Hogan Lovells

Medicare further expands payment for and coverage of telehealth and similar services

November 7, 2018

Through several recently published rules, the Centers for Medicare & Medicaid Services (CMS) is making it possible for Medicare beneficiaries to have greater access to health care services provided remotely through telehealth or "telehealth-like" methods and to implement telehealth provisions included in the Bipartisan Budget Act of 2018 (BBA), as we discussed in a previous alert. The recently posted Medicare physician fee schedule (PFS) and home health prospective payment system (HH PPS) final rules and the Medicare Advantage and Prescription Drug Benefit proposed rule all included provisions that establish or would establish new rules concerning telehealth or related services. Viewed together, this demonstrates the CMS' belief that telehealth and related communication technology-based services can provide expanded access to high-quality and cost-effective health services and that the CMS will be providing more flexibility to encourage the use of these services. These changes recognize growing beneficiary and health care professional comfort with the use of communication technology in the provision of health services. The changes also implicitly acknowledge the growing demand for the convenience of telehealth services. It remains to be seen whether these Medicare program developments will result in expanded coverage of telehealth services under any state Medicaid programs.

Medicare physician fee schedule final rule

On November 1, the CMS posted the Medicare physician fee schedule final rule. Because the Medicare statute limits payment for telehealth services to beneficiaries in certain geographic areas (primarily rural) and limits the "originating sites" where beneficiaries can get access to telehealth services, the CMS has used its rule-making authority to bypass these restrictions by identifying and paying for certain telehealth-like services described below as "communication technology-based services" outside the telehealth benefit. The CMS also is paying for new remote monitoring services, as described below. Medicare will begin paying separately for all of these new services in January 2019. The CMS has expressed interest in recognizing innovations in the use of new communication technologies. The CMS also noted that several of these new services are aimed at avoiding the scheduling of office visits that may not be necessary by providing a lower level payment for a separate service. The rates for these new services are provided in a chart below.

Virtual check-in (HCPCS code G2012)

Under Healthcare Common Procedure Coding System (HCPCS) code G2012, Medicare will pay separately for "brief communication technology-based services," also referred to as a "virtual check-in," provided certain conditions are met. This five to 10 minute non-face-to-face telephone or computer-based interaction can be provided only to established patients in order to assess whether the patient's condition warrants an office visit. If the visit is in follow-up to a related evaluation and management (E/M) service provided within the past seven days, or if it results in an office visit within the next 24 hours or the soonest available appointment, then the CMS will consider it to be bundled into those visits and it will not be separately reimbursed. The payment will be lower than the rate for the lowest level E/M in-person service, and because these "visits" will be subject to Medicare coinsurance, the patient's verbal consent (oral consent, as opposed to written or electronic consent) must be obtained and noted in the medical record. The CMS has said it will monitor utilization of this code to determine whether frequency limits are warranted.

Remote evaluation of prerecorded patient information (HCPCS code G2010)

Similar to the virtual check-in, Medicare also will pay separately for professional evaluation of prerecorded images or video transmitted by established patients for the purpose of determining whether an office visit is warranted. After reviewing the images or video sent by patients, the clinician must follow up with the patient within 24 business hours by phone, email, text message, or other mode of communication. As with the virtual check-in, if this remote evaluation originates from a related E/M service within the past seven days or results in an office visit within the next 24 hours or the next available appointment, the service will be considered bundled and not separately payable. Beneficiary consent (oral, written, or electronic) to the service must be documented because the service would be subject to coinsurance.

Interprofessional internet consultation (CPT®[1] codes 99446-49 and 99451-52)

The CMS also finalized its proposal to pay separately for four existing and two new Current Procedural Terminology (CPT®) codes describing consultations between physicians or other qualified health professionals when they are for the benefit of a specific patient. These consultations occur when a treating physician seeks the opinion and/or treatment advice of a consulting physician or other health professional with specific expertise, and the CMS noted that the current lack of reimbursement for these interactions often leads to the scheduling of an office visit for the patient even though the patient's presence is not necessary and a telephone or internet consultation between health care professionals would be sufficient. The CMS views its recognition of these services as part of the movement away from a strictly fee-for-service-based system and toward a more care management-based approach to providing quality care to beneficiaries with multiple complex conditions. The CMS is requiring documentation of beneficiary consent to receive these services because they will be subject to coinsurance, and it will monitor use of the consultations and consider refinements in documentation and billing policies if warranted.

Remote patient monitoring (HCPCS codes 99453, 99454, and 99457)

Having already established payment for chronic care management services in 2016, which are non-face-to-face, in 2019 the CMS will establish payment for three codes to report "Chronic Care Remote Physiologic Monitoring." These include a code for the initial setup and patient education regarding use of remote monitoring of physiologic parameters such as weight, blood pressure, pulse oximetry, and respiratory flow rate, and another code that can be billed monthly for the costs associated with the supplies and transmission of data. A separate code can be reported for

[1] CPT Copyright 2018 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.

20 minutes or more of a physician or other health care professional's time on treatment management during the month, but this service cannot be provided by auxiliary personnel and billed "incident to" a professional's service. The CMS will be issuing further guidance on the specific kinds of technology and scope of services covered under these codes.

Medicare telehealth services (HCPCS codes G0513 and G0514)

In addition to the new types of services described above, the CMS annually updates the list of approved Medicare telehealth services, and this year added two codes for reporting "prolonged preventive services." These codes, which are similar to existing E/M codes, are for reporting preventive services that require direct patient contact beyond the typical service time.

Use of telehealth in treatment of substance use disorders

The physician fee schedule final rule also implements provisions in the recently passed Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, which is focused on addressing the opioid crisis, expanding the use of telehealth for treatment of substance use. Effective July 1, 2019, the geographic restrictions applicable to most telehealth services will not apply to use of telehealth for the treatment of diagnosed substance use disorders or co-occurring mental health disorders. The patient's home will also be an acceptable originating site, although no facility fee will be paid. Implementation of this SUPPORT for Patients and Communities Act provision was issued as an interim final rule with a 60-day comment period, and the CMS solicits comments on this provision.

Medicare home health prospective payment system final rule

On October 31, the CMS posted the HH PPS final rule, which will allow home health agencies to include the costs of remote patient monitoring as an allowable administrative cost (e.g., operating expense) on their cost report if the remote monitoring is used to assist in the care planning process. This will allow such expenses to be factored into the costs per visit. Commenters on the proposed rule suggested that the CMS should take an even broader approach to telehealth and include payment for virtual visits. The CMS declined to do so, but described the inclusion on the cost report of costs associated with remote patient monitoring as a necessary first step in determining whether the use of such technology improves outcomes for home health patients. This suggests the CMS may further expand payment for the use of telehealth in home health in the future.

Expanded coverage of telehealth by Medicare Advantage plans

In implementing the Bipartisan Budget Act of 2018, the CMS also is proposing to allow Medicare Advantage (MA) plans to offer expanded coverage for "clinically appropriate additional telehealth benefits" beginning in plan year 2020. The CMS would allow the plans to treat them as "basic benefits" for purposes of bid submission and payment, making it more likely that plans will offer them. Under the proposal, MA plans could offer Part B covered services as "additional telehealth benefits" outside the scope of services currently allowed under the Medicare telehealth benefit and not subject to the location restrictions applicable to telehealth services. To preserve beneficiary choice, any Part B service covered by plans as an "additional telehealth benefit" must also be available through an in-person visit and not only via telehealth. In addition, the CMS is proposing to continue allowing plans to offer supplemental benefits (e.g., benefits not covered by original Medicare) via remote technologies or telemonitoring services that do not qualify as "additional telehealth benefits."

The CMS is not proposing to define which services are "clinically appropriate" to be offered as "additional telehealth benefits," but would instead allow MA plans the flexibility to make that determination for themselves each year, consistent with professionally recognized standards of care. The MA plan would have to use contracted providers to provide these additional telehealth benefits and other MA regulations, including those regarding provider credentialing and selection would apply. Plans would be responsible for ensuring that the telehealth provider was in compliance with applicable licensing requirements and other state laws for the state in which the enrollee is located. The CMS has solicited comments on its proposed approach and on the impact such telehealth providers should have on determinations of MA network adequacy.

Comments on the proposed changes for Medicare Advantage plans are due December 31, 2018.

Taken together, these recent changes by Congress and the CMS indicate significant interest in making more health services available to Medicare beneficiaries via telehealth and similar technologies and to continue testing whether and when such services can be used to expand access to high-quality, cost-effective care, and to improve care coordination.

Appendix: Remote monitoring services payment rates

Code	Description	Calendar year 2019 PFS national average payment rates (final rule)
G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous seven days, nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment	Facility: US$9.37 Non-Facility: US$12.61
G2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; five to 10 minutes of medical discussion	Facility: US$13.33 Non-facility: US$14.78
99446	Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; five to 10 minutes of medical consultative discussion and review	Facility: US$18.38 Non-facility: NA
99447	Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review	Facility: US$36.40 Non-facility: NA
99448	Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative	Facility: US$54.78 Non-facility: NA

Code	Description	Calendar year 2019 PFS national average payment rates (final rule)
	discussion and review	
99449	Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review	Facility: US$72.80 Non-facility: NA
99451	Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient's treating/requesting physician or other qualified health care professional, five or more minutes of medical consultative time	Facility: US$37.48 Non-facility: US$37.48
99452	Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes	Facility: US$37.48 Non-facility: US$37.48
99453	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; setup and patient education on use of equipment	Facility: NA Non-facility: US$19.46
99454	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days	Facility: NA Non-facility: US$64.15
99457	Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month	Facility: US$32.44 Non-facility: US$51.54
G0513	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service)	Facility: US$62.35 Non-facility: US$65.95

Code	Description	Calendar year 2019 PFS national average payment rates (final rule)
G0514	Prolonged preventive service(s) (beyond the typical service of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (listed separately in addition to code for preventive service)	Facility: US$62.35 Non-facility: US$65.95

Contacts

Brooke Bumpers
Counsel, Washington, D.C.
T +1 202 637 5800
brooke.bumpers@hoganlovells.com

Sheree R. Kanner
Partner, Washington, D.C.
T +1 202 637 2898
sheree.kanner@hoganlovells.com

Beth L. Roberts
Partner, Washington, D.C.
T +1 202 637 8626
beth.roberts@hoganlovells.com

Elizabeth (Beth) Halpern
Partner, Washington, D.C.
T +1 202 637 8609
elizabeth.halpern@hoganlovells.com

Ken Choe
Partner, Washington, D.C.
T +1 202 637 5675
ken.choe@hoganlovells.com

Craig H. Smith
Partner, Miami
T +1 305 459 6615
craig.smith@hoganlovells.com

Thomas Beimers
Partner, Minneapolis, Washington, D.C.
T +1 612 402 3025
T +1 202 637 5600
thomas.beimers@hoganlovells.com

www.hoganlovells.com