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The diverse faces of telemedicine delivery and reimbursement

by John P. Benson, JD, AHFI, CFE, CIFI

John P. Benson (john@verisys.com) is co-founder and CEO, Verisys Corporation in Alexandria, VA.

- linkedin.com/in/johnpbenson

There is no debate about the value of telemedicine. However there is quite a tangle of variances in documentation and reimbursement regulations between federal and state governments as well as private payers.

Barriers to reimbursement

Because the U.S. has a multiple payer healthcare system, the rules addressing reimbursement are designed as barriers to suit respective business models based on access vs. risk vs. sustainability and, in the case of private payers, risk vs. revenue and profit. Risk primarily encompasses a lack of controls that introduces waste, abuse, or fraud into a system or process.

With disparity of self-interest between the federal government, individual states, and private payers, the sheer volume of reimbursement rules applied by payers is mindboggling. And federal and state governments and standard-setting organizations still have not addressed the confusion by working to align rules of reimbursement in a coherent and manageable way.

There are conditions that sit inside of business rules that activate upon dozens of contingencies. Cost, access rules, patient safety, documentation, and HIPAA privacy concerns should be at the center of the discussion of rules, codes, regulations, laws, and best practices, but self-serving concerns create layers of bureaucracy that prevent universal access to quality care through the use of telemedicine.

Another barrier to widespread telemedicine adoption is risk aversion on the part of practitioners and institutions. Because the rules of delivery and reimbursement are ambiguous and convoluted, navigating the ever-changing landscape is a robust exercise — a recipe for risk, lost revenue, and fines.

Telemedicine can ultimately save payers and, hopefully, employers and consumers money, because it has been shown to reduce Emergency Room visits and re-admittances, creates a higher saturation of preventive care, provides immediate response to episodes related to chronic disease, and supports compliance with treatment plans.[1] ,[2] Wellness is not reimbursable, whereas telemedicine is, and it plays an ever more important role in population wellness.

Guidelines and frameworks

If the goal is to provide quality healthcare at a lower cost, it seems reasonable that regulators, payers, and standard setters would organize around a common set of guidelines that all healthcare providers and payers can agree upon and drive the process forward. The simple set consists of:

- Rules for patient access, privacy, and safety

- Controls that prevent fraud
- Processes to promote a streamlined, documented transaction

This basic framework strikes a balance with the components of an ideal model:

- Patient safety through the delivery of quality care by appropriately credentialed providers who have been screened, verified, and are continuously monitored;
- Ease of appropriate access to virtual healthcare, because it is the virtual transaction that is going to drive a valuable outcome;
- Non-intrusive, transactionally zero-cost controls to prevent fraud, waste, and abuse;
- Reimbursement models that translate to lower costs and lower prices; and
- A clear runway for enhanced innovation, specifically, the removal of barriers, rather than the addition of regulatory and administrative demands.

To elaborate on patient safety, the primary purpose of regulating healthcare is to assure the provider is correctly licensed, qualified to practice, and is without adverse actions indicating potential harm to a patient. And, most importantly, it ensures the patient is matched to the provider who can deliver the best possible outcome based on their qualifications, credentials, and experience.

Once there is assurance of the provider, the excessive regulations governing telemedicine are transient and arbitrary, given the extreme deviance from one regulatory scheme to another. Gaining a thorough understanding of the variances of regulations is a challenge, because there are indecipherable subtleties that change daily.

The Center for Connected Health Policy[3] publishes a number of resources, including an interactive state-by-state guide to laws and reimbursement policies affecting telemedicine, a PDF listing of laws and reimbursement policies for each state, as well as an interactive directory of pending legislation and regulation. The 262-page PDF, updated in the fall of 2017, confirms that every state differs wildly in defining the practice of and reimbursement for telemedicine.

Reimbursement criteria

To illustrate, we examine scenarios by creating a cross section of four primary categories of reimbursement criteria: Where, Who, What, and How.

Where

The where has two sub categories: geographic location and type of institution — both pertaining to the origination site. The origination site is where the patient is receiving the clinical service, and the distant site is where the practitioner provides the service to the patient.

Who

The who defines the types of practitioners who can include telemedicine within their scope of practice. Each payer has a unique list of practitioner types based on specialty or sub-specialty that qualify for reimbursement when practicing telemedicine. The lists vary widely and, oftentimes, providers who can provide substantial value using a virtual platform are simply not reimbursable by a given payer.

What

Payers have defined specific services that qualify for reimbursement. In many cases, the type of service may also influence the where component, which requires detailed and frequent cross-referencing to assure there is no unintentional, non-compliant event.

How

The how category is expanding with the evolution of technology. Payers impose restrictions on the mode of communication exchange based on compliance with HIPAA as well as other parameters. Payers have not aligned about reimbursement on the three primary modes of communication being used in telemedicine today: real-time communication, store-and-forward/asynchronous, and remote patient monitoring.

Current regulations

To further illustrate the current nature of regulations, let's have a look at how Medicare, Medicaid, the Veterans Administration (VA), and private payers structure reimbursement based on the where category.

If one were to guess at motive in designing reimbursement policy by reviewing actions of payers, one could say Medicare and Medicaid look at ways to prevent fraud, waste, and abuse; the VA looks at telemedicine as a way to open access; and private payers are profit driven and run a business model of restricting and over-managing care.

Medicare

By way of an example of efforts to locate and prove non-compliant events, we review a Medicare Payment Advisory Commission (MedPAC) study[4] conducted by the U.S. Department of Health & Human Services (HHS) Office of Inspector General (OIG).

Medicare has seen a 300% increase in telemedicine spending, from $61,302 in 2001 to $17,601,996 in 2015. This increase prompted the MedPAC study of 2,009 Medicare claims that revealed more than half of the professional fee claims from the distant site facility were not matched by originating-site facility fee claims. Even though there is no field on the reimbursement form to list the originating site, this scenario was utilized as a telltale of claims paid on services that did not meet other Medicare regulations.

The April 2018 audit review revealed that The Centers for Medicare & Medicaid (CMS) made payments for services that did not meet Medicare requirements to the tune of $3,699,848 on 100 claims for a one-year audit period from 2014–2015.

Of the 100 randomly selected claims that were audited, 31 did not meet requirements (i.e., 27 claims werewhere based, seven were who based, one was what based, two were how based, and one was for services from a provider located outside the U.S.; several claims fell into more than one category). Of the 31 non-compliant claims made between 2014 and 2015, requirements may have already shifted to where the same claim today would be within the regulatory parameters.

Auditing, investigating, and adjudication by the payer comes at great expense because of the intricacy and disparate nature of guidelines and regulations. Add to that the incidental billing deviations due to the inherent lack of rules and process clarity, and one gets to chaos rather quickly. Unfortunately, practitioners will hesitate to practice for fear of fines and prosecution, payers will be preoccupied with enforcement and creating new nuances, and the patient is either deprived of access to needed medical attention or is denied coverage and faces

financial disadvantage.

Veterans Administration

The VA has taken a different approach to telemedicine in response to the scrutiny it has faced around long wait times experienced by its veteran patient population. In 2017, the House Veterans Affairs Committee passed a bill (HR 2123 115, introduced by former VA Secretary David Shulkin, MD) referred to as the "Anywhere to Anywhere VA Health Care" program.[5] The bill states that beneficiaries can receive telemedicine care from doctors licensed in any state.

Increasing access to healthcare for veterans is a worthy mission, but the California licensing board voiced concerns over the protection of healthcare consumers. Kimberly Kirchmeyer, executive director of the Medical Board of California said in an article published in Healthcare IT News[6] that the medical board in the patient's home jurisdiction is unable to discipline a provider licensed in another state, thereby creating a gross lack of transparency on a provider's misconduct or inadequacies, because they are beyond regulatory reach. It is a valid concern, yet it is easily overcome with technology and cross-jurisdictional cooperation.

Innovation

While regulations are sorted out, the next generation of healthcare is pointing to platform-agnostic, on-demand healthcare with full access to pricing and outcomes transparency with direct cash payments by patients or employers. The opportunity here is to accelerate the velocity of easy access, low-cost, quality healthcare delivery.

Hospitals and clinics are using technology companies to deploy telemedicine platforms, and some create strategic alliances and white label the technology for a branded offering as a competitive advantage. Admittedly, this list is incomplete, but telemedicine delivery platform providers are proliferating and partnering with clinics, individual practitioners, and large healthcare delivery systems (alphabetical): Alpha Telehealth, American Well/Amwell, CareClix, Clocktree, Encounter Telehealth, eVisit, Doctor on Demand, GenieMD, InTouch Health, MDLIVE, MDVIP, Philips, Polycom, RelyMD, Sherpaa, SnapMD, Synzi, and Teladoc.

Professional service platforms that offer consumers fixed, disclosed fees are in widespread use for the financial, real estate, and legal service industries. Technology innovators create self-service, fully transparent applications that set the consumer free from opaque pricing models, profit-motivated advice and direction, and dependence on a professional's availability. It is time to do the same in healthcare.

Consumers have an appetite for price transparency and the power to choose the how, where, when, and who for on-demand health services. Consumer-accessed technology platforms that privately and securely share data, verify provider credentials and qualifications to perform a particular scope of service, aggregate and report outcomes, and offer price transparency may drive a fully digital, cloud available, streamlined approach to basic healthcare.

Summary

Today, patients generally deal with an opaque system that drives them to obtain healthcare from a provider they don't know, without knowing what will happen to them, or what outcome will be obtained, or what the price of care will be. The virtual medicine revolution is an opportunity for the healthcare consumer to take control, in some significant way, of their healthcare journey. The question is, will everyone get out of the way and allow that to happen?

Takeaways

- Telemedicine advancement is restricted by disparate reimbursement rules.
- Reimbursement policy for telemedicine is addressed differently by every payer.
- Providers hesitate to practice telemedicine because of reimbursement confusion.
- Medicare's telemedicine spending has increased 300% between 2001 and 2015.
- Healthcare consumers desire price transparency, access, and choice.

1 Eric Wicklund: "Using Telehealth to Help Patients With Medication Adherence" mHealth Intelligence; March 9, 2018. Available at https://bit.ly/2Iel7tS
2 Mandy Roth: "Pediatric telemedicine stems utilization, points to cost savings" HealthLeaders; July 9, 2018. Available at https://bit.ly/2u5H9tg
3 The National Telehealth Policy Resource Center, Center for Connected Health Policy: State Laws and Reimbursement Policies. Available at https://bit.ly/2jVtRZF
4 HHS: Office of Inspector General: CMS Paid Practitioners for Telehealth Services That Did Not Meet Medicare Requirements. April 2018. Report No. A-05-16-00058. Available at https://bit.ly/2J56ZUE
5 House Rule 2123 — VETS Act of 2017. Available at https://bit.ly/2OuI82u
6 Jessica Davis: "House passes bill supporting national VA telehealth program" Healthcare IT News; November 2, 2017. Available at https://bit.ly/2zg86ho