



American Telemedicine Association

**State Medicaid Best Practice
Telehealth for High-risk
Pregnancy**

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State Medicaid Best Practice **Telehealth for High-risk Pregnancy**

High-risk pregnancies are determined by medical conditions including high blood pressure, gestational diabetes, chronic illness, or history of preterm labor or genetic disorder.¹ Further, complications resulting from high-risk pregnancy and prenatal births lead to difficulty with labor, miscarriage, and higher rates of infant mortality.² The best intervention for patients with high-risk pregnancy includes consultation from a maternal-fetal specialist and close monitoring and surveillance. Telehealth is a tool to enable a provider to identify problems early in the pregnancy and provide treatment to avoid further complications and preterm labor.

The purpose of telemedicine used in obstetrical and natal care is to improve high-risk pregnancy outcomes, reduce time spent during neonatal ICU and unnecessary hospital stays, and reduce unnecessary patient transportation. There are a number of clinical applications for telehealth when dealing with high-risk pregnancy. Telemedicine has been used to read ultrasounds, interpret non-stress tests, counsel patients, manage diabetes and postpartum depression, and support parents and children postpartum from remote sites. Another example of clinical applications for telehealth available to high-risk pregnant patients include FDA approved Bluetooth home monitoring for obstetrical diabetes and hypertension management.

Although a physician consult would seem sufficient enough to deal with a patient with high-risk pregnancy, it is important to understand that tools including ultrasound image interpretation and remote patient monitoring are just as important to provide comprehensive care. Most states only cover store-and-forward telemedicine when used in the specialties of dermatology or ophthalmology.³ Reimbursing for this clinical application of store-and-forward would allow specialists to remotely interpret obstetrical ultrasounds and echocardiograms. Further, home uterine activity monitoring is one example of telehealth that is commonly used in patients at-risk for preterm labor. Yet, although research has shown the clinical benefits of using home uterine monitoring, it is not a covered benefit under many Medicaid plans.⁴

Medicaid Overview

Medicaid is the largest payer of maternal-related services, and trends indicate that the rates of pre-term births are increasing.⁵ As a result, Medicaid may be disproportionately affected. The goal, when using telehealth, is to provide early interventions in order to enable women to have healthy deliveries, minimize complications, and reduce neonatal ICU services, maternal physician visits, preterm labor and complications, and caesarian sections thus preventing costly hospital stays.

There are a number of benefits to using telehealth with high-risk pregnancies. Reductions in medical and transportation costs, time lost from work, and improved efficiency for health care providers represent benefits of telemedicine. Particularly in rural areas, users of telemedicine have claimed improvements in co-management and collaboration between urban and rural providers, distributed liability, reduced anxiety in rural patients who would otherwise be forced to navigate urban centers. Some states understand these benefits and reimburse for telemedicine and other services to coordinate and improve care for Medicaid beneficiaries with at-risk

pregnancies. Some states have gone beyond the threshold of covering telemedicine encounters only when provided by a physician and now cover similar services when performed by a licensed midwife: Arizona, Michigan, Nevada, New Mexico, North Carolina, Virginia, and Wisconsin.

Created by the Affordable Care Act (ACA) and authorized under the Social Security Act, Title V, Section 511 (42 USC 711), states may leverage grant funds from the Maternal, Infant, and Early Childhood Home Visiting Program to improve maternal and newborn health using telehealth. This evidence-based program provides states with \$1.5 billion over five years to offer home visiting services to families with young children to improve outcomes in health, education, child abuse, and family wellbeing.⁶ States like Iowa have proposed to use the program's grant funding to explore creative uses of telehealth to enhance child and family support services.

State Policy Best Practices

To improve patient access to healthcare through telehealth expansion, ATA has analyzed enacted state telehealth policies and highlighted those respective states with the best policy models for telehealth services. These best practice models can be used as benchmarks for other states considering new or revising existing telehealth policies.

For services related to high-risk pregnancy, ATA examined enacted laws, published fiscal notes and bill reports, published regulations, and Medicaid provider manual guides for the states with Medicaid coverage in those areas. ATA also reviewed state issued reports and clinical programs demonstrating quality and cost-effective telehealth deployment and utilization. The criteria used to identify states with model policies regarding telehealth and high-risk pregnancy include:

- Inclusive definitions of technology with little to no restrictions on the types of technology approved for use in a clinical service
- Geographic area served
- Applicable health services and conditions
- Provider eligibility
- Reimbursement methodology
- Level of coverage and affected health care plans.

The following information identifies notable policies from three states: Arkansas, Pennsylvania, and Virginia.

Arkansas

Arkansas has established statewide coverage and reimbursement of telehealth to improve access to maternal-fetal specialists and neonatal services and meet the needs of Medicaid beneficiaries who experience high-risk pregnancies. To bridge the gaps in access to quality care, Medicaid reimburses for physician consultations and real-time image interpretation when provided via interactive two-way video-conferencing. The program rules require that the patient and provider must be able to hear and see each other in real-time. The state will also cover telehealth-provided services during a non-emergency office/clinic/hospital outpatient visits or inpatient hospital visit.⁷ The patient must be located at one of the eligible originating sites: in-patient or

non-emergency hospital, physician office or clinic, ambulatory surgical center, FQHC, or emergency department.

Arkansas is one of two states that reimburse for telehealth when used to interpret fetal echography and echocardiograms. Although these types of diagnostic procedures may qualify for Medicaid reimbursement when not performed in real-time, the rules define telemedicine as “interactive medical transactions occurring in real-time.”⁸ The state’s Medicaid plan limits coverage of telehealth consultations to two per client per year; however beneficiaries of all ages are eligible for a benefit extension based on medical necessity.⁹

Unlike other payors who require modifier codes “GT or GQ” when billing for telehealth-provided services, Arkansas created a unique set of modifier codes for billing claims. Remote specialists must use modifier code “U1” for evaluation and management consultative services, and “W” for telehealth-provided ultrasound interpretations.¹⁰ The originating site is not eligible for an originating site fee, but may bill for the technical component of ultrasound or radiological procedures using modifier code “Y.”¹¹

Pennsylvania

Data from 2009 shows Pennsylvania’s Medicaid fee-for-service plan financed 57,371 births.¹² Pennsylvania’s Medicaid plan has reimbursed for telehealth-provided consultations by maternal-fetal medical specialists since 2007. The agency instituted this policy reform due to the statewide shortage of maternal-fetal medical specialists and to improve the quality of care for expectant mothers. The Medicaid plan’s 2007 proposal initially reimbursed specialists when they used either interactive video-conferencing or the telephone to provide telehealth consultations.¹³ However, the 2012 revision of PA’s telehealth Medicaid guidelines limits coverage and reimbursement of telehealth-provided services only when real-time, interactive video-conferencing is used.¹⁴ Providers are no longer reimbursed for the use of telephone-only consultations.

Telehealth encounters may occur at any originating site and not just at the referring provider’s office. Remote site specialists who are enrolled in the state’s Medicaid program may bill using CPT codes 99241, 99242, 99243, 99244, and 99245 with GT modifier. Telehealth consultation reimbursement fees range from \$30 to \$151.44 per consultation without frequency limits.¹⁵ Prior authorization is not required.

Originating sites consist of enrolled office sites where a physician, certified registered nurse practitioner, or certified nurse midwife is participating in the telehealth encounter. In the event that one of these providers is unavailable to participate in the telehealth encounter, then a registered nurse, medical assistant, or other clinical professional must be available to assist the patient.

Unlike most states, the originating site provider may bill for an office visit (e.g., 99213, 99214, and 99215) in addition to the originating site fee, if the telehealth encounter is performed at the same time as an office visit. If an office visit procedure is not performed, then the originating site provider may only bill for the originating site fee. Providers may bill for an originating site fee using procedure code Q3014 and GT modifier. The originating site fees range is \$15.72.¹⁶

Virginia

Virginia Medicaid is highlighted for its reimbursement of physician telehealth consultations, as well as the coverage of remote imaging interpretations of fetal echocardiograms and obstetric ultrasounds.¹⁷ While most Medicaid plans cover a limited or capitated number of obstetric ultrasounds for pregnant women, only Virginia allows a specialist to remotely interpret the ultrasound reading using telehealth.

Since 2003, Virginia has adopted policies that have promoted the use of telehealth, including telestroke services, to the state's most vulnerable patients. The state is one of few that cover telehealth services for beneficiaries enrolled in the fee-for-service and managed care Medicaid plans. VA's telehealth policies do not place any restrictions on the preferred location of the patient during the telemedicine encounter. Access to telehealth services are not inhibited by policies relegating distance, geography, health condition, or ability. This means that a maternal-fetal specialist may consult on a high-risk pregnancy or neonatal case while the patient is located in a federally qualified health clinic (FQHC), rural health clinic, community health center, or critical access hospital to name a few.

Providers are required to be trained and competent in the telehealth equipment used for the encounter, and comply with all federal and state privacy and security laws. In addition, providers billing for telemedicine services must notify the Medicaid agency at least ten days before the service date.¹⁸ The telehealth provider only has to notify the agency once of its intentions to use telehealth to enhance their consultative service.

Evidence-Based Outcomes for Telehealth and High-risk Pregnancy

Numerous studies have convincingly shown the value of varied clinical applications of telehealth used to mitigate the complications of high-risk pregnancy and reduce costs.¹⁹⁻²² Further, effective research has also demonstrated the positive effects and health outcomes when telehealth is used in neonatal ICU care.²³⁻²⁴

In collaboration with the Arkansas Medicaid Program, the University of Arkansas for Medical Sciences created the Antenatal and Neonatal Guidelines, Education and Learning System (ANGELS) using real-time telehealth consultations and call-center support to enhance access to specialty care including maternal-fetal medicine consultations and tertiary level obstetric care. As a result of this multi-provider network, ANGELS has contributed to a reduction of the 60-day infant mortality rate and helped reduce medical complications associated with high-risk pregnancy while offering a cost-effective telemedical solution to the Medicaid program.²⁵⁻²⁷

In 2009 the Virginia High-Risk Obstetrics Telehealth Program was created with the support of state and federal grants. Operated through the University of Virginia, the network was developed to improve access to specialized prenatal care for women with high-risk pregnancies in communities with maternal-fetal specialty shortages, and includes partners from five rural counties. Over the course of three years, the program has seen a reduction in missed

appointments and preterm deliveries by 25 percent. There have also been reductions in the number of NICU days from approximately 22 to 13 days.²⁸

Model Medicaid Policy Considerations

Based on state best practices, ATA suggests the following basic provision for policymakers and health care stakeholders to start from in developing telehealth-supported services for high-risk pregnancy policies to fit their needs.

Medicaid will provide coverage for obstetrical and natal services; which includes the use of real-time audio and video, store-and-forward technology, and remote patient monitoring; to the same extent that the services would be covered if they were provided through in-person consultation.

More specifically, model policies for Medicaid coverage of comprehensive telehealth-supported services for high-risk pregnancy should include:

- Definitions of technology with little to no restrictions on the types of technology approved for use in a clinical service;
- Unrestricted geographic coverage areas or patient settings;
- Applicable health services related to obstetrical or natal care, and conditions such as high blood pressure, gestational diabetes, chronic illness, or history of preterm labor or genetic disorder;
- Eligible telehealth providers such as physicians, maternal-fetal specialists, neonatal specialists, certified midwives, clinical nurse specialists, and nutrition and diabetes educators;
- Allowances for innovative payment models other than fee-for-service. Reimbursement considerations should be made for managed care, medical homes, accountable care organizations, and other service and payment innovations; and
- Parity coverage for services that are also provided in-person as well as coverage under Medicaid expansion plans created under the Affordable Care Act (ACA).

ATA is also supporting a Congressional proposal to create a federal Medicaid option for states to create and use a "birthing network," modeled on other federal Medicaid benefit options. This legislation would include some incentives beyond the scope of existing Medicaid, notably an enhanced federal matching rate of 90% for the first two years of a state's program and shared savings opportunity for participating providers. Independent budget analysis estimated savings of \$186 million over 10 years for Medicaid nationally under the model. The savings would mostly come from leveraging telehealth to more effectively treat major conditions associated with high-risk pregnancies, including pre-term labor, gestational hypertension, mild preeclampsia, and gestational diabetes mellitus. The Congressional proposal is section 201 of H.R. 3306, introduced by Rep. Gregg Harper (R-MS) in October 2013.

¹ Butler, Adrienne, et al. "Preterm Birth: Causes, Consequences and Prevention". Institute of Medicine. July 2006.

² Ibid.

³ State Medicaid Best Practice Store-and-Forward Telemedicine. American Telemedicine Association. July 2013.

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- ⁵ “Children and Pregnant Women in Medicaid and CHIP”, session brief dated November 17, 2011 (MACPAC analysis of HCUP 2009 data).
- ⁶ Maternal, Infant, and Early Childhood Home Visiting Program General Information. Available at: <http://mchb.hrsa.gov/programs/homevisiting/index.html>
- ⁷ AR Provider Manual, Section II: Physician/Independent Lab/CRNA/Radiation Therapy Center 252.000
- ⁸ Ibid. 252.200.
- ⁹ Ibid. 226.200.
- ¹⁰ Ibid. 292.812.
- ¹¹ Ibid. 292.813.
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