

# Medicaid Payment for Telerehabilitation

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**ABSTRACT.** Palsbo SE. Medicaid payment for telerehabilitation. *Arch Phys Med Rehabil* 2004;85:1188-91.

**Objective:** To assess current payment practice for telerehabilitation in state Medicaid programs.

**Design:** Telephone survey.

**Setting:** State Medicaid programs.

**Participants:** State Medicaid directors.

**Interventions:** Not applicable.

**Main Outcome Measure:** Descriptive.

**Results:** Half of the 35 state Medicaid programs contacted reimbursed at least some telemedicine services other than radiology in 2002. The primary reason for reimbursing for telemedicine is to make services available when there is no local practitioner. Consultation and evaluation and management services were most likely to be reimbursed (12 states). Seven state programs reimbursed telepsychology, and 4 states reported reimbursing for telespeech and language pathology, physical therapy, or occupational therapy.

**Conclusions:** Telemedicine helps Medicaid programs deliver specialized care to locations with provider shortages. Telerehabilitation is not yet widespread, despite its potential benefit to people with disabilities who cannot travel to a clinic for rehabilitation therapy. Most Medicaid programs calculate the financial costs and patient benefits when considering payment policies, and about half of states require a state law to allow payment for telerehabilitation. Minnesota, Hawaii, and Nebraska, among the responding states, currently reimburse for telerehabilitation. Research is needed to evaluate the appropriateness of telerehabilitation for Medicaid beneficiaries.

**Key Words:** Medicaid; Prospective reimbursement; Rehabilitation; Telemedicine.

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**T**ELEMEDICINE IS an encounter between a health care professional and a patient in which a diagnosis is made and treatment is prescribed while the patient and health professional are separated by physical distance. The health care market is becoming more receptive to telemedicine, and increasing numbers of insurers are reimbursing telemedicine encounters. Between 1997 and 2003, approximately 6 civilian rehabilitation hospitals and several Veterans Administration (VA) hospitals began pilot or demonstration programs to pro-

vide physical medicine and rehabilitation (PM&R) services using televideo equipment.

Presently, telerehabilitation programs are interactive sessions that provide visual assessment using videoconferencing equipment or videophones. Active programs include postoperative pain management through psychotherapy, chronic pain management through psychotherapy, cognitive assessment, physical and speech therapy, wheelchair seating clinics, exercise therapy to prepare for kidney transplants, and occupational therapy. The US Department of Defense and Jim Thorpe Rehabilitation Hospital are piloting telerehabilitation to public schools, for children with special needs.

As of 2002, state Medicaid programs appear to be the largest potential volume purchasers of telerehabilitation services, especially in rural areas. The present study surveyed directors of state Medicaid programs to learn how receptive states would be to paying for telemedicine in general, and for telerehabilitation services, in particular.

## METHODS

A survey was developed with the input of advisors who had conducted state inventories in the past or who were providing telerehabilitation. The present survey asked whether the state Medicaid program currently (in 2002) reimbursed for any telemedicine and, if so, under what circumstances. If a state paid for any service, additional questions were asked about payment for specific visit and PM&R procedure codes. Because I was interested in how receptive Medicaid programs may be to using telerehabilitation for urban residents, several questions on geographic restrictions were asked. I also asked about the state's ability to produce regular reports on the number and types of telemedicine services in their Medicaid program. A copy of the survey is available from the author. The survey and study protocol were approved by the MedStar Research Institute Institutional Review Board.

All 50 states and the District of Columbia were surveyed during summer 2002. The survey was administered via computer-assisted telephone interview with Medicaid directors or a designee knowledgeable about telemedicine reimbursement policy and practice. Respondents received a hard copy of the survey questions before the interview to allow them ample time to collect information. Responses were logged in electronically directly into a relational database and tabulated data for analysis.

## RESULTS

### Overview of Medicaid Telemedicine Reimbursement

Of the 51 Medicaid programs for which contact was attempted, 35 completed the survey, yielding a 69% response rate (table 1). Seven Medicaid programs that reimburse for telemedicine did not respond (Arizona, Colorado, Georgia, Iowa, Montana, South Dakota, Utah). This report presents results only from the responding programs.

In 2002, 16 respondents (ie, excluding the 7 nonrespondents with known programs) paid for at least 1 telemedicine service. Of these 16 states, 9 have specific statutes enacted by the state legislature authorizing and defining the scope of telehealth

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Supported by the National Institute on Disability and Rehabilitation Research, Rehabilitation Engineering and Research Center, Center on Telerehabilitation, US Department of Education (grant no. H133E990007-00C). This article reflects the opinion of the author and not necessarily that of the federal government, the US Department of Education, the National Rehabilitation Hospital, or MedStar Health.

No commercial party having a direct financial interest in the results of the research supporting this article has or will confer a benefit on the author(s) or on any organization with which the author(s) is/are associated.

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0003-9993/04/8507-8528\$30.00/0

doi:10.1016/j.apmr.2003.09.008

**Table 1: Medicaid Reimbursement for Telemedicine in 2002, Responding States**

State	Reimburse in 2002?	Plan to Explore?	Pay Consulting, Referring, or Both?	Modes of Telehealth Reimbursed
AL	No	Yes		
AR	Yes		Both	Interactive
CA	Yes		Both	Interactive
CT	No	No		
DC	No	No		
DE	No	No		
FL	No	Yes		
HI	Yes		Consulting	Interactive, store & forward
ID	No	Yes		
IL	Yes		Both	Interactive, store & forward
IN	No	No		
KS	Yes		Consulting	Interactive
KY	Yes		Consulting	Interactive
LA	Yes		Both	Interactive, store & forward
ME	Yes		Consulting	Interactive
MD	No	Yes		
MS	No	No		
MN	Yes		Both	Interactive, store & forward
MO	No	Yes		
NE	Yes		Both	Interactive, store & forward
NV	No	No		
NJ	No	No		
NC	Yes		Both	Interactive
ND	Yes		Both	Interactive
OK	Yes		Consulting	Interactive, store & forward
OR	No	No		
PA	No	Yes		
RI	No	Yes		
TX	Yes		Both	Interactive
VA	Yes		Both	Interactive
WA	No	Yes		
WI	No	No		
WV	Yes		Consulting	Interactive
WY	No	Yes		

NOTE. Data from Georgia are missing.

activities. Of the 19 respondents who did not currently reimburse, 9 planned to explore telehealth reimbursement.

Several questions were asked about who was paid for telemedicine encounters. Ten programs reimbursed for both consulting (hub) and referring (spoke) sites, and 6 reimbursed only at the consulting site. These 16 programs reimbursed the consulting physician the same fee as for a face-to-face encounter, except for North Carolina, which split the fee (75% for the consulting provider, 25% to the referring provider). Eleven states also paid the referring provider the same fee as for a face-to-face encounter, and 7 states paid less. Fifteen states paid for interactive encounters in which the patient, referring clinician, and consulting clinician were all present simultaneously (table 1). Of these, 5 states also paid for store-and-forward encounters, such as a videotape or electrocardiogram of a patient that was mailed to the remote clinician for viewing

at a later time. Two states said they only paid for store-and-forward encounters.

States were asked to describe their motivation for paying for telehealth under Medicaid. All programs reported that a shortage of practitioners was the driving force. Half also cited personal hardship that travel would cause the beneficiary (eg, traveling a long distance). States were further asked if state law imposed a geographic restriction on telehealth reimbursement, such as limiting reimbursement to rural areas. Six states restricted Medicaid reimbursement to areas in rural counties, counties with small populations or few hospitals, or areas identified by the federal government as having a shortage of health professionals. Some states would pay for out-of-state telemedicine services, but only if the service was not available within the state and the out-of-state provider was licensed to practice within that state.

Several questions were asked about states' ability to monitor use of telemedicine, both in fee-for-service (FFS) and capitated Medicaid arrangements. Eleven states added a modifier to the procedure code that indicated that the procedure was done by telemedicine. Most of these states could produce regular reports on the number and types of telemedicine services for FFS Medicaid but not for prepaid or capitated Medicaid.

**Medicaid Reimbursement for Telerehabilitation**

I collaborated with telerehabilitation practitioners to identify the PM&R procedure codes that are strong candidates for appropriate application using videophone or videoconferencing equipment (tables 2, 3). These included 11 psychotherapy procedures, 5 speech-language pathology procedures, 21 physical and occupational procedures, and 28 medical consultation or evaluation and management procedures.

The most frequent category (12 states) of services reimbursed by state Medicaid programs when provided by telemedicine was "inpatient consultations and inpatient follow-up consultations" (see table 2). The next most frequent category (11 states) was "confirmatory consultation," followed by 2 categories (10 states each): "evaluation and management for established patients" and "office consultation." Nine state Medicaid programs said they reimbursed for "evaluation and management for new patients." Only 6 states said they reimbursed for telepsychotherapy.

Four states—Hawaii, Louisiana, Minnesota, and Nebraska—stated that their 2002 Medicaid programs reimbursed for telerehabilitation services. Among nonrespondents, Oklahoma also paid for telerehabilitation services.

**DISCUSSION**

The official policy of the Centers for Medicare and Medicaid Services is to encourage states to incorporate telemedicine technology into their Medicaid programs to improve beneficiary access, quality of care, and clinician-patient communication. However, only 21 Medicaid programs (16 of whom responded to this survey) reimbursed for telemedicine in 2002, suggesting limited acceptance of telemedicine as a delivery modality. Even fewer states have reimbursement structures in place to pay for telerehabilitation other than consultations or evaluation and management. I was particularly surprised at the small number of state Medicaid programs that would pay for telepsychotherapy, given its wide use in the penal system, the veterans systems, the private sector, and the body of evidence and clinical trials documenting its effectiveness.

The main justification that states used for Medicaid telemedicine was local shortages of practitioners, especially in rural areas. There appears to be little appreciation of the potential application for telerehabilitation to overcome the trans-

**Table 2: Physician and Psychologist Telemedicine Encounters by CPT Code, for Responding States Whose Medicaid Programs Reimbursed Each Code in 2002**

CPT Codes	Provider Type	Procedure	State											
Physician services (by medical doctors)														
99241-5	MD	Office consult, 15–80min	AR	CA	HI	KY	MN	ND	NE	TX	VA	WV		
99251-5	MD	Inpatient consult, 20–110min	AR	CA	HI	KY	LA	MN	NC	ND	NE	TX	VA	WV
99261-3	MD	Follow-up inpatient consult, 10–30min	AR	CA	HI	KY	LA	MN	NC	ND	NE	TX	VA	WV
99271-5	MD	Confirmatory consult, simple-complex	AR	CA	HI	KY	MN	NC	ND	NE	TX	VA	WV	
99201-5	MD	EM, new outpatient, 10–60min	AR	CA	HI	IL	LA	MN	ND	NE	TX			
99211-5	MD	EM, established outpatient, 5–40min	AR	CA	HI	IL	LA	MN	NC	ND	NE	TX		
Psychotherapy services (by psychologists or medical doctors)														
90804-9	MD	Individual psychotherapy with medication mgmt (20–80min) (psychologists cannot do medication mgmt in any state; HI will not pay for physician unless case includes medication mgmt; VA does not pay for psychologists)	CA	HI	KY	MN	ND	NE	VA					
90847	Psych	Family psychotherapy with patient (15min)	CA	HI		MN	ND							
90862	MD	Medication mgmt with minimal psychotherapy	CA	HI		LA	MN	ND	NE					

Abbreviation: CPT, Current procedural terminology; EM, emergency medicine; mgmt, management.

portation barriers faced by people with disabilities who live in urban areas.

In 2002, there was no information on the use of telerehabilitation in state Medicaid programs. Only 1 responding state—Nebraska—said it could produce a report on the volume of physical, occupational, and speech therapy services. The lack of information makes it very difficult to monitor the diffusion of telerehabilitation in state Medicaid programs across the United States.

If clinical trials show that telerehabilitation is both clinically and cost effective, then rehabilitation professionals will have to

open discussions with their state Medicaid program about reimbursement and practice guidelines. Some states (eg, North Carolina) will require clinicians to have an initial face-to-face encounter with their patients. Some states, such as Arkansas, will allow the Medicaid director to make the decision, whereas other states, including Florida, Kentucky, Minnesota, Missouri, Texas, and Wisconsin, will require a new law.

Further, the professional associations for rehabilitation providers should begin to formulate position statements on the appropriate use of telerehabilitation, to have a knowledgeable voice in the states' deliberations.

**Table 3: Therapist Telemedicine Encounters by CPT Code, for Responding States Whose Medicaid Programs Reimbursed Each Code in 2002**

CPT Code	Provider Type	Procedure	State			
V5362	SLP	Speech screening (articulation)	HI	MN	NE	
V5363, V5364, 92507	SLP	Language screening (receptive or expressive); treatment of swallowing dysfunction and/or oral function for feeding; individual SLP therapy (1 unit)	HI	MN	NE	
92506, 92525, 92526, 96105	SLP	Speech-language evaluation (60min); swallowing evaluation (1 unit); swallowing oral function. Therapy (1 unit); assessment of asphagia (60min)	HI	LA	MN	NE
X5515	PT	Wound care		MN		
X4515	OT	Motor skills (15min)		MN		
X4524	OT	Preventive skills (15min)		MN		
97537	OT	Community/work reentry (15min)		MN	NE	
97542	OT, PT	Wheelchair manipulation/propulsion	HI	MN	NE	
97003-4	OT	OT evaluation (45min) and reevaluation	HI	MN	NE	
97535	OT	Self-care, home mgmt training (15min)	HI	MN	NE	
97770	OT	Cognitive or sensory integration	HI	MN		
97001-2	PT	PT evaluation (30min) and reevaluation	HI	MN	NE	
97116	PT	Therapeutic process, gait training (15min)	HI	LA	MN	NE
97530	OT, PT	Therapeutic activities (15min)	HI	LA	MN	NE
97110	OT, PT	Therapeutic exercise (15min)	HI	LA	MN	NE
97112	OT, PT	Neuromuscular reeducation (15min)	HI	LA	MN	NE
97140	OT, PT	Manual therapy techniques (15min)	HI	LA	MN	NE
97532	OT	Development of cognitive skills (15min)	HI	LA	MN	NE
97504	PT	Orthotics fitting and training, upper and lower extremity	HI	LA	MN	NE

Abbreviations: OT, occupational therapy; PT, physical therapy; SLP, speech-language pathology.

**Study Limitations**

In some states, it was very difficult to find someone highly knowledgeable about Medicaid reimbursement policies and practices for telemedicine. It was even more difficult to find someone who knew much about rehabilitation. Because state laws and Medicaid programs are constantly changing, the specific information in the tables may be outdated. Seven states that pay for telemedicine did not respond to our survey. This may bias the results by understating the actual prevalence of telerehabilitation.

**CONCLUSIONS**

Most state Medicaid programs are not receptive to telemedicine. Few states other than Minnesota, Hawaii, and Nebraska have considered payment for telerehabilitation. Research on the clinical and cost effectiveness of telerehabilitation is needed so Medicaid program personnel can make informed decisions and provide accurate information to state legislators. The studies should measure how much telerehabilitation improves access to rehabilitation therapy and decreases missed appointments for patients in urban areas.

**Acknowledgments:** Cheryl Lacsamana, BS, assisted with data analysis. Donal Lauderdale, MSE, conceived the study and supervised data collection.

**References**

1. Robinson DF, Savage GT, Campbell KS. Organizational learning, diffusion of innovation, and international collaboration in telemedicine. *Health Care Manage Review* 2003;28(1):68-78.
2. Palsbo S, Bauer D. Telerehabilitation: managed care's new opportunity. *Manag Care Q* 2000;8(4):56-64.

3. Rosen MJ, Lauderdale DE. Proceedings: State of the Science Conference on Telerehabilitation and Applications of Virtual Reality. Washington (DC): National Rehabilitation Hospital Pr; 2002.
4. Day SX, Schneider PL. Psychotherapy using distance technology: a comparison of face-to-face, video and audio treatment. *J Counseling Psychol* 2003;49:499-503.
5. Gammon D, Sorlie T, Bergvik S, Hoifodt TS. Psychotherapy supervision conducted by videoconferencing: a qualitative study of users' experiences. *J Telemed Telecare* 1998;4(Suppl 1):33-5.
6. Appel PR, Bleiberg J, Noiseux J. Self-regulation training for chronic pain: can it be done effectively by telemedicine? *Telemed J e-Health* 2002;8:361-7.
7. Schopp LH, Johnstone BR, Merveille OC. Multidimensional telecare strategies for rural residents with brain injury. *J Telemed Telecare* 2000;6(Suppl 1):146-9.
8. Brennan D, Georgeadis A, Barker L. Comparison of story retelling between face-to-face and remote telerehabilitation sessions by brain-injured persons. In: Rosen MJ, Lauderdale DE, editors. Proceedings: State of the Science Conference on Telerehabilitation and Applications of Virtual Reality. Washington (DC): National Rehabilitation Hospital Pr; 2001. p 31-4.
9. Amir O, Shabtai E. Public information services in the field of communications disorders: comparison between teleservice and e-service. *Telemed J e-Health* 2002;8:369-75.
10. Russo H. Medicaid telemedicine and telehealth update. Washington (DC): Center for Telemedicine Law; 2000.
11. Hagglund K, Clay DL. Rural healthcare initiatives in spinal cord injury. *Am Rehabil* 1997;23(1):2-6.
12. Centers for Medicare and Medicaid Services. Medicaid and telemedicine. Available at: <http://cms.hhs.gov/states/telemed.asp>. Accessed September 25, 2003.