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CLIENT ALERT

CMS Final Rule Expands Medicare's Reimbursement for Physician Services Furnished Using Communication Technology

By Kathleen M. Premo, Elizabeth Scarola, and Matthew Sprankle

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On November 1, 2018, the Centers for Medicare & Medicaid Services ("CMS") finalized proposals to pay separately for a newly defined type of physicians' service furnished using communication technology: the "virtual check-in" ("Final Rule").[1] The Final Rule permits physicians and certain "qualified practitioners" (defined below) to be reimbursed for providing communication technology-based services to established patients[2] beginning on January 1, 2019. The Final Rule promotes Medicare beneficiaries' access to these telehealth services by removing certain restrictions traditionally placed on the delivery of telehealth services and by creating various payment codes for telehealth and telehealth-like services.[3]

I. CMS Pays for the Newly Defined "Virtual Check-In"

Beginning January 1, 2019, reimbursement will be available to physicians and certain "qualified practitioners"—i.e., those who can report evaluation and management ("E/M") services in accordance with applicable state law and CMS billing and coding standards—for a brief non-face-to-face check-in with established patients to assess whether the established patients' condition requires an office visit. The brief communication technology-based service is billable under HCPCS code G2012. An established patient must not have had a related E/M service provided within the previous seven days, and the payable services must also not lead to an E/M service or procedure within the next 24 hours. If the review of the patient-submitted image/video leads to an E/M service within the next 24 hours, then the event is considered bundled into the pre- or post-visit time of the associated E/M service, and it will not be separately billable.

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[1] The Final Rule is available at https://www.federalregister.gov/documents/2018/11/23/2018-24170/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions. *See* Part I of this Client Alert for information about the "virtual check-in."

[2] "Established patients" are those who have "received professional services from the physician or qualified health care professional or another physician or qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past 3 years."

[3] *See* Part II of this Client Alert.

Notably, CMS will allow audio-only, real-time telephone interactions in addition to synchronous, two-way audio interactions that are enhanced with video or other kinds of data transmission. So long as the brief communication service meets the aforementioned requirements, there is no frequency limitation as to the number of such services that providers may submit in fiscal year 2019.

Despite the request from commenters, CMS declined to expand services beyond the scope of qualified billing professionals to established patients. For example, CMS declined to act on a request from a commenter that telemedicine services provided by physical therapists be payable. In its response, CMS noted that similar check-ins provided by clinical staff can be "important aspects of coordinated care," but such clinical staff services are currently included in the relative value units for other codes, including those that describe E/M visits, several care management services, and procedures with global periods.

II. CMS Expands Access to Telehealth Services for Medicare Beneficiaries

The Final Rule is a departure from Medicare's typical restrictions[4] on telehealth services, including (i) restrictions on applicable "originating sites" (i.e., where the patient may be located for the interaction to be covered)[5] and (ii) limits on appropriate telehealth "modalities" (i.e., permissible means of delivering the telehealth service).

A. Removing Originating Site Restrictions for Services Delivered via Telehealth

Effective January 1, 2019, CMS plans to add the following locations to its list of originating sites: Medicare beneficiary homes for those receiving home dialysis for end-stage renal disease, renal dialysis facilities, and mobile stroke units (ambulances equipped to handle acute stroke). This change allows health care providers to implement telehealth services in locations that had not been previously covered under Medicare,[6] giving providers the opportunity to provide care to a wider range of patients and give patients greater access to the treatment they need.

Similarly, under the Final Rule, health care providers may deliver (and be reimbursed for) services via telehealth to patients with substance use disorders for treating substance use and co-occurring mental health disorders beginning on January 1, 2019. For more

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[4] Amy Lerman, "OIG Updates FY 2017 Work Plan to Include Review of Medicare Claims for Telehealth Services Provided to Rural Beneficiaries: Will Substantive Change to Medicare Reimbursement for Telehealth Follow?" *TechHealth Perspectives* (blog), July 26, 2017, https://www.techhealthperspectives.com/2017/07/26/oig-updates-fy-2017-work-plan-to-include-review-of-medicare-claims-for-telehealth-services-provided-to-rural-beneficiaries-will-substantive-change-to-medicare-reimbursement-for-telehealth-follow/.

[5] Medicare has restricted coverage of telehealth services to beneficiaries who reside within certain geographic rural areas and who seek such services at specific "originating sites" (a patient beneficiary's home is not included in the current Medicare definition for "originating site").

[6] By making this statement regarding the addition of the above originating sites, CMS is planning to implement the requirements of the Bipartisan Budget Act of 2018.

information about this change, see a recent blog post[7] covering the SUPPORT for Patients and Communities Act (known as the "SUPPORT Act"), which sought to address originating site restrictions by granting Medicare coverage of telehealth services to eligible beneficiaries in their homes.

These changes are significant for many stakeholders. Health care providers will soon be paid for delivering a service via telehealth to a patient in his or her home regardless of where that patient's home is located. Providers will receive this reimbursement at the same rate as if the service were to be furnished in person. Medicare beneficiaries win here, too—those with substance use disorders may now access care simply by setting up a telehealth appointment for services delivered to their home.

B. Providing Reimbursement for Various Additional Telehealth Services

Telehealth has traditionally been described as having the following three "modalities" by which the telehealth service is delivered to patients: (i) two-way, interactive audio-video ("synchronous" telehealth); (ii) store-and-forward technology;[8] and (iii) remote patient monitoring ("RPM"). Medicare previously has reimbursed solely for telehealth services transmitted using an "interactive 2-way telecommunications system (with real-time audio and video)." The Final Rule provides for expanded access to all three modalities.

In addition to providing reimbursement for synchronous "virtual check-ins," CMS announced that it is finalizing the addition of prolonged preventive services (HCPCS codes G0513 and G0514) to Medicare's "reimbursement for telehealth services" list. Met with unanimous support from commenters, these codes signify time spent by health care providers "beyond the typical service time of the primary procedure." These wellness visits must be furnished via telehealth "in the office or other outpatient setting requiring direct patient contact beyond the usual service." G0513 establishes payment for the first 30 minutes of this preventative care service; G0514 pays for each additional 30 minutes.

The Final Rule also establishes payment for the "Remote Evaluation of Pre-Recorded Patient Information," a "store and forward"-like service that CMS states is not subject to traditional Medicare telehealth service restrictions because this evaluation is not a substitute for an in-person service that is currently separately payable under the Physician Fee Schedule ("PFS"). This service intends to determine whether follow-up office visits or other services would be necessary. Although CMS considered implementing this code for both new and established patients, the Final Rule only permits payment for HCPCS code G2010 for established patients (those who have had a prior in-person or telerehab past visit with the qualified provider). Health care providers must also ensure that they provide

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[7] Charles C. Dunham, IV & Matthew Sprankle, "The SUPPORT for Patients and Communities Act: Expanding Medicare Coverage of Telehealth Services to Combat the Opioid Crisis," *TechHealth Perspectives* (blog), Nov. 5, 2018, https://www.techhealthperspectives.com/2018/11/05/the-support-for-patients-and-communities-act-expanding-medicare-coverage-of-telehealth-services-to-combat-the-opioid-crisis/.

[8] Section 1834m of the Social Security Act defines "store-and-forward technologies" as "asynchronous transmission of health care information."

a timely diagnosis within 24 business hours in order to be eligible for payment under this code. Providers will be happy to know that a diagnosis can be delivered by e-mail, phone call, virtual visit, or text message, or through the patient portal. However, like "virtual check-ins," in order for these services to be payable, they must be stand-alone services separately billed to the extent that there is no resulting E/M office visit and there is no related E/M office visit within the previous seven days of the remote service being furnished.

Further recognizing the importance of touch points for patients with chronic conditions, the Final Rule creates three CPT codes for RPM telehealth-like services, entitled "Chronic Care Remote Physiologic Monitoring" (CPT codes 99453, 99454, and 99457). Since these services are "inherently non face-to-face" (and, thus, they do not have an in-person counterpart), CMS determined that RPM services are *not considered* a Medicare telehealth service and therefore are not restricted under Medicare's narrow coverage of telehealth services.[9] CMS did not offer any specific technology that qualifies under these codes; however, it does plan to issue guidance in the future "to help inform practitioners and stakeholders on these issues."[10] Notably, CPT code 99457 permits RPM services to be delivered by physicians, qualified health care professionals, or clinical staff, including registered nurses and medical assistants (depending on state licensing scope).

III. The Final Rule's Impact on Providers

The Final Rule demonstrates CMS's commitment to enhancing patient access, including the use of technology-based platforms. The use of communication technology-based services will provide new options for physicians to treat patients. These services could (i) help avoid unnecessary office visits, (ii) consist of services that are already occurring but are not being separately paid, or (iii) constitute new services. The move is anticipated to reduce the costs of health care and benefit vulnerable patient populations.

CMS noted that providers generally support expansions of Medicare coverage to telehealth. Several commenters requested the addition of services to the list of Medicare telehealth services in specialized areas, including physical therapy telerehab services. CMS continues to evaluate the cost-effectiveness of expansion of such services and will add services to the list of Medicare telehealth services described in the calendar year 2003 PFS final rule (67 FR 799888).

[9] CPT code 99453 describes the remote monitoring of physiologic parameters related to initial setup and patient education regarding the use of equipment.[9] CPT code 99454 also involves remote monitoring of physiological parameters but related to the remote device(s)'s "supply with daily recording(s) or programmed alert(s) transmission." CPT code 99457 permits billing for "[r]emote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month." This new code will be much easier to track since payment is based on the time spent per calendar month (rather than the per 30-day intervals of its prior iteration), which will better align with claims submission and recordkeeping practices.

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This Client Alert was authored by **Kathleen M. Premo, Elizabeth Scarola,** *and* **Matthew Sprankle.** *For additional information about the issues discussed in this Client Alert, please contact one of the authors or the Epstein Becker Green attorney who regularly handles your legal matters.*