TELEHEALTH IS COMPLICATED… TELEMONITORING IS NOT

When one is looking at telehealth, the originating site must be considered. For instance, A county outside a Metropolitan Statistical Area (MSA) or a rural Health Professional Shortage Area (HPSA) in a rural census tract except for patients getting treatment for substance use disorders or treatment of strokes. None of that is a factor in tele-monitoring.

Telehealth services require an interactive audio and video telecommunications system that permits real-time communication between the patient and the physician. That is not a requirement in tele-monitoring.

Yes, you can make good money with the telehealth services if you need to and have the system set up, but tele-monitoring is available to all physicians, Nurse practitioners and Physician Assistants and results show that this service greatly reduces the number of hospital admits, re-admits and emergency room visits. Tele-monitoring can be in place in almost any office within a week, while tele-health programs take considerably longer.

The Centers for Medicare & Medicaid Services (CMS) began a program geared towards the tele-monitoring of patients with hypertension and diabetes, in conjunction with the Texas Medicaid system. This is the third year of this program, whereas CMS supports the Texas Medicaid system for providing remote patient monitoring on Medicare-Medicaid QMB patients. Whereas Medicare just started paying for remote patient monitoring in 2019, Texas Medicaid has been paying Texas providers for 2 ½ years as part of this program. In fact, the payments have been about $228 per month, per patient, to Texas Medicaid providers as part of this program. In the first couple of years, the results have been quite impressive. One official with the program reported "we've seen a great reduction in the number of hospital admits, re-admits and emergency room visits with patients receiving remote patient monitoring on this system". One Texas internal medicine physician reported in April: "Last week, I had a Medicare patient hospitalized for 3 days due to hypoglycemia. Had I had this program in place for her, I would have been able to capture the problem in time and avoided the entire hospitalization".

The program is quite simple for Medicare patients nationwide, since the inception of payment on the three new CPT codes 99453, 99454 and 99457 in 2019. CMS has still (as of mid July 2019) not issued directives or memorandums on their payment, but they have been paying an average of $108 per month, per patient, to physicians providing this service this entire year. This equates out to about $68 per patient net profit per month for physicians enrolled in programs such as TeleCare-USA or others. A practice with 500 Medicare patients with hypertension and/or diabetes could easily be netting $32,000 a month or $384,000 a year by providing this service to their patients, without the practice having to buy even one piece of equipment. For more information on either the Medicare patient program or the Texas Medi-Medi program, check out https://telecare-usa.com/ or reach out to donself@donself.com