

Private Payer Reimbursement for Telemedicine Services in the United States

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Abstract

Telemedicine has garnered significant attention over the past decade as a solution to cost and access challenges facing healthcare. Yet, utilization rates for clinical services have not reached their full potential. One of the major barriers to the adoption of telemedicine technologies that has been cited in the literature is the lack of universal reimbursement from private payers. The purpose of this investigation was to capture a current picture of private payer reimbursement for telemedicine services in the United States. This current investigation was a follow-up to a survey conducted by the American Telemedicine Association and AMD Telemedicine in 2003. Data indicates that the United States is progressing toward more private reimbursement for telemedicine services, but at a disappointingly slow pace. While this investigation does suggest that we are making small improvements in private payer reimbursement, the change appears to be lag behind a pace needed to optimize telemedicine deployment. Without progress in the area of private payer reimbursement, we cannot expect to see the widespread adoption of telemedicine services.

Introduction

Telemedicine, the use of telecommunication technologies to deliver health care over a distance, has evidenced dramatic attention and growth over the past few decades. Through telemedicine technologies, not only can we deliver care to rural areas in which care may not be available, but we can also provide an efficient and potentially cost effective care alternative to people suffering from debilitating conditions all across the county. Preliminary research well documents the fact that telemedicine is a feasible alternative to traditional healthcare (Dunn, Choi, Almagro, Recla, & Davis, 2000; Mair, Wilkenson, Bonnar, Scalvini et al, 2004; Wooten, & Angus, 1999) as telemedicine patients have reported good acceptance rates and satisfaction with the technologies and treatment via telemedicine has been proven to be efficacious (Finkelstein, Khare, & Vora, 2003; Gustke, Balch, West, & Rogers, 2000; Woods, Kutlas, Johnson, Waller, Grigsby, Stachura, & Rahn, 1999). In fact, there are so many current instances of utilization of telecommunication technologies for the delivery of healthcare and education, that it is nearly impossible to count the number of telemedicine programs in existence (Whitten, 2001).

Despite the fact that telemedicine has been around for decades and there has been enormous growth in the number of telemedicine programs in the 1990s, actual telemedicine consultations are not as ubiquitous as one would have originally anticipated. Among other issues such as provider perceptions, licensure, data standards, and privacy (Center for Telehealth and eHealth Law, 2006; Jacobson & Selvin, 2000; Goodwin, K., 2001; Whitten & Mackert, 2005), one of the major barriers to the adoption of telemedicine technologies that has been cited in the literature is the lack of universal reimbursement for telemedicine services from private payers (Center for Telemedicine Law, 2003; Glanz, 2004). To date, universal reimbursement for telemedicine has been ignored by both public and private payers as Medicaid does not universally reimburse in all 50 states, nor do private payers.

By understanding the history of telemedicine reimbursement, we are better able to recognize the challenges that it has faced. Effective in January, 1999, The Balanced Budget Act of 1997 (BBA) was the first piece of legislation to mandate that Medicare must reimburse for some telemedicine services. However, the BBA included many constraints (that were unrealistic to the actual provision of telemedicine services) that limited reimbursement. These constraints included limiting reimbursement to rural health professional shortage areas (HSPA), excluding store-and-forward telemedicine services, implementing a 75%/25% fee split between the teleconsulting physician and the referring practitioner, limiting reimbursement to specific eligible CPT codes, and restricting the list of eligible presenters to exclude registered nurses. Although the Centers for Medicare & Medicaid Services (CMS), formerly HCFA, had originally estimated that they would be reimbursing between \$60 million to \$690 million in 1999, due to the strict limitations placed by the BBA, between April 1, 1999 and September 30, 2000, a period of 18 months, only \$20,000 in reimbursements had been made on 301 telemedicine encounters (Wachter, 2001).

In 2000, Congress passed the Consolidated Appropriations Act of 2001. Included in this act was H.R. 5661, also known as The Benefits Improvement and Protection Act of 2000 (BIPA). BIPA sought to address many of the constrictive limitations placed on telemedicine reimbursement by the BBA. Effective October 1, 2001, new changes to telemedicine reimbursement included the abolishment of the fee splitting requirement in favor of a \$20 origination facility fee, elimination of the presenter requirements, expanded eligible CPT codes, expanded the geographical locations for eligible origination sites to include counties that are not

located in Metropolitan Statistical Areas (MSA) as well as federal telemedicine demonstration projects, and permitted reimbursement for store and forward services in federal demonstration projects in Alaska and Hawaii (Center for Telemedicine Law, 2003). These changes have led to increases in reimbursement for telemedicine. According to the Telemedicine Information Exchange, as of 2005, 34 states are currently receiving Medicaid reimbursement for telemedicine services.

While the majority of the history of telemedicine reimbursement deals with public payers, there has been some legislation passed in different states regarding private payer reimbursement. Currently, California, Louisiana, Texas, Oklahoma, and Kentucky, are the only five states in the Union that have government mandated legislation regarding private payer reimbursement for telemedicine (ATA, 2004). Despite the fact that there are only five states where reimbursement of telemedicine is mandated, people are receiving reimbursement for these services across the country. A 2003 survey conducted by the American Telemedicine Association and AMD Telemedicine discovered that of 72 telemedicine programs that provide billable telemedicine services, 38 programs in 25 states received private reimbursement. Despite the assumption among telemedicine programs that private payers will resist reimbursing for telemedicine services, the ATA and AMD Telemedicine survey found that over 100 private insurers reimbursed (as of 2003) for telemedicine services. In addition it was found that private payers were looking to Blue Cross / Blue Shield for leadership in the field of telemedicine reimbursement as BCBS was reimbursing in 21 states for telemedicine services while Medicaid was only reimbursing in 18 states (ATA, 2003).

Related work by Whitten and Kuwahara (2003) looking at considerations payers use when making reimbursement decisions, suggests that private payer reimbursement in the United States is sporadic and variable. They suggest that in order to foster more consistent reimbursement for telemedicine services in the short term, it is essential that we increase consumer and market demand for these services as well as promote provider acceptance and adoption. They also suggest that in the long term, additional work in the area of demonstrating the clinical effectiveness of telemedicine will encourage telemedicine reimbursement.

The US Census Bureau's Current Population Survey reports that in 2004, 68.1% of US citizens were covered by a private insurance plan, including both employer-sponsored and individually purchased, while 27.2% are covered by government sponsored health coverage (US Census Bureau, 2005). Recent estimates indicate that over half of the total healthcare expenditures (54.4%) in the US are privately funded. Private funding includes all non-government sources such as insurance companies, private industries, and consumers (National Center for Health Statistics, 2004). Because private payers are responsible for over half of the total national expenditures on healthcare and almost 70% of US citizens are covered by private health insurers, more comprehensive private payer insurance company reimbursement is necessary in order to drive continued development of telemedicine programs and increase the total number of telemedicine consults. Without private payer reimbursement, we will not see the growth in telemedicine that is expected.

To date, reimbursement for telemedicine services, particularly private reimbursement, has been a confusing and often times difficult proposition for people providing telemedicine services. The intent of this project was to conduct a follow-up to the 2003 American Telemedicine Association and AMD Telemedicine survey on private payer reimbursement. This undertaking aims to take a step in better understanding the progress that has been made in the

area of private payer reimbursement since the prior investigation. This article next presents the methodology employed in the study and the turns to results and a discussion of the findings.

Materials and Methods

The purpose of this investigation was to capture a current picture of private payer reimbursement for telemedicine services in the United States. This current investigation was a follow-up to a survey conducted by the American Telemedicine Association and AMD Telemedicine in 2003. A series of five research questions were developed in order to guide this investigation:

RQ1: How many telemedicine programs that provide billable telemedicine services are currently receiving reimbursement from private payers?

RQ2: What are the characteristics of what is being billed to private payers by telemedicine programs?

RQ3: Is there any difference in the amount of reimbursement for telemedicine services than for traditional fact-to-face consults?

RQ4: Are telemedicine programs that bill private payers for telemedicine services billing a facility fee?

RQ5: Do telemedicine programs that bill private payers for telemedicine services also receive reimbursement from HMOs or other types of capitated contracts?

In order to recruit participants for this survey, 116 telemedicine programs providing potentially billable telemedicine services were identified from several different sources including previous participants from the 2003 survey, membership lists of the American Telemedicine Association, OAT grantees, and programs listed on the Telemedicine Information Exchange website. Additional participants were recruited based on information obtained during surveys with previously identified telemedicine programs. Participants were asked to list any other telemedicine networks in their state or region that we should contact for the survey.

Representatives from all 116 telemedicine programs were contacted between September and November 2005 via phone and/or email to participate in this 14 item survey. Once contact had been made and representatives had agreed to participate, all surveys were conducted over the phone. Because the survey was focused on the details surrounding private payer reimbursement, those organizations that stated they did not receive reimbursement from private payers did not actually complete the survey. Rather, it was noted that reimbursement from private payers was not received. In some cases, respondents were unable to fully answer the questions included in the survey. In these cases, follow up phone calls or emails were made. The survey had a completion time of approximately 10 minutes. Of the 116 contacted, we received responses from 65 organizations giving us a 56% response rate. In order to provide answers to our primary research questions, descriptive statistics were employed to analyze data.

Results

Data from the surveys indicates that of the 63 respondents who provide potentially billable telemedicine services, 57% are currently receiving reimbursement from private payers. This is up only 4% from data reported in 2003. Specific aspects of reimbursement are detailed below.

Private Payer Reimbursement

Of the 65 responses, 36 organizations (55%) reported that they currently receive reimbursement from private payers and 27 (42%) reported that they do not, leaving 63 of the 65 organizations that provide billable telemedicine services. The remaining two organizations, which were included in the initial survey, responded that while they provided telemedicine services at the time of the original survey, they no longer provide these services. Of those organizations that receive private payer reimbursement for telemedicine services, approximately half are programs with an academic affiliation (44%) and approximately half are nonprofit organizations (47%). The remaining three organizations include a state agency, a managed care/private company organization, and an organization claiming to have an academic/nonprofit/state agency affiliation.

Characteristics of Billed Telemedicine Services

Self reported data from organization representatives show that telemedicine programs across the United States are billing approximately 130 private payers for approximately 75 clinical specialties. It should be noted that these are not exhaustive numbers and are estimates based on self-reported data. Many survey participants were unable to provide an exhaustive list of all clinical specialties they offer via telemedicine or each private payer their organization receives reimbursement from. In terms of the amount of telemedicine activity submitted to private payers, self reported data from the telemedicine programs receiving private payer reimbursement ranged from 5 – 100% of all telemedicine activity. Data analysis revealed that average estimates of the amount of telemedicine activity submitted to private payers by respondents was in the moderate range with a mean of 40% and standard deviation of 29%.

Differences in Reimbursement between Traditional and Telemedicine Consults

Speaking volumes for the current state of private payer reimbursement in the United States, the majority of respondents claimed that there is no difference in the amount of reimbursement from private payers for telemedicine visits as opposed to traditional face-to-face consults (81%). Though there were some respondents who were unable to answer the question (17%), only one respondent claimed that there was a slight variation in what private payers reimburse for when it comes to telemedicine consults vs. traditional consults.

Facility Fees

Over half of the telemedicine organizations that receive private payer reimbursement reported that they do not bill a facility fee to their private payers (58%). While some organizations do bill a facility fee to private payers (17%), there were some organizations where some the billing of facility fees was inconsistent among spoke sites as some clinics do bill the facility fee and others do not (19%).

HMOs and Capitated Contracts

In terms of reimbursement from HMOs, a majority of respondents stated that they do not receive reimbursement from HMOs or any other type of capitated contract (56%) while there was a small contingent that does (31%) or did not know (11%).

Discussion

After reviewing the data from this current investigation and comparing it to results from the previous study conducted in 2003, it is evident that while not a lot has changed, things are slowly progressing toward more private reimbursement for telemedicine services. Since the previous study, we have seen an increase in the number of private payers who are being billed for these services.

One interesting finding from this study is the lack of telemedicine programs billing private payers a facility fee. While the right to bill a facility fee to private payers is not mandated as it is via Medicare, because many private payers are thought to be following Medicare guidelines for telemedicine reimbursement, this is an interesting finding. It is unclear whether or not this fee is not being billed due to inefficiencies in the billing process or because private payers are unwilling to reimburse for this fee. A few respondents from this survey did shed some light onto why their organization does not currently bill a facility fee. While some respondents stated that the approximately \$20 fee was not worth the time spent on the billing process, others stated that they didn't think that they private payer would reimburse for it.

Currently, there is instability in the field of telemedicine programs. Many healthcare organizations begin telemedicine programs based on start-up funds from federal and state grants. According to the list of OAT grantees published on the OAT website, at least 72% of our respondents who receive reimbursement for telemedicine services have received funding from OAT at some point. Because the listing of grantees is not complete for all years (see <http://telehealth.hrsa.gov/>), it is possible that more have received OAT funds at some point in time. The Office for the Advancement of Telehealth (OAT) has granted over \$250 million in funding for telemedicine/telehealth demonstration and evaluation projects, including those projects that were funded while OAT was a part of the Rural Health Outreach Grant Program (OAT, 2005). Once the grants are finished though and the contracts are terminated, some healthcare organizations have ceased to offer telemedicine services and programs have closed their doors.

In order for telemedicine programs across the country to become more stable and economically viable, it is essential that healthcare organizations offering telemedicine services begin to start billing private payers, especially since many states cannot rely on Medicaid for reimbursement. Economic sustainability should be the next stream for telemedicine research. This includes striving to better understand reimbursement issues as well as finding appropriate business models for the delivery of telemedicine services. Better marketing of telemedicine services as well as better education regarding these issues will help drive potential consumers to demand these types of services. It is this type of demand that will lead to the growth of telemedicine.

In order to foster growth in the field of telemedicine, it is imperative that we begin to understand not only why there is a lack of private payer reimbursement for telemedicine services in the United States, but why more telemedicine programs do not pursue private reimbursement. In addition to delaying the growth of telemedicine programs, the lack of universal private payer

reimbursement has potentially negative impacts on how telemedicine services are perceived by the healthcare industry as well as the general population. Because telemedicine is not currently being treated the same as traditional delivery modalities, it may be seen as some as inferior.

While this investigation does suggest that we are making small improvements in private payer reimbursement, the change appears to be slow. Further work in this area should determine what the causes of this slow change are and what can be done to resolve the issue. Without progress in the area of private payer reimbursement, we cannot expect to see the widespread adoption of telemedicine services in the immediate future.

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