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Maryland Telehealth Update

Overview

Telehealth holds the promise of being an effective health care delivery alternative for achieving the goals of health care reform, including supporting the delivery of more comprehensive care. Effective use of telehealth can increase access to care, improve patient outcomes, and generate cost savings. Telehealth adoption in Maryland has increased slowly in recent years; however, the use of telehealth remains low. Approximately 61 percent of general acute care hospitals in Maryland have reported using telehealth, while about nine percent of physicians have reported using telehealth.[1, 2] Payment and coverage of services delivered using telemedicine[3] along with practice transformation to incorporate telehealth in care delivery have been among the biggest challenges for telemedicine adoption. Maryland has enacted legislation to minimize these barriers, including legislation focused on telehealth coverage and identifying opportunities to expand telehealth through a collaborative of stakeholders–the Telemedicine Task Force (Task Force).[4, 5]

Telehealth Coverage

State-regulated Payors. Beginning in October 2012, Maryland law required private payor reimbursement for certain telemedicine services. *Md. Insurance Code Ann. § 15-139, Health Insurance – Coverage for Services Delivered through Telemedicine*, requires health insurers and health maintenance organizations to provide coverage for health care services appropriately delivered through telemedicine, and prohibits denial of coverage because a health care service was provided through telemedicine rather than an in-person consultation. Telemedicine, as currently defined in *Md. Code Ann., Insurance § 15–139*, means: *as it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a site other than the site at which the patient is located. Telemedicine does not include: an audio-only telephone conversation between a health care provider and a patient, an electronic mail message between a health care provider and a patient, or a facsimile transmission between a health care provider and a patient.* For additional information regarding medical policy on reimbursed services, contact your payor representative.

Maryland Medical Assistance Program (Maryland Medicaid). Telemedicine reimbursement from Maryland Medicaid has recently expanded.[6, 7] Legislation enacted in 2007 created a Maryland Medicaid reimbursement pilot for telemental health services, and the General Assembly expanded Medicaid reimbursement to two additional pilot programs in 2013: the Rural Access Telemedicine Program and the Cardiovascular Disease and Stroke Telemedicine Program. Effective October 1, 2014, the Maryland Medical Assistance Program will reimburse approved providers for services rendered to Program participants via telemedicine statewide. The Program will implement this expanded telemedicine service for both providers and participants, regardless of geographic location. Participants may be in the fee-for-service program, a managed care organization, or a long-term services and supports waiver program. Providers must already be enrolled in the Program and need to apply with Medicaid for telemedicine in order to receive Medicaid reimbursement for services. Additional telemedicine provider information is available at: mmcp.dhmh.maryland.gov/SitePages/Telemedicine%20Provider%20Information.aspx.

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[1] MHCC, *Health Information Technology: The Sixth Annual Assessment of Maryland Hospitals*, September 2014.
[2] 2013 Maryland Board of Physicians Licensure file, a database of physician responses to the bi-annual licensure survey.
[3] The 2013/2014 Task Force recommended transitioning from the term telemedicine to the term telehealth, which includes related terminology, such as telemedicine, telecare, telelearning, etc.
[4] *Telemedicine Task Force – Maryland Health Care Commission*, Senate Bill 776 (Chapter 319) (2013 Regular Session); not codified in law. Available at: mgaleg.maryland.gov/2013RS/chapters_noln/Ch_319_sb0776E.pdf.
[5] The Task Force was originally convened in 2010 in response to a report by the Maryland Department of Health and Mental Hygiene (DHMH), *Improving Stroke Care through Telemedicine in Maryland*, as well as the recommendations of the Maryland State Advisory Council on Heart Disease and Stroke.
[6] *Maryland Medical Assistance Program – Telemedicine*. Senate Bill 198 (Chapter 141) (2014 Regular Session). Available at: mgaleg.maryland.gov/2014RS/chapters_noln/Ch_141_sb0198T.pdf.
[7] Maryland Register, proposed amendments to regulations .01—.07, .11, and .12 under COMAR 10.09.49 *Telemedicine Services*, October 3, 2014. Available at: www.dsd.state.md.us/MDRegister/4120/Assembled.htm#_Toc399847133.

Medicare. Medicare reimbursement for telehealth services is restricted to rural areas, and in Maryland, less than five percent of census tracts are designated as rural.[8] Medicare reimbursement generally includes telehealth consultations, screenings, and care coordination; reimbursement in 2014 covers approximately 68 telehealth services.[9] Medicare is including additional services under the telehealth benefit in 2015, including annual wellness visits, psychoanalysis, psychotherapy, and prolonged evaluation and management services.[10] A list of the 2014 and 2015 covered services is provided below.

Calendar Year 2014 Covered Telehealth Services			
Code	**Short Descriptor**	**Code**	**Short Descriptor**
90791	Psych diagnostic evaluation	99215	Office/outpatient visit est
90792	Psych diag eval w/med srvcs	99231	Subsequent hospital care
90832	Psytx pt&/family 30 minutes	99232	Subsequent hospital care
90833	Psytx pt&/fam w/e&m 30 min	99233	Subsequent hospital care
90834	Psytx pt&/family 45 minutes	99307	Nursing fac care subseq
90836	Psytx pt&/fam w/e&m 45 min	99308	Nursing fac care subseq
90837	Psytx pt&/family 60 minutes	99309	Nursing fac care subseq
90838	Psytx pt&/fam w/e&m 60 min	99310	Nursing fac care subseq
90951	Esrd serv 4 visits p mo <2yr	99406	Behav chng smoking 3-10 min
90952	Esrd serv 2-3 vsts p mo <2yr	99407	Behav chng smoking > 10 min
90954	Esrd serv 4 vsts p mo 2-11	99495	Trans care mgmt 14 day disch
90955	Esrd srv 2-3 vsts p mo 2-11	99496	Trans care mgmt 7 day disch
90957	Esrd srv 4 vsts p mo 12-19	G0108	Diab manage trn per indiv
90958	Esrd srv 2-3 vsts p mo 12-19	G0109	Diab manage trn ind/group
90960	Esrd srv 4 visits p mo 20+	G0270	Mnt subs tx for change dx
90961	Esrd srv 2-3 vsts p mo 20+	G0396	Alcohol/subs interv 15-30mn
96116	Neurobehavioral status exam	G0397	Alcohol/subs interv >30 min
96150	Assess hlth/behave init	G0406	Inpt/tele follow up 15
96151	Assess hlth/behave subseq	G0407	Inpt/tele follow up 25
96152	Intervene hlth/behave indiv	G0408	Inpt/tele follow up 35
96153	Intervene hlth/behave group	G0420	Ed svc ckd ind per session
96154	Interv hlth/behav fam w/pt	G0421	Ed svc ckd grp per session
97802	Medical nutrition indiv in	G0425	Inpt/ed teleconsult30
97803	Med nutrition indiv subseq	G0426	Inpt/ed teleconsult50
97804	Medical nutrition group	G0427	Inpt/ed teleconsult70
99201	Office/outpatient visit new	G0436	Tobacco-use counsel 3-10 min
99202	Office/outpatient visit new	G0437	Tobacco-use counsel>10min
99203	Office/outpatient visit new	G0442	Annual alcohol screen 15 min
99204	Office/outpatient visit new	G0443	Brief alcohol misuse counsel
99205	Office/outpatient visit new	G0444	Depression screen annual
99211	Office/outpatient visit est	G0445	High inten beh couns std 30m
99212	Office/outpatient visit est	G0446	Intens behave ther cardio dx
99213	Office/outpatient visit est	G0447	Behavior counsel obesity 15m
99214	Office/outpatient visit est	G0459	Telehealth inpt pharm mgmt

[8] Medicare beneficiaries are eligible for telehealth services only if the services are presented from an originating site located in: a rural Health Professional Shortage Area, either located outside of a Metropolitan Statistical Area (MSA) or in a rural census tract, as determined by the Office of Rural Health Policy; or a county outside of a MSA. Sixty-three census tracts, or roughly 4.5 percent, out of 1,406 total census tracts in Maryland, are federally designated rural. A listing of Maryland Health Professional Shortage Areas is available at: hpsafind.hrsa.gov/HPSASearch.aspx. A map of Maryland rural areas is available at: hsia.dhmh.maryland.gov/opca/Documents/Map%20Rural%20Designation%202014.pdf.

[9] Centers for Medicare & Medicaid Services, *Telehealth Services: Rural Health Fact Sheet Series*, April 2014. Available at: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcsfctsht.pdf.

[10] Centers for Medicare & Medicaid Services, *Policy and payment changes to the Medicare Physician Fee Schedule for 2015*, October 2014. Available at: www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2014-Fact-sheets-items/2014-10-31-7.html.

Calendar Year 2015 Covered Telehealth Services			
Code	**Short Descriptor**	**Code**	**Short Descriptor**
90791	Psych diagnostic evaluation	99231	Subsequent hospital care
90792	Psych diag eval w/med srvcs	99232	Subsequent hospital care
90832	Psytx pt&/family 30 minutes	99233	Subsequent hospital care
90833	Psytx pt&/fam w/e&m 30 min	99307	Nursing fac care subseq
90834	Psytx pt&/family 45 minutes	99308	Nursing fac care subseq
90836	Psytx pt&/fam w/e&m 45 min	99309	Nursing fac care subseq
90837	Psytx pt&/family 60 minutes	99310	Nursing fac care subseq
90838	Psytx pt&/fam w/e&m 60 min	99354	Prolonged service office
90845	Psychoanalysis	99355	Prolonged service office
90846	Family psytx w/o patient	99406	Behav chng smoking 3-10 min
90847	Family psytx w/patient	99407	Behav chng smoking > 10 min
90951	Esrd serv 4 visits p mo <2yr	99495	Trans care mgmt 14 day disch
90952	Esrd serv 2-3 vsts p mo <2yr	99496	Trans care mgmt 7 day disch
90954	Esrd serv 4 vsts p mo 2-11	G0108	Diab manage trn per indiv
90955	Esrd srv 2-3 vsts p mo 2-11	G0109	Diab manage trn ind/group
90957	Esrd srv 4 vsts p mo 12-19	G0270	Mnt subs tx for change dx
90958	Esrd srv 2-3 vsts p mo 12-19	G0396	Alcohol/subs interv 15-30mn
90960	Esrd srv 4 visits p mo 20+	G0397	Alcohol/subs interv >30 min
90961	Esrd srv 2-3 vsts p mo 20+	G0406	Inpt/tele follow up 15
96116	Neurobehavioral status exam	G0407	Inpt/tele follow up 25
96150	Assess hlth/behave init	G0408	Inpt/tele follow up 35
96151	Assess hlth/behave subseq	G0420	Ed svc ckd ind per session
96152	Intervene hlth/behave indiv	G0421	Ed svc ckd grp per session
96153	Intervene hlth/behave group	G0425	Inpt/ed teleconsult30
96154	Interv hlth/behav fam w/pt	G0426	Inpt/ed teleconsult50
97802	Medical nutrition indiv in	G0427	Inpt/ed teleconsult70
97803	Med nutrition indiv subseq	G0436	Tobacco-use counsel 3-10 min
97804	Medical nutrition group	G0437	Tobacco-use counsel>10min
99201	Office/outpatient visit new	G0438	Ppps, initial visit
99202	Office/outpatient visit new	G0439	Ppps, subseq visit
99203	Office/outpatient visit new	G0442	Annual alcohol screen 15 min
99204	Office/outpatient visit new	G0443	Brief alcohol misuse counsel
99205	Office/outpatient visit new	G0444	Depression screen annual
99211	Office/outpatient visit est	G0445	High inten beh couns std 30m
99212	Office/outpatient visit est	G0446	Intens behave ther cardio dx
99213	Office/outpatient visit est	G0447	Behavior counsel obesity 15m
99214	Office/outpatient visit est	G0459	Telehealth inpt pharm mgmt
99215	Office/outpatient visit est		

Telemedicine Task Force

As required by Maryland law, the Task Force convened in July 2013 to identify opportunities to expand telehealth adoption in the State. The Task Force consists of three advisory groups: Clinical Advisory Group (CAG), Finance and Business Model (F&B) Advisory Group, and Technology Solutions and Standards (TSS) Advisory Group. About 90 individuals, representing roughly 65 organizations from both private and public sectors, participated in Task Force meetings; the Task Force met approximately 30 times between July 2013 and July 2014. A final report on

recommendations for expanding telehealth adoption in Maryland was submitted to the Governor, Senate Finance Committee, and House Health and Government Operations Committee in October 2014.[11]

The CAG recommended ten use cases for implementation in pilot projects to accelerate use of telehealth.[12] These use cases are intended to: have an impact on vulnerable populations; be consistent with the goals of health care reform; and be implementable, testable, and cost-effective.[13, 14] The use cases are as follows:

1. *Improve transitions of care between acute and post-acute settings through telehealth*
2. *Use telehealth to manage hospital Prevention Quality Indicators*[15]
3. *Incorporate telehealth in hospital innovative care delivery models through ambulatory practice shared savings programs*
4. *Require value-based reimbursement models to factor in reimbursement for telehealth*
5. *Use telemedicine in hospital emergency departments and during transport of critically ill patients to aid in preparation for receipt of patient*
6. *Incorporate telehealth in public health screening and monitoring with the exchange of electronic health information*
7. *Deploy telehealth in schools for applications including asthma management, diabetes, childhood obesity, behavioral health, and smoking cessation*
8. *Use telehealth for routine and high-risk pregnancies*
9. *Deploy telehealth services widely at community sites, connected to health care professionals and/or the statewide health information exchange*
10. *Use telehealth for remote mentoring, monitoring and proctoring of health care practitioners through telehealth for the expansion, dispersion and maintenance of skills, supervision, and education*

The Task Force also developed supporting recommendations for the use cases. The F&B advisory group focused on identifying the finance and business model challenges of implementing the use cases, such as: reimbursement structure; practitioner availability for remote care delivery, monitoring, and care coordination; and practice transformation and redesign. The F&B advisory group recommended that organizations deploying the use cases develop solutions unique to their organization and patient population to mitigate the challenges. Sustainability of the use cases is unlikely absent addressing the financial and business model challenges.

The TSS advisory group determined the use cases could be implemented with current telehealth technology and identified a barrier to telehealth diffusion as the lack of availability of information about telehealth services. The TSS advisory group recommended the development of a telehealth provider directory (telehealth directory) that will be a publicly available online listing of Maryland telehealth providers. The Task Force also recommended transitioning from using the term *telemedicine* to the term *telehealth* because telehealth encompasses a broader scope of health care delivery.[16] The Task Force recommended adopting the following definition for *telehealth*: *the delivery of health education and services using telecommunications and related technologies in coordination with a health care practitioner.*[17, 18]

The Task Force requests the General Assembly provide $2.5 million for the implementation of select telehealth use cases. The MHCC proposes to use its grants-making authority for issuing telehealth use case pilot projects. If funding is

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[11] MHCC, *Maryland Telemedicine Task Force Final Report,* October 2014. Available at: mhcc.maryland.gov/mhcc/pages/hit/hit/documents/TLMD_MD_TLMD_TTF_Rpt_10141017.pdf.
[12] Use cases are defined as a pilot projects narrow in scope to test concepts before introducing them more widely.
[13] Some of the telehealth use cases are already in practice today.
[14] The use cases are not intended to imply which health care services should be reimbursed by payors.
[15] Hospital prevention quality indicators are a set of measures used nationally to assess quality and access to care in communities. For more information, visit: qualityindicators.ahrq.gov/modules/pqi_resources.aspx.
[16] Telemedicine, as currently defined in Md. Code Ann., Insurance § 15–139, is: *as it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a site other than the site at which the patient is located.*
[17] Telehealth includes the following technologies: real-time audio video conferencing; store-and-forward; remote monitoring; and mobile health.
[18] DHMH may specify by regulation the types of health care providers eligible to receive reimbursement for services delivered to Maryland Medicaid patients through telemedicine. DHMH may also authorize coverage and reimbursement for health care services delivered through store-and-forward technology or remote patient monitoring subject to the limitations of the State budget and in accordance with Medicaid regulations.

appropriated, MHCC will request innovative telehealth pilot project applications. The funding amount per awardee will be determined based on the number and strength of the proposals made in the grant applications. Implementation of the funded pilot projects will be structured as two-year partnerships, in which MHCC and each grantee will work collaboratively to implement and assess the impact of telehealth on quality of care, access to care, and cost of care. Part of the funding will be used to implement the telehealth provider directory.

Remarks

As Maryland continues to implement health care reform, the use of telehealth will become progressively more relevant. The Task Force recommendations, if implemented, are expected to improve quality of care, help contain health care costs, and increase patient and provider satisfaction. There is growing interest in telehealth use among payors, practitioners, health care patients, and consumers as technology progresses, coverage expands, and health care reform goals are achieved. Telehealth is viewed as a component of improving health care delivery and addressing inequities in access to care. Implementing telehealth is a complex and evolving endeavor.[19] Collaboration among stakeholders is essential in implementing the use cases to foster more rapid diffusion of telehealth.

[19] Journal of Telemedicine and e-Health, *National Telemedicine Initiatives: Essential to Healthcare Reform*, 2009.