th most populated state, with an estimated population of 617,000 people, or 1.1 people per square mile. The majority of Alaska's population resides in regional centers throughout the state, with large areas of unoccupied, rural land. Approximately 83% of the state's population resides in eight boroughs. These include the Municipality of Anchorage, Matanuska-Susitna Borough, Fairbanks North Star Borough, Kenai Peninsula Borough, Kodiak, Bethel, North Slope, and Juneau Borough. Climate, geographical location, job types, demographic and other factors create unique challenges for the health care delivery system. Many of these same factors have also caused the state to have a very atypical transportation and communications infrastructure. Technological conveniences and advances found in other states at moderate costs are significantly more expensive in Alaska.

The Secretary of Health and Human Services periodically determines geographical regions that are termed, "health professional shortage areas (HPSAs)". HPSAs are regions that have a shortage of primary care physicians, dentists, and/or mental health care practitioners. For primary care, an HPSA generally has a population to full-time-equivalent primary care physician ratio of at least 3,500:1. HPSAs can be designated as large as whole county areas or as small as hospital service areas or census tracts. The entire state of Alaska is a health professional shortage area¹. Few states with the landmass, technological challenges and complex socioeconomic factors comparable to that of Alaska face such substantial shortages in the availability of health care practitioners.

The Secretary of Health and Human Services also periodically determines "medically underserved areas (MUAs)". MUA designations are primarily used for determining areas where Community and Migrant Health Centers may locate. Federally Qualified Health Centers' cost-based reimbursement is also dependent on MUA status. MUA determinations are based on whether an area exceeds a score for an Index of Medical Underservice (IMU). The IMU is an index value based on 1) infant mortality rate; 2) poverty rates; 3) percentage of elderly; and 4) primary care physicians to population ratios. As with HPSA designations, an area (MUA) or a population (MUP) may be designated. The following areas have been given the MUA designation as of October 2000: Aleutians East Borough, Anchorage Borough, Bethel Census Area, Bristol Bay Borough, Kenai Peninsula, Matanuska-Susitna Borough, Nome Census Area, North Slope Borough, Northwest Arctic Borough, Skagaway-Hoonah-Angoon Borough, Yakutat Borough, Wade-Hampton Census Area, and the Yukon-Koyukuk Census Area.

To deliver health care services in this environment, Alaska is researching a Medicaid telehealth delivery model that facilitates services with consideration of the following:

¹ Information provided by the Alaska Division of Medical Assistance.

- Delivery of and increased access to high quality medical services.
- Delivery of services to a sparse population in cities and villages separated by a rugged, vast, varied terrain with atypical climatic and solar phenomenon.
- Delivery of services to a population whose health practices may be influenced by ethnic, cultural, religious, and socio-economic factors.
- Availability of medical services to the greatest number of Alaskans using limited resources.
- Delivery of telehealth services in the most appropriate, cost-effective manner.
- Most efficient integration of Alaskan medical practitioners.
- Promoting and efficiently using available technology to facilitate the delivery system, with consideration for quality medical service delivery.
- Advancing telehealth services through the acquisition of new technologies.

This report presents, examines, and recommends policies for coverage and reimbursement of telehealth services that could be implemented under the Alaska Medicaid program or set forth a methodology that could provide a foundation for Medicaid and other payers. Specifically, this report addresses the following questions:

- Who will be reimbursed for telehealth services? Which provider types will be eligible initially, and/or eventually?
- Which telehealth services may be reimbursable?
- How will Alaska define the types of media that may be used or the components that must be present as part of the reimbursable encounter in qualifying that a telehealth service has been rendered? What types of available technology will be acceptable for use (BBS, Internet, videoconferencing, ISDN, T1, T3, satellite, etc?)
- How will technological quality be standardized?
- How will telehealth coverage and reimbursement be introduced to the practitioner community?
- How will ATAC encourage the growth and development of a telehealth delivery system and set policy for funding and guidance?
- Will practitioner licensing be regulated and standardized?
- Will financial resources be made available to practitioners for startup and ongoing support of technical applications?
- Are there preferable data standards, bandwidth requirements, equipment, or other mechanisms that Alaska should require providers to observe to insure the quality of data images and other telehealth services?

- Will there be enhanced reimbursement for telehealth services?
- How will consulting practitioners and referring practitioners be reimbursed? Will they share a payment? Will they be paid separately?
- Will Medicaid consider any of practitioners' costs for equipment, line charges, or on-going technical services for reimbursement?
- How will practitioners indicate, on a claim form, that a service was provided via telehealth mechanisms? Will a modifier be used? Will local codes be developed?
- What will be the projected utilization pattern for telehealth services?

The basic premise and assumption for telehealth services is that such services should be delivered in a manner equivalent to the same encounter occurring in a live, face-to-face interaction between the patient and the practitioner. The most important question in deciding what to reimburse and how to reimburse for telehealth services is whether telehealth services are a distinct procedure or whether telehealth services are simply an alternate delivery method for procedures.

Medicare does not specifically recognize telehealth as a discrete medical procedure. Instead, it is thought of as a method for delivering care. The Centers for Medicare and Medicaid Services (CMS) [formerly known as the Health Care Financing Administration (HCFA)], the federal agency that regulates Medicaid and Medicare, permits states to reimburse for telehealth services provided to Medicaid beneficiaries. According to CMS, for billing purposes, states may require established Current Procedural Terminology (CPT) codes with telehealth modifiers. Alternatively, new state procedural codes can be created to track and identify medical care delivered by telehealth technology. Most importantly, individual state regulations for Medicaid telehealth reimbursement must comply with Federal Medicaid guidelines as well as the laws that govern medical practice in each state. Because telehealth is viewed by CMS as a mode of health care delivery, and not an actual procedure, state Medicaid offices are not required to report telehealth utilization statistics to CMS.

Alaska Medicaid's telehealth delivery model may follow one of four paths.

1. Adopt policies and procedures currently used by Medicare.
2. Adopt policies and procedures Medicare will implement as of October 1, 2001.
3. Adopt policies and procedures used by other state Medicaid programs.
4. Create a hybrid system, borrowing policies and procedures from both Medicare and other state Medicaid programs.

Medicare

To date, Medicare has established rules that impose several restrictions on the delivery of telehealth services, and how such services are reimbursed. Legislators have challenged its limitations by introducing several bills supporting the expansion of reimbursement for telehealth services. On December 21, 2000, former President Bill Clinton signed a bill introduced by Senator J. Jeffords entitled the "Telehealth Improvement and Modernization Act of 2000" (H.R. 5661), which amended and expanded Medicare's telehealth provisions. The effective date of this new legislation

is October 1, 2001. Below are highlighted features of Medicare's current policy, and the subsequent amendments under the new Medicare provisions relevant to telehealth services.

Modes of telehealth service delivery

Current policy

Medicare only reimburses interactive modes of telehealth consultations, thus excluding store-and-forward modes of telehealth technology. Interactive technology includes audio-video equipment permitting two-way, real-time consultation among the patient, consulting practitioner, and referring practitioner as appropriate to the medical needs of the patient and as needed to provide information to and at the direction of the consulting practitioner. Telephones, facsimile machines, and electronic mail systems do not meet the definition of interactive telecommunication systems.

New policy effective 10/01/01

Interactive modes of telehealth consultations are still required as a condition for payment; however, the use of asynchronous "store-and-forward" technology is allowed and will be reimbursed only when the originating site is a Federal telemedicine demonstration program in Alaska or Hawaii. The originating site and distant site practitioner must be included within the definition of the demonstration project.

Health coverage

Current policy

Covered services include initial, follow-up, or confirming consultations in hospitals, outpatient facilities, or medical offices delivered via interactive audio and video telecommunications systems (CPT codes 99241-99245, 99251-99255, 99261-99263, and 99271-99275).

New policy effective 10/01/01

Covered services have expanded to include consultation, office visits, individual psychotherapy, and pharmacologic management delivered via a telecommunications system with the following CPT codes: consultations (99241-99275), office or other outpatient visits (99201-99215), individual psychotherapy (90804-90809), and pharmacologic management (90862).

Geographic eligibility for reimbursement

Current policy

Reimbursement is available for telehealth services rendered to Medicare beneficiaries in rural Health Professional Shortage Areas (HPSAs) only. The referring health care practitioner and the teleconsultation must originate from a designated rural HPSA,

and the beneficiary must reside in a county in a rural area designated as a Health Professional Shortage Area. However, there are two very important points that must be noted. First, the beneficiary is deemed to be residing in an HPSA if the teleconsultation takes place in such an area. Second, the consultation need not take place in the portion of the county that is in the HPSA, so long as it occurs in a county that is, in part, designated as an HPSA.

New policy effective 10/01/01

Eligible geographic areas will be expanded beyond rural HPSAs to include counties that are not in a metropolitan statistical area (MSA). Furthermore, entities participating in a Federal telemedicine demonstration project as of December 31, 2000 qualify as an originating site without being subject to the HPSA or MSA requirements.

Provider eligibility for reimbursement

Current policy

Medicare reimbursement for a teleconsultation is contingent on the type of practitioner that refers the patient. A referring practitioner may be a physician, a physician's assistant, a nurse practitioner, a clinical nurse specialist, a nurse-midwife, a clinical psychologist, or a clinical social worker. Any of these provider types may present the patient to the consulting practitioner. The referring practitioner must be present at the time of the consultation. Registered nurses, as well as other allied health staff, are not included on the list of eligible personnel who may refer or present a patient for a consultation. Consulting practitioners may be physicians, physician assistants, nurse practitioners, clinical nurse specialists, or nurse midwives.

The medical examination of the patient must be under the control of the consulting practitioner. The patient must be present, and the technology must allow the consulting practitioner to examine the patient. The consultation must involve the participation of the referring practitioner as appropriate. The consultation results must be in a written report that is furnished to the referring practitioner (merged).

New policy effective 10/01/01

Medicare no longer requires an eligible beneficiary to be presented by a referring physician or practitioner at the originating site for the administration of an interactive telehealth service, unless it is deemed medically necessary.

Payment for services

Current policy

The payment is to be shared between the referring practitioner and the consulting practitioner. Practitioners who provide teleconsultations are reimbursed at 75% of the rate of an in-person (non-telehealth) consultation. The consulting practitioner will receive the Medicare payment and then remit 25% of that payment to the referring

practitioner. The GT modifier, which means, “via interactive audio and video telecommunication systems,” must be used on all claims for telehealth services. Only the consulting practitioner may bill for telehealth services. The referring practitioner cannot submit a Medicare claim for the teleconsultation. Payments do not include any reimbursement for telephone line charges, facility fees, etc. The beneficiary may not be billed for these charges or fees. The amount of the payment for teleconsultations may not exceed the current fee schedule amount that would be paid if the services were rendered via traditional face-to-face methods.

New policy effective 10/01/01

Consulting practitioners at the distant site are no longer required to share 25% of the total payment with the referring practitioner. Instead, the consulting practitioner will receive full payment in the amount equal to the current fee schedule for that service (*only certain practitioners are recognized as consulting practitioners). The amount should also be equal to the amount that would have been paid without the use of telemedicine. The referring practitioner at the originating site will receive a \$20 originating site facility fee from October 1, 2001 to December 31, 2002. In subsequent years, this fee will be updated annually by the Medicare Economic Index (MEI). The beneficiary is responsible for any unmet deductible amount and applicable coinsurance.

In addition to this, a “GQ” modifier has been created to supplement the appropriate CPT code when telehealth services are delivered “via asynchronous telecommunication systems” (e.g. store and forward technology).

Evaluating Medicare Policy

As the largest, most influential health care payer, Medicare has been heralded for reimbursing telehealth services. Most public and private insurance payers look to Medicare when deciding coverage and reimbursement policies for various services. Medicare’s recognition of telehealth services will likely spawn a wider acceptance and practice of this method of medical service delivery. Like most other Medicare policies, public and private payers will surely adapt Medicare telehealth policies to fit special and unique circumstances that exist in smaller, medically divergent markets. Medicare, after all, sets policies on a nationwide basis.

Critics have espoused a number of varying and often contradictory opinions about the alleged shortcomings of Medicare’s current telehealth policies. They argue that less than six percent of all telehealth encounters taking place meet current Medicare criteria. There are, in fact, some areas inherent in these policies that limit the capabilities and usefulness of telehealth services. For example, by requiring consulting practitioners to provide the referring physician 25% of any reimbursement payment, consulting practitioners lack the incentive to provide telehealth services, when they could otherwise be reimbursed at 100% for a face-to-face consultation with a beneficiary. In addition to this, by limiting the allowed mode of telehealth services to only interactive technology, one cannot benefit from the use of store-and-forward applications, which can sometimes be the only way to

offer services in very remote areas. In both cases, access to care becomes an issue, thus limiting the potential usefulness of telehealth.

In response to the shortcomings and limitations of current Medicare policy, the Telehealth Improvement and Modernization Act of 2000 has provided a means for which advances can be made in telehealth care. For example, by eliminating the fee-sharing requirement between the consulting and referring practitioner and paying them separately for their time and services, both practitioner types have incentive to participate as a provider of telehealth services. Furthermore, the use of “store-and-forward” technology is permitted in Alaska, as long as the originating site is a participant of a Federal telemedicine demonstration project. This particular policy amendment does indicate some progress; however, by restricting “store-and-forward” technology to sites participating in a Federal telemedicine demonstration project, there is still a limit on the usefulness of telehealth, particularly for the state of Alaska since store-and-forward can sometimes be the only way to extend medical services to individuals in isolated areas.

Other State Medicaid Programs

Several state Medicaid programs have adopted policies for reimbursing telehealth services. Discussed in detail in the report, “Alaska Telehealth Advisory Council Medicaid Telehealth Reimbursement Research Project; I.: Other States’ Practices,” the highlights of selected programs are included below.

Most states reimburse for physician consultations when provided using interactive video teleconferencing equipment. California, North Dakota and Virginia also recognize other selected services provided by psychiatrists. In Georgia and Texas, physician consultations are restricted by the requirement that consulting providers be located at teaching hospitals. Georgia requires consulting providers to be located at a medical center managed through the Medical College of Georgia, and Texas requires consulting physicians to be employed by or affiliated with an accredited medical or osteopathic school.

West Virginia requires its referring providers to be in rural health shortage areas. Similarly, Texas requires its referring providers to be in rural areas (a county with a population of less than 50,000) or an underserved area (an area that meets the definition of a Medically Underserved Area or Medically Underserved Population by the U.S Department of Health and Human Services). Some states are liberal regarding the scope of services that can be provided via telehealth. For example, the state of Nebraska will soon implement a telehealth initiative that recognizes most state plan services when furnished using interactive video teleconferencing. Kentucky’s recently passed telehealth law appears to recognize almost as many telehealth services as Nebraska, however these services will have to be provided through a network created by the telehealth law. Kansas and Utah reimburse for a select number of home health services provided through telehealth. This allows home health providers in these states to monitor recipients via telehealth instead of home visitation.

Four states – Kentucky, Nebraska, South Dakota, and Minnesota - reimburse for store and forward telehealth practices. California and Louisiana allow store and forward consultations to be reimbursed, but these claims are not to be submitted with telehealth modifiers. Most states reimburse for services at both the referring and consulting site. However, most of these states insisted that the referring practitioner must provide a real time interactive service (presenting the patient to the consulting practitioner, for example) during the telehealth encounter in order to be reimbursed.

In West Virginia, reimbursement is made only at the consulting site. However, on the day the teleconsultation occurs, the referring physician may bill for the office, outpatient, or inpatient visit that preceded the need for a consultation. Additionally, the referring physician could bill for other services as ordered by the consultant or for services unrelated to the medical problem for which a consultation was requested. However, the referring physician is prohibited from billing for a second visit for his or her role in presenting the patient at the time of the consultation.

In North Carolina, a single consultation fee is split between the consulting and referring sites. The consulting provider receives 75% of the fee, and the referring provider receives 25% of the fee. Kansas and Utah only reimburse the consulting providers. The Kansas Medicaid Program leaves it up to the participating telehealth providers to determine whether the referring provider will receive a percentage of the consulting provider's reimbursement received from Medicaid.

Eight of the surveyed states use either a GT or a TM modifier to indicate that a consultation was provided via telehealth. The state of Minnesota only requires the consulting provider to use a GT modifier. In addition, it requires consulting providers to use a GT modifier to indicate if a consultation was done via store and forward technology. Arkansas, Georgia, Illinois, and Virginia have developed local codes specific to telehealth services. Similarly, the state of Kansas reserves the use of four CPT codes for its home health telehealth program (99350 thru 99353). These four codes cannot be used by home health agencies delivering traditional, face-to-face home health services. Louisiana, Montana and Oklahoma do not track telehealth services at all. These states do not use telehealth modifiers, nor have they developed any special telehealth codes. Kentucky has not yet decided if it will use modifiers or special codes. The state of Maine requires telehealth claims to include the diagnostic code V630 as a secondary diagnosis. Nebraska telehealth claims submitted on HCFA1500 forms must use the place of service code to indicate a telehealth encounter. Other modifiers will be used on other claim forms in Nebraska. Finally, North Carolina uses pricing modifiers. This allows North Carolina to split a single consultation fee between the referring and consulting providers. As stated above, 75% of the consultation fee goes to the consulting provider and 25% of the consultation fee goes to the referring provider. The consulting practitioner uses a GT modifier and the referring practitioner uses a YS modifier. The North Carolina claims system calculates the 75/25 percentages based on these modifiers.

Iowa and Nebraska reimburse providers for line charges and other telehealth infrastructure. Under Iowa's now defunct pilot telehealth program, Iowa paid a

supplemental “facility fee” to cover the cost of scheduling and technical support associated with teleconsultations. For providing these site coordination services, sites were reimbursed \$11.73. The local billing code was W1282. In addition to the facility fee, the originating site received a transmission fee of \$7.20. The local billing code for the transmission fee was W1281.

In Iowa, a patient’s referring provider could be a physician, physician assistant, or nurse practitioner. However, if a non-physician practitioner presented a patient, only supplemental transmission and site coordination services could be billed. Nebraska’s telehealth initiative has not yet been implemented. However, the Nebraska Medicaid Program intends to pay for line charges, otherwise known as or transmission costs. Nebraska filed a state plan amendment in order to reimburse for line charges, because it will be paying more for state plan services when they are provided via telehealth.

The state of Oklahoma does not currently reimburse for additional costs associated with providing telehealth services. However, a bill passed by the Oklahoma Legislature during the past legislative session allows the use of the Oklahoma Universal Service Fund to provide one free telehealth line or wireless connection. This law has not yet been implemented. The Oklahoma Corporation Commission must first promulgate rules for this expansion.

Evaluating Other States’ Initiatives

Other State Medicaid programs that have instituted programs to cover and reimburse telehealth services have used Medicare telehealth policy as the foundation for their programs. Other states have elected to either follow Medicare policies to the letter or to adopt portions of Medicare policy with slight home-grown modifications to accommodate the unique circumstances of the individual state. Table 1.1, below, illustrates the degree of symmetry between most state Medicaid telehealth programs and Medicare’s program.

All of the 16 states used in the comparison reimburse interactive media, as does Medicare. Only 3 of the 16 state Medicaid programs reimburse telehealth services delivered via store and forward technology. Medicare does not. Medicare only reimburses for telehealth consultations. Only 1 state Medicaid program does not reimburse consultations. Only 2 states reimburse other services in addition to consultations. Medicare reimburses both the referring practitioner and the consulting practitioner, requiring them to share a payment. Only Kansas differs from Medicare policy regarding payment and fee sharing. Nine of sixteen use modifiers. Four of sixteen use local codes. Five use neither modifiers or local codes, only HCPCS Level 1 and Level 2. One state offers enhanced reimbursement. One state reimburses for equipment and infrastructure. Four states restrict services more than the same service delivered via non-telehealth means would be restricted.

There may be some aspects of other states’ policies that, if adopted, could cause undesirable outcomes for Alaska. A few of these are highlighted below:

- ✓ The use of state created modifiers and local codes to indicate when services are being provided by telehealth will not comport with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- ✓ States not using a modifier or other mechanism to identify telehealth services may not have the ability to track and analyze specific service aspects such as utilization trends, expenditures, or service access.
- ✓ States splitting consultation fees such that the referring practitioner receives 25% and the consulting practitioner receives 75% may pose a disincentive for the provision of telehealth services, since the consulting practitioner receives higher reimbursement for non-telehealth services. Consequently, this could limit service access and have no effect on reducing professional shortages.
- ✓ States not providing enhanced reimbursement for telehealth services may pose a disincentive for the provision of telehealth services, since practitioners would be responsible for funding the acquisition of and on-going costs for technical applications used to deliver telehealth services. A fee enhancement might help offset such costs.
- ✓ States limiting telehealth reimbursement to HPSAs risk shifting access problems to other regions of the state and creating cost-inefficiencies for practitioners who require a large patient base to support the often-expensive technological infrastructure supporting telehealth applications.

Table 1.1: Telehealth Coverage and Reimbursement—Medicare, Other States

	Current Medicare	Medicare after 10/1/01	AR	CA	GA	IL	IA	KS	LA	MN	MT	NE	NC	ND	SD	TX	VA	WV
Interactive Media	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Store and Forward	N	Y	N	N	N	N	N	N	Y	Y	N	N	N	N	Y	N	N	N
Reimburse Consultations	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Reimburse Other Services	N	N	N	N	N	N	N	Y	N	N	N	Y	N	N	N	N	N	N
Reimburse Referring Practitioner	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Reimburse Consulting Practitioner	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Use Modifiers	Y	Y	N	Y	N	N	Y	N	N	Y	N	Y	Y	Y	Y	Y	N	Y
Use Local Codes	N	N	Y	N	Y	Y	N	N	N	N	N	N	N	N	N	N	Y	N
Enhanced Reimbursement	N	N	N	N	N	N	N	N	N	N	N	Y	N	N	N	N	N	N
Reimburse Equipment and Infrastructure	N	N	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N
Restricted More than Non-Telehealth Services	N	N	Y	Y	N	N	N	N	N	Y	N	Y	N	N	N	N	N	N

What does this mean? Intuitively, there is not a great deal of creativity and innovation in Medicaid telehealth policy. As with most policy issues, a number of state Medicaid programs have looked to Medicare as the template for their initiatives. The question that must be considered is whether current or future Medicare telehealth policies are viable in Alaska.

Applying Other Payer’s Telehealth Policies in Alaska

The second report in this series, “Alaska Telehealth Advisory Council Medicaid Telehealth Reimbursement Project: II—Issues for Consideration,” explored aspects of Alaska’s geography, culture, health delivery system, and technological infrastructure that make it dissimilar to the other 49 states. Highlights of the report included the following observations:

1. Alaska has a large landmass with a sparse population, with geographical and climactic challenges that complicate conventional mobility.
2. The Secretary of Health and Human Services has deemed a majority of Alaska’s boroughs as health professional shortage areas.
3. Native Alaskan culture and socio-economic factors influence access to health services.
4. There is an opportunity for expansion of available Internet and electronic claims processing capabilities to the Alaska health professionals community.
5. Alaska is on the verge of rapid technological growth, as more companies invest resources in developing Internet and wireless capabilities in the state.

6. Alaska is geographically separated from the lower 48 states, its closest neighbors being Russia and Canada. Due to a lack of infrastructure that would otherwise support the development of international services, Alaska has elected to limit the network of health professionals to those in the United States.

For these reasons, Alaska should develop a telehealth reimbursement model that is mindful of the foundation and experiences of Medicare and the other state Medicaid programs while also addressing the unique aspects of the people, the health delivery system, and the technological infrastructure of the state. Consequently, Alaska’s telehealth delivery model will likely illuminate the healthcare landscape in the same unique fashion as the state so readily celebrates its differences from the other 49 states.

Proposed Telehealth Delivery Model for Alaska

Recognizing (1) Alaska’s unique health delivery environment, (2) Alaska’s statewide medical professional shortage, (3) the infancy of telehealth initiatives nationwide, and (4) the establishment of new, less restrictive Medicare telehealth policies, we propose that ATAC consider the policy options recommended below:

Table 1.2: Proposed Telehealth Model for Alaska Medicaid

Coverage	Alaska Policy
Allow Interactive Media	Yes
Allow Store and Forward Media	Yes
Reimburse Consultations	Yes
Reimburse Other Services	Yes
Reimburse Referring Practitioner	Yes
Reimburse Consulting Practitioner	Yes
Reimbursement	
Use Modifiers	Yes
Use Local Codes	No
Allow Enhanced Reimbursement	No
Reimburse Equipment and Infrastructure Separately	No
Restrict Services More than Non-Telehealth Services	No

Coverage

Coverage is concerned with two main aspects of telehealth. First, it must be determined what services may be delivered and reimbursed via telehealth applications. Second, it must be determined what media may be used to render reimbursable telehealth services. Specifically, coverage must address the following issues:

1. What services should be covered?
2. In what geographical regions will services be reimbursed?
3. Who may be a referring/ presenting provider?
4. Who may be a consulting provider?
5. What types of media may be used to render telehealth services?
6. How will practitioner licensing be regulated and standardized?
7. How will technological quality be standardized? Are there preferable data standards, bandwidth requirements, equipment, etc.?

Below are selected options available to Alaska, followed by a specific recommendation. Options listed below are either (1) Medicare policy, (2) other state Medicaid program policy, or (3) hybrid variations of Medicare policy and/or other state Medicaid program policy.

1. What Services Should Be Covered?

Option 1: Covered services include initial, follow-up, or confirming consultations, office or other outpatient visits, individual psychotherapy, and pharmacologic management in hospitals, critical access hospitals, rural health clinics, federally qualified health centers, or medical offices (CPT codes 99201-99215, 99241-99275, 90804-90809, and 90862).

Option 2: Covered services include initial, follow-up, or confirming consultations, diagnostic and interpretative services, individual psychotherapy, and pharmacologic management in hospitals, rural health clinics, federally qualified health centers, outpatient facilities, medical offices, nursing facilities, or beneficiary residences (CPT codes 99201-99215, 99241-99275, 90804-90809, and 90862).

Option 3: Covered services include initial, follow-up, or confirming consultations in hospitals, outpatient facilities, or medical offices (CPT codes 99241-99245, 99251-99255, 99261-99263, and 99271-99275).

Option 4: Covered services include initial, follow-up, or confirming consultations, and interpretative services in hospitals, outpatient facilities, medical offices, and nursing facilities (CPT codes 99201-99215, 99241-99275, 90804-90809, and 90862).

Recommendation: It is recommended that Alaska adopt Option 2. It is also recommended that Alaska Medicaid determine, on a HCPCS code-level basis, specific procedures that will be reimbursed via telehealth.

Option 1 is based on new Medicare policy. Alaska requires a great deal of flexibility in order to insure that its telehealth model serves the greatest number of people and alleviates noted professional shortages. Option 2 facilitates a greater number of medical circumstances to be accommodated. It is recommended that, in the infancy of the delivery model, providers be allowed flexibility in providing telehealth services. Alaska Medicaid should periodically evaluate the types of services billed. This will allow the state the opportunity to decide what telehealth applications are acceptable. Telehealth is an innovative approach to delivering medical services, and as such, should not be prematurely limited in an environment that may offer new and unexpected applications.

2. In What Geographical Regions Will Services Be Reimbursed?

Option 1: Restrict service locations to those in Health Professional Shortage Areas, to counties outside of a metropolitan statistical area (MSA), and to entities participating in a Federal telemedicine demonstration project.

Option 2: Allow services statewide without geographical restrictions.

Option 3: Restrict services to medically underserved areas, as determined by the Division of Medical Assistance.

Option 4: Allow services statewide, restricting services to the state of Alaska, provided that such services are available in the state. Develop protocol explicitly stating that, only under certain conditions, should services be provided out-of-state.

Recommendation: It is recommended that Alaska adopt a policy consistent with Option 4, allowing telehealth services statewide, but restricting services to in-state if such services are available. By doing this, Alaska Medicaid can better monitor the

administration of telehealth services and limit complications that may arise as licensure requirements vary from state to state.

3. Who May Be a Referring/ Presenting Provider?

Option 1: Allow any primary care provider who can independently bill Medicaid to serve as a referring provider, regardless of specialty or certification. Any midlevel practitioner or other qualified practitioner, under the supervision of a practitioner who may independently bill Medicaid, may be designated as the presenting practitioner.

Option 2: Permit physicians, physician assistants, nurse practitioners, clinical nurse specialists (MSN or equivalent), nurse-midwives, social workers, or clinical psychologists to refer/ present the patient. Exclude registered nurses, as well as other allied health staff.

Option 3: Allow providers currently reimbursed for HCPCS Evaluation and Management codes to be eligible to serve as referring providers.

Recommendation: It is recommended that Alaska adopt a policy consistent with Option 3. Additional allowances may be made on a case-by-case basis where appropriate. For example, in a remote area, in the absence of reimbursable presenting practitioners, Alaska may allow a facility or other normally excluded practitioner to refer and/or present patients for telehealth services.

4. Who May Be a Consulting Provider?

Option 1: A consulting practitioner may be a physician, physician assistant, nurse practitioner, clinical nurse specialist, nurse midwife, or mental health professional.

Option 2: Allow any recognized practitioner, (1) eligible for Alaska Medicaid reimbursement, (2) rendering a Medicaid qualified consulting service, (3) to eligible Alaska Medicaid recipients to be a consulting provider. Exclusions should apply, including, for example transportation services.

Option 3: A consulting practitioner may be a physician.

Recommendation: It is recommended that Alaska adopt a policy consistent with Option 2. A presenting provider may be found only during interactive telehealth encounters, rather than store and forward encounters where a practitioner does not actually present the patient. In store-and-forward encounters, it is the patient's

medical file that is being delivered to a consulting practitioner. Facilities currently reimbursed at a percentage or per diem rate may be eligible as presenting providers.

5. What Types of Media May be Used to Render Telehealth Services?

Option 1: Restrict reimbursement to live, interactive, telecommunication media. Consultations must take place via interactive telecommunication systems. These include audio-video equipment permitting two-way, real-time consultation among the patient, consulting practitioner, and referring practitioner as appropriate to the medical needs of the patient and as needed to provide information to and at the direction of the consulting practitioner. Telephones, facsimile machines, and electronic mail systems do not meet the definition of interactive telecommunication systems.

Option 2: Restrict reimbursement to live, interactive, telecommunication media with the exception of allowing “store-and-forward” technology to be used by entities participating in a Federal telemedicine demonstration project.

Option 3: Restrict reimbursement to “store-and-forward” applications. These include telephones, facsimile machines, electronic mail, paper, computer diskettes, and other such mechanisms that do not necessarily include live interaction between the patient and the practitioner.

Option 4: Allow reimbursement for both live, interactive, telecommunication media and “store-and-forward” applications.

Recommendation: It is recommended that Alaska adopt a policy consistent with Option 4. Both store-and-forward and interactive media should be allowed. Both interactive technology and store-and-forward applications are required to meet Alaska’s stated telehealth objectives. Such circumstances should be determined on a procedure-level basis upon the adoption of a specific medical policy.

6. How Will Practitioner Licensing Be Regulated and Standardized?

Option 1: Require that both the referring and consulting practitioners be licensed to practice medicine in Alaska. Both must be enrolled in Alaska Medicaid.

Option 2: Require that the referring and consulting practitioners be licensed in the state(s) in which each is located. Both must be enrolled in Alaska Medicaid.

Option 3: Require that the referring and consulting practitioners be licensed in the state in which the consultation is rendered. Both must be enrolled in Alaska Medicaid.

Recommendation: It is recommended that Alaska adopt a policy consistent with Option 2.

7. How Will Technological Quality Be Standardized? Are There Preferable Data Standards, Bandwidth Requirements, Equipment, Etc.?

Option 1: Establish minimum data transfer, bandwidth, and image specifications.

Option 2: Establish no minimum standards.

Option 3: Require practitioners to undergo a readiness review/evaluation prior to eligibility for reimbursement.

Recommendation: It is recommended that Alaska adopt a policy consistent with Option 1. Recommended minimum standards are discussed later in this document.

Reimbursement

Reimbursement is concerned with three main aspects of telehealth. First, it must be determined how practitioners will indicate telehealth services on a claim form. Second, the fees reimbursed for telehealth services must be determined. Third, it must be determined how the referring practitioner and the consulting practitioner will be reimbursed for the services each provides. Finally, the projected utilization impact of telehealth services must be examined. Specifically, an examination of reimbursement must address the following issues:

1. Will any financial resources be available to practitioners for startup and ongoing support of technical applications?
2. What will be the fee structure for telehealth services? Will there be enhanced reimbursement for telehealth services?
3. How will consulting practitioners and referring practitioners be reimbursed? Will they share a payment? Will they be paid separately?
4. How will practitioners indicate, on a claim form, that a service was provided via telehealth mechanisms? Will a modifier be used? Will local codes be developed?
5. What restrictions, if any, should be applicable to services delivered via telehealth?

1. Will Any Financial Resources Be Available To Practitioners For Startup And Ongoing Support Of Technical Applications?

Option 1: Medicaid fees for telehealth services will reimburse a portion of practitioners' startup and ongoing costs for technical applications.

Option 2: Practitioners will be encouraged to use private funds and solicit grants and other opportunities to fund startup and ongoing costs for technical applications.

Option 3: Medicaid will reimburse practitioners a one-time fee to off-set the costs of startup and ongoing costs for technical applications.

Recommendation: It is recommended that Alaska adopt a policy consistent with Option 2.

2. What Will Be The Fee Structure For Telehealth Services? Will There Be Enhanced Reimbursement For Telehealth Services?

Option 1: The amount of the payment for teleconsultations may not exceed the current fee schedule amount that would be paid if the service were rendered in the traditional manner.

Option 2: The amount of payment for teleconsultations will be the current fee schedule amount plus an enhanced percentage.

Option 3: The amount of payment for teleconsultations will be less than the current fee schedule amount.

Recommendation: It is recommended that Alaska adopt a policy consistent with Option 1.

3. How Will Consulting Practitioners And Referring Practitioners Be Reimbursed? Will They Share A Payment? Will They Be Paid Separately?

Option 1: Consistent with current Medicare policy, the referring and consulting provider share a single payment, with the consulting provider receiving 75% of the payment. The referring practitioner bills for an office visit at the time he or she determines the need for a telehealth consultation.

Option 2: Consistent with the new Medicare policy (effective October 1, 2001), the consulting practitioner receives full payment in the amount equal to the current fee schedule for that service. The referring practitioner at the originating site will initially receive a \$20 originating site facility fee. In subsequent years, this fee should be updated annually by the Medicare Economic Index (MEI).

Option 3: The consulting practitioner receives 100% of the payment. The referring practitioner bills for an office visit at the time he or she determines the need for a telehealth consultation.

Option 4: At the initial consultation, the referring provider is reimbursed for an office visit. The consulting practitioner receives 100% of a fee for services delivered during the consultation. The presenting practitioner is reimbursed a small fee for time and resources used at the time the patient is presented to the consulting practitioner. This fee might be based upon CPT code 99211, a minimal-level office visit, currently reimbursed by Alaska Medicaid at \$31.44.

Recommendation: It is recommended that Alaska adopt a policy consistent with Option 4. This option appears most equitable, since it acknowledges and reimburses the referring provider for services rendered at the initial consultation and at the time the patient is presented to the consulting practitioner. It takes into consideration the work

that is performed by the referring practitioner. Likewise, it cannot be assumed that the value of the service rendered by the consulting practitioner is only 75% of a service delivered in person. This assumption is contrary to the premise that telehealth services are of equal quality to services rendered in a traditional face-to-face scenario.

4. How Will Practitioners Indicate, On A Claim Form, That A Service Was Provided Via Telehealth Mechanisms? Will A Modifier Be Used? Will Local Codes Be Developed?

Option 1: Practitioners will use HCPCS Level 1 and Level 2 codes, supplemented with a required “GT” modifier, for billing and tracking. The “GT” modifier is the Medicare modifier denoting services delivered, “via interactive audio and video telecommunication systems.” The “GT” modifier will be required for all telehealth services, regardless of whether they are delivered via store-and-forward technology or live interactive media.

Option 2: Practitioners will use HCPCS Level 1 and Level 2 codes supplemented with a required “GT” modifier or “GQ” modifier for billing and tracking. The “GT” modifier is the Medicare modifier denoting services delivered, “via interactive audio and video telecommunication systems.” The “GQ” modifier denotes services delivered via “asynchronous telecommunication systems”, or store and forward.

Option 3: Practitioners will use HCPCS Level 3 codes, developed by Alaska Medicaid.

Option 4: Practitioners will use HCPCS Level 1 and Level 2 codes, with no modifier.

Recommendation: It is recommended that Alaska adopt a policy consistent with Option 2. It should be noted that the “GT” and “GQ” modifiers are Medicare-compliant modifiers that are consistent with the provisions of the Health Insurance Portability and Accountability Act (HIPAA). By using the “GT” modifier, the consulting practitioner verifies that the beneficiary was located at an eligible site at the time of the telehealth service. Likewise, by using the “GQ” modifier, the consulting practitioner verifies that the asynchronous medical file was collected and transmitted from a Federal telemedicine demonstration project in Alaska or Hawaii. Option 3 is not practical, since HIPAA has mandated the end of HCPCS Level 3 codes—commonly referenced as “local codes”. Under the Administrative Simplification provisions of HIPAA, the Secretary of Health of Human Services has been directed to adopt national electronic standards for automated transfer of certain healthcare data between healthcare payers, plans, and providers. HIPAA seeks to simplify and encourage the electronic transfer of data by replacing the many nonstandard formats currently used nationally, with a single set of electronic standards that would be used throughout the healthcare industry. The use of this modifier most likely complies with HIPAA’s Administrative Simplification provisions. Option 4,

while less cumbersome than Option 1, would not allow telehealth utilization outcomes measurement.

5. What Restrictions, If Any, Should Be Applicable To Services Delivered Via Telehealth?

Option 1: Telehealth services will be restricted no more than same services delivered via face-to-face (non-telehealth) means.

Option 2: Telehealth services will be reimbursed only when the service received could not otherwise be reasonably obtained within a thirty mile radius of the beneficiary's home.

Option 3: The referring practitioner must obtain prior approval from Alaska Medicaid before presenting the patient to the consulting practitioner.

Recommendation: It is recommended that Alaska adopt a policy consistent with Option 1.

Summary of Recommended Options

If the suggested telehealth reimbursement model is adopted, Alaska Medicaid's telehealth policies will

1. Allow telehealth services statewide, restricting services to the state of Alaska, provided that such services are available in the state.
2. Allow providers currently reimbursed for HCPCS Evaluation and Management codes to be eligible to serve as referring/ presenting providers. See Table 1.3.
3. Allow any recognized practitioner, (1) eligible for Alaska Medicaid reimbursement, (2) rendering a Medicaid qualified consulting service, (3) to eligible Alaska Medicaid recipients to be a consulting provider. Exclusions should apply, including, for example, transportation services.
4. Allow both live interactive encounters and store-and-forward encounters.
5. Require that the referring and consulting practitioners be licensed in the state(s) in which each is located.
6. Require minimum technological standards for data transfer and imaging.
7. Prohibit separate reimbursement of equipment and on-going technological costs to practitioners.
8. Reimburse telehealth services at no less than the current fee schedule amount paid for the same service rendered in the traditional manner.
9. Reimburse both the consulting and referring practitioners separately at the full fee for services provided by each. Pay the presenting practitioner a low-level office visit fee for presenting the patient.
10. Require that HCPCS Level 1 and Level 2 codes use a "GT" modifier to bill telehealth services using interactive telecommunications, with the GT modifier triggering enhanced reimbursement. A "GQ" modifier should be used to bill telehealth services using store and forward technology. (Should the "GQ" modifier trigger enhanced reimbursement?)

Specific Provider Coverage Recommendations

Tables 1.3 and 1.4, below, present recommendations for service reimbursement to referring, presenting, and consulting providers for telehealth services. The following definitions are applicable to the information presented:

- Referring Provider- the provider who, upon initial evaluation of the patient, determines the need for a telehealth consultation. Only providers currently reimbursed for HCPCS Evaluation and Management codes may be eligible as referring providers.
- Presenting Provider- the provider who introduces the patient to the consulting provider and may assist in the telehealth consultation. This may be the referring provider or a health care professional who is employed with and delegated by the referring provider. A presenting provider may be found only during interactive telehealth encounters, rather than store and forward encounters where a practitioner does not actually present the patient. In store-and-forward encounters, it is the patient's medical file that is being delivered to a consulting practitioner. Facilities currently reimbursed at a percentage or per diem rate may be eligible as presenting providers.
- Consulting Provider- the provider who evaluates the patient, appropriate medical data and/ or images via telehealth means upon recommendation of the referring provider. Only providers currently reimbursed for HCPCS Consultation codes may be eligible as consulting providers; so long as they are providing professional services within the scope of their practice, which is different than providing an assessment as an ancillary professional.

Table 1.3: Summary of Recommendations: Referring, Presenting, and Consulting Privileges for Institutional Providers

Provider Type	Referring	Presenting	Consulting
Inpatient Hospital	No	Yes	No
Inpatient Psychiatric	No	Yes	No
Outpatient Hospital	No	Yes	No
IHS Clinic Services	Yes	Yes	Yes
Home Health	Yes	Yes	Yes
FQHC/ RHC	Yes	Yes	No
Drug Abuse Center	No	Yes	No

Table 1.4: Summary of Recommendations: Referring, Presenting, and Consulting Privileges for Non-Institutional Providers

Provider Type	Referring	Presenting	Consulting
Physician	Yes	Yes	Yes
CHA/P	Yes	Yes	No
Chiropractor	No	Yes	No
Mental Health	Yes	Yes	Yes
Family Planning	Yes	Yes	No
Hospice	No	Yes	No
Nutrition Services	No	Yes	No
Dental Services	Yes	Yes	Yes
Vision Services	Yes	Yes	Yes
Podiatry Services	Yes	Yes	Yes
Nurse Practitioner	Yes	Yes	Yes
Occupational Therapy/ PT/SP/RT	No	Yes	No
EPSDT Provider	Yes	Yes	No

Telehealth services are not appropriate for and will not be reimbursed for the following provider types:

- home/ community based services
- laboratory/ radiology/ technical services
- pharmacy
- durable medical equipment
- transport services
- accomodation services
- rehab
- audiology, and
- ESRD

Please note the following general rules, mentioned above:

- Only providers currently reimbursed for HCPCS Evaluation and Management codes may be eligible as referring providers.
- Facilities currently reimbursed at a percentage or per diem rate may be eligible as presenting providers.
- Only providers currently reimbursed for HCPCS Consultation codes may be eligible as consulting providers; so long as they are providing professional services within the scope of their practice, which is different than providing an assessment as an ancillary professional.
- Exceptions apply to FQHCs, RHCs, and nurse practitioners.

Additional Considerations for the Recommended Telehealth Model

This section is intended to briefly outline several additional factors, arising from the potential implementation of the recommended telehealth model. A more detailed discussion of these and various other items may be found in the next segment of this series of reports—“IV. Telehealth Implementation and Monitoring Plans”.

Projected Utilization Impact

Based on other states’ experiences and other anecdotal evidence, it is projected that the implementation of the recommended telehealth reimbursement model will increase utilization of selected services between two and ten percent.

Practitioner Costs

To deliver telehealth services, practitioners must have access to appropriate instruments, communication devices, and professional services. It is anticipated that participating practitioners will require file processing and annotating software, cameras, printers, scanners, foot switches, otoscope probes, ophthalmoscopes, dermscopes, remote stethoscopes, remote EKG machines, culposcopes, dentalscopes, pathology-scopes, video-enabling software, audio-enabling software, host-client transfer protocol software, personal computers, Internet Service Providers, and other items. A more comprehensive price list for selected telehealth equipment is included in Appendix A.

Interfacing with Other Telehealth Initiatives

ATAC and Alaska Medicaid are aware of the development and activities of several other telehealth initiatives in Alaska. It is anticipated that the development and growth of the Alaska Medicaid telehealth model will capitalize upon and offer economies-of-scale through collaborations with each of these initiatives. Each is highlighted below, including potential opportunities for collaboration.

Alaska Telemedicine Project

The Alaska Telemedicine Project (ATP) is a consortium of partners seeking to improve the delivery of health care in Alaska through telecommunication and information systems. This consortium includes Alaska health care providers, telecommunication carriers, the University of Alaska Anchorage and the state of Alaska. In 1996, on behalf of the members of the Alaska Telemedicine Project, the Applied Science Laboratory of the University of Alaska Anchorage was awarded a \$2M contract from the National Library of Medicine to evaluate the uses of narrow bandwidth telemedicine and telehealth applications and technologies in “frontier” Alaska. Frederick W. Pearce, Ph.D. is the Principal Investigator.

The “Alaska Telemedicine Testbed Project” (ATTP) developed, deployed and evaluated the use of narrow bandwidth telemedicine for otolaryngology and dermatology. Twenty-six villages and four regional medical hubs in western Alaska were chosen from among twelve proposals for participation in the project: Bethel, Dillingham, Kotzebue, and Nome. Ear, nose and throat (ENT) services were chosen for statistical reasons, as they exhibited no evaluation bias for gender and age. In addition, otitis media was viewed as a serious clinical problem in rural Alaska.

ATTP was developed and deployed an Alaska Telemedicine Workstation designed to work in villages and clinics and to be used as productive tools by Community Health Aides. A one-year delay in the customization of Medvision software was a major obstacle in deployment and evaluation of timelines. ATP was designed to deliver a three-pronged evaluation to the National Library of Medicine. Using 1996 air transportation records as baseline for study, ATTP was designed to discover the following:

- Whether patient and providers perceived telemedicine encounters as good or better than current transportation-based models of healthcare delivery for ENT and dermatology
- Whether the use of advanced telecommunications and information technologies could mitigate “professional isolation”, the most cited reason for the high turnover of healthcare professionals in rural Alaska

- A cost and benefits study designed to analyze the benefits of telemedicine and telehealth services
- To identify the “cost per transaction” of each telemedicine encounter

Since 1997, there have been over 1,500 clinical encounters for ENT and an additional 4,500 clinic encounters for dermatology, emergency medicine, and assorted clinics. A preliminary analysis of data suggests that both patients and providers perceive telemedicine to be “as good or better” than transportation-based models of health care delivery. Preliminary cost analysis suggests that the average encounter is under \$40 and falling. Evidence that telemedicine and advanced telecommunications and information technologies could have a positive impact on the length of stay on jobs by rural health care providers proved inconclusive. The NLM has provided additional funding to ATTP for finalizing data collection, manuscript preparation, and for implementing seven additional sites in private clinics serving non-Native and Native populations. A qualitative evaluation will be applied to add to data sets for final evaluation and publication in fiscal year 2001.

Specific collaboration opportunities are listed below.

1. To obtain information on the medical efficacy of delivering services via telehealth
2. To obtain cost-benefit information for modeling potential Medicaid transportation cost savings
3. To obtain information on practitioner participation and practitioner acceptance
4. To obtain information on specific technological successes
5. To obtain information on Medicaid beneficiaries who may have been studied
6. To obtain specific information on Indian Health Services
7. To share information from ATAC, ANTHC, and Alaska Medicaid studies, as appropriate.

Alaska Federal Health Care Access Network ²

The Alaska Federal Health Care Access Network (AFHCAN) was created as a result of a partnership of the Department of Defense (DOD), Indian Health Service (IHS), Veterans Administration (VA), United States Coast Guard (USCG), and managing partner, the Alaska Native Tribal Health Consortium (ANTHC). This partnership, the Alaska Federal Health Care Partnership (AFHCP) began as an effort to improve federal health care in Alaska. AFHCP continues to seek avenues to extend and improve access to health care services for federal beneficiaries in Alaska. The goal is being achieved through AFHCAN.

AFHCAN’s role is to improve access to health care for federal beneficiaries in Alaska through the use of sustainable telehealth systems. AFHCAN supports 37 member

² Information provided by Linda Lekness of ANMC.

organizations, representing over 235 sites across Alaska for the benefit of over 200,000 federal beneficiaries. These member organizations include: IHS/Tribal Entities (32); DOD (2); VA (1); USCG (1); and State of Alaska Public Health Nursing (1). (Note: the State of Alaska Public Health Nursing is considered as one member organization, but has seven sites.

AFHCAN is designed as a four-year (1999 – 2002) project with an estimated \$30,000,000 budget. The first year, Fiscal Year 1999, focused on project development. The second year, Fiscal Year 2000, the focus was on planning, implementation, and preparing for initial deployment of equipment to sites. Based on needs and priorities for each organization, initial deployment in general, was planned to include a clinical workstation (computer, video otoscope, digital camera, and digital ECG) to sites.

This year, Fiscal Year 2001, the focus is on initial deployment to all sites. This year will also evaluate and plan for additional telemedicine applications such as health education kiosk and video conferencing and the development of a comprehensive long-term sustainability plan. During the final and fourth year of the project, Fiscal Year 2002, the focus will be on continuing implementation and support of the telehealth system. Monitoring and evaluation will be ongoing throughout the duration of the project.

Specific Collaboration Opportunities and Benefits to ATAC Efforts

1. Opportunity to obtain information on the medical efficacy of delivering services via telehealth.
2. Opportunity to obtain cost information for installing and maintaining telehealth infrastructure.
3. Opportunity to obtain information on practitioner participation and practitioner acceptance.
4. Opportunity to obtain information on specific technological successes.
5. Opportunity to obtain information on Medicaid beneficiaries who may have received services.
6. If not already available, opportunity to include Alaska Medicaid information at patient kiosks.
7. Opportunity to share information from ATAC, ANTHC, and Alaska Medicaid studies, as appropriate.
8. Benefits from establishment of technological infrastructure.
9. Benefits from practitioner participation and awareness.

Alaska Distance Education Technology Consortium³

Through the efforts of Alaska Senator Ted Stevens, the United States Congress established the Alaska Distance Education Technology Consortium. The Consortium's charge is to:

³ Information obtained and copied, from the Alaska Distance Education Technology Consortium's website, with permission from Dr. Michael Sfraga.

- Review the current and future distance education and technology needs for the State of Alaska
- Determine the role of educators, telecommunication companies, community organizations, government agencies, and other stakeholders in meeting these needs
- Develop a long-term distance education and technology strategic plan, including benchmarks for evaluation, that more effectively develops, coordinates, enhances, and expands distance education opportunities as well as Alaska's information technology infrastructure
- Provide to Senator Stevens and the Alaska Delegation a final Consortium report in the Spring of 2001

Specific Collaboration Opportunities and Benefits to ATAC Efforts

1. Opportunity to obtain information on specific technological successes.
2. Opportunity to share information from ATAC, ANTHC, and Alaska Medicaid studies, as appropriate.
3. Opportunity for partnerships and future collaboration.

USDA Distance Learning and Telemedicine Program⁴

The Distance Learning and Telemedicine Program (DLT) awards loans, grants, and loan and grant combinations to advance education and health care in rural communities. Funds may be used to purchase computer hardware and software, audio and video equipment, computer network components, terminal equipment, data terminal equipment, inside wiring, interactive video equipment, facilities that further DLT services, instructional programming, technical assistance, or training. Awards are based on several criteria, including (1) Need for Services and Benefits, (2) Rurality of the Project Service Area, (3) Economic Need as Estimated by the National School Lunch Program, (4) Ability to Leverage Resources, (5) Innovativeness, (6) Cost Effectiveness of the System, and (7) Project Participation in EZ/ECs, and Champion Communities. The minimum amount funded for a single project is \$50,000, and the maximum typically does not exceed 10 million dollars.

Past Alaskan organizations receiving grants from the DLT include:

The Tanana Chiefs Conference, Inc.; Fairbanks, Alaska (\$259,064)

Serving the Yukon-Koyukuk and Southeast Fairbanks census areas, The Tanana Chiefs Conference, Inc. (TCC) provides medical services to tribal members and beneficiaries residing in Fairbanks and 25 tribal villages in interior Alaska using standard phone lines, off-the-shelf computer hardware, and other telehealth technologies. Services include

⁴ Information obtained from the USDA web-site located at <http://www.usda.gov/rus/dlt/dlml.htm>.

diagnosis, treatment, and follow up in various medical specialties, including cardiology, dermatology, orthopedics and behavioral health.

Norton Sound Health Corporation; Nome, Alaska (\$313,025)

Serving the Nome and Bering Straits census areas, the Norton Sound Health Corporation uses telehealth technology to overcome geographical, transportation, and technological barriers in the Bering Straits Region of Alaska. The project uses 15 village clinics, IRA tribal government offices and two health care providers in Nome, linking them to specialists in Anchorage.

Aleutians East Borough; Anchorage, Alaska (\$233,767)

Serving the Aleutians East Borough, the "Electronic Bridge Project" links hospitals, training centers, government offices, and schools. The project uses a 128-Kb satellite circuit, wide area, digital Internet Protocol network to exchange health care information, training classes, and videoconferencing with hospitals in Anchorage.

City of Galena; Galena, Alaska (\$186,490)

Serving the Yukon-Koyukuk census area, the Galena Health Center, the Galena Mental Health Center, the Tanana School, the Project Education Charter School, and Galena Schools have combined resources for this initiative. The consortium provides health services, mental health services, educational classes and learning opportunities to Galena and Tanana, Alaska. Video, voice, and data information is exchanged over existing telecommunication lines.

Specific Collaboration Opportunities and Benefits to ATAC and ANTHC Efforts

1. Opportunity to obtain information on the medical efficacy of delivering services via telehealth.
2. Opportunity to obtain cost information for installing and maintaining telehealth infrastructure.
3. Opportunity to obtain information on practitioner participation and practitioner acceptance.
4. Opportunity to obtain information on specific technological successes.
5. Opportunity to obtain information on Medicaid beneficiaries who may have received services.
6. Opportunity for Alaska Medicaid practitioners to propose new projects and seek funding.
7. Opportunity to share information from ATAC, ANTHC, and Alaska Medicaid studies, as appropriate.
8. Benefits from establishment of technological infrastructure.
9. Benefits from practitioner participation and awareness.

Conclusion

The recommended telehealth delivery model for Alaska Medicaid is based on a hybrid blend of Medicare policies and other state Medicaid programs' policies. The model is designed to:

- (1) encourage practitioner participation,
- (2) alleviate the health professional shortage in Alaska,
- (3) increase the scope of services available to Alaska Medicaid beneficiaries,
- (4) improve the health status of Alaska Medicaid beneficiaries, and
- (5) observe Alaska Medicaid fiscal objectives.

The recommendations included in this report chart a preliminary course for implementing a telehealth delivery model. It is anticipated that additional planning and coordination will be necessary prior to the implementation of an operational model. Most prominently, the initiation of a telehealth reimbursement model will require Alaska to decide the specific HCPCS codes that should be reimbursable. It is anticipated that some additional policy decisions will have to be explored prior to the implementation of the model.

The cost of technology will have a marked impact on the success of Alaska's telehealth model. It is not reasonable to assume that practitioners will acquire the more expensive technologies in response to Medicaid's telehealth initiatives. Practitioners who provide services via the more expensive, interactive, technologies will serve Medicaid as a consequence of Medicare and/or commercial clientele. Service coverage and fee scale development should consider how Medicare's current and anticipated policies will influence practitioner technology acquisition.

There are a number of telehealth and other initiatives being undertaken in Alaska concurrent to ATAC's efforts. These initiatives and those of ATAC will have positive outcomes for all stakeholders. Each initiative offers infrastructure, funding ideas, awareness, experience and information. Collectively, the outcomes of the individual initiatives will be invaluable to the overall growth of telehealth services in Alaska. Collaboration between any or all of the initiatives should continue to be strongly considered.

Finally, it may be prudent to allow a great amount of flexibility in the early, implemented, telehealth model. It is recommended that the model be evaluated and refined to achieve particular outcomes as Medicare policy evolves, as the practitioner community changes, and as service access trends develop.

Concurrent to the study documented in this report, ATAC authorized a medical efficacy study designed to examine potential health-related outcomes associated with telehealth services. This report was prepared prior to the delivery of final findings from the medical efficacy study. The findings in this report should be considered with regard for the final outcome and recommendations produced by the study.

APPENDIX A: Typical Costs for Selected Telehealth Infrastructure⁵

Device/ Service	Description	Price
Camera	Digital Camera	\$6,500
Computer	Personal Computer w/ Operating System, Keyboard, Monitor, Speakers, Scanner, Printer, and Microphone	\$3,500
Computer Multimedia	Diskettes, CDs, other supplies	\$100
Culposcope	Culposcope for use with camera	\$5,000
Dentalscope	Dentalscope for use with camera	\$5,000
Dermascope	Dermascope for use with camera	\$1,700
DSL Line	Installation and Annual Fee	\$1,200
Foot Switch	Foot-switch for hands-free photographs	\$100
Internet Service Provider	Regular, modem-based service (annual)	\$350
ISDN Line	Installation and Annual Fee	\$6,300
Ophthalmoscope	Ophthalmoscope for use with camera	\$1,000
Otoscope Probe	Otoscope for use with camera	\$2,800
Pathology Scope	Microscope for use with camera	\$14,000
Phone Line	Installation and Annual Charges	\$575
Point to Point Software	PC Anywhere Windows 95/98/NT v. 9.2 Host and Remote	\$1,500
Power Cleaner	Non-switch type, UPS, 1KVA	\$600
Remote EKG w/ Telemetry	Electrocardiograph--3 channel, interpretative	\$10,000
Remote Stethoscope	Stethoscope for use with a computer	\$3,000
T1 Line	Installation and Annual Fee	\$20,500
Telehealth Application	CU-SeeMe (Desktop Enabler)	\$89
Tympanometer	Recording Tympanometer for Audiology	\$1,600
VSM w/ Telemetry	Vital Signs Monitor	\$10,000
Web Camera	Internet-Capable Camera	\$325

⁵ Information compiled from various publicly-accessible, commercial Internet sources, including on-line catalogues. Some amounts are based on the average cost of multiple manufacturers' retail prices.