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Understanding Medicare's New Remote Evaluation of Pre-Recorded Patient Information (Asynchronous Telemedicine)

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Starting January 1, 2019, the Medicare program will cover certain medical services delivered via asynchronous telemedicine technologies. The Centers for Medicare and Medicaid Services (CMS) just published the final rule for the 2019 Physician Fee Schedule, introducing a new code, officially titled *"Remote Evaluation of Pre-Recorded Patient Information"*(HCPCS code G2010). This article provides the top 10 things to know about the new code and explains how it will work.

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Frequently Asked Questions Medicare's Remote Evaluation of Pre-Recorded Patient Information

1. What are Remote Evaluations of Pre-Recorded Patient Information? The code is defined as "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 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment)."

2. What Modalities are Allowed? This code is used only for store & forward / asynchronous telemedicine technologies that involve pre-recorded, patient-generated still or video images. However, images or video must be submitted by the patient; it cannot be solely based on a questionnaire or non-image data. CMS rejected proposals to include, within the scope of this code, email/messaging or questionnaires/assessments that do not include an image or other visual item. Other types of patient-generated information, such as information from heart rate monitors or other devices that collect patient health marker data, would not be within the scope of G2010, but could potentially qualify as remote patient monitoring. For more information, read the Medicare Remote Patient Monitoring Reimbursement FAQs.

After the practitioner reviews and interprets the image(s), the practitioner must provide a follow-up response to the patient within 24 hours. The follow-up need not be provided via asynchronous technology, and may instead be delivered via other telehealth modalities (i.e., phone call, audio/video communication, secure text messaging, email, or patient portal communication).

3. How Does this Service Differ from Virtual Check-Ins (HCPCS code G2012)? This service is distinct from virtual check-ins in that G2010 involves the practitioner's evaluation of a patient-generated still or video image transmitted by the patient, and the subsequent communication of the practitioner's response to the patient. In contrast, a virtual check-in is a service that occurs in real time and does not involve the asynchronous transmission of any recorded image. For more information, read the Medicare Virtual Check-Ins FAQs.

4. Can this Code be Used with New Patients? CMS limits this code to established patients only. With regard to what constitutes an "established patient", CMS defers to CPT's definition of this term. CPT defines an established patient as one who has 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.

It's worthy to note that many industry advocates supported coverage of this code for new patients, particularly in dermatology and ophthalmology. This service could also be valuable in urology, as it would provide a way to assess new patients with conditions such as hematuria (blood in the urine) in a timely manner. However, the American Medical Association urged CMS to restrict the code only to established patients, arguing that the physician should conduct a face-to-face examination (either in-person or via interactive audio-video) if it is a new patient. CMS was ultimately persuaded by comments allowing separate payment only for established patients, not new patients.

5. Is There a Patient Co-Payment for Remote Evaluations of Pre-Recorded Patient Information? Yes, as a Medicare Part B service, the patient is responsible for a co-payment for the service. While several groups asked CMS to eliminate any beneficiary co-payment for the service, CMS explained that it does not have the authority to change the applicable beneficiary cost sharing for most physician services. Providers are cautioned to bill the patient (or the patient's secondary insurer) for the co-payment, as routine waivers of patient co-payments can present a fraud & abuse risk under the federal Civil Monetary Penalties Law and the Anti-Kickback Statute.

6. Is Patient Consent Required? Yes, patient consent is required for this service. The consent can be verbal or written, including electronic confirmation that is noted in the medical record for each billed service (i.e. every time the patient wants to obtain a virtual check-in). This is a bit frustrating for the patient's user experience, particularly as CMS could have allowed a process where the patient gave consent once, and the practitioner kept a copy on file.

7. Who Can Deliver the Service? Remote Evaluations of Pre-Recorded Patient Information can be delivered by physicians or qualified health care professionals.

8. Are There Any Frequency Limits? There is no frequency limitation on this code. Even without an express frequency limitation, Remote Evaluations of Pre-Recorded Patient Information, like all other practitioner's services billed under Medicare, must be medically reasonable and necessary to be reimbursed.

9. Are There Any Timeframe Limitations? CMS considered and appreciated the comments to remove the timeframe limitations, but ultimately decided to retain them in the code. Of particular disappointment is that CMS retained the "or soonest available appointment" language. CMS agreed that in each individual case, it might be challenging to prove whether or not other appointments were available prior to the visit, especially since beneficiary convenience is also presumably a factor for when appointments are scheduled. However, CMS concluded that as a whole, retaining the language in the code description could help to guard against the potential for abuse that would be present if CMS instead adopted a purely time-based window for bundling of this service. Here's what the rules mean in plain English:

- If the review of the patient-submitted image and/or video originates from a related E/M service provided within the previous 7 days by the same physician or other qualified health care professional, then the service is considered bundled into that previous E/M service and G2010 would not be separately billable (provider liable). In that event, do not bill either the patient or the Medicare program for G2010.
- If the review of the patient-submitted image and/or video leads to an E/M service or procedure with the same physician or qualified health care professional within the next 24 hours or soonest available appointment, then the is considered bundled into the pre- or post-visit time of the associated E/M service, and therefore will not be separately billable (provider liable). In that event, do not bill either the patient or the Medicare program for G2010.

10. Are There Any Patient Location Requirements? The patient need not be located in a rural area or any specific originating site. The patient can be at home. Providers frustrated with the labyrinthine and narrow Medicare coverage of telehealth services can take comfort in the fact that Remote Evaluations of Pre-Recorded Patient Information are not considered a Medicare telehealth service.

Conclusion

Medicare's coverage of asynchronous telemedicine services under G2010 represents a good step toward encouraging providers to efficiently use new technologies to deliver medical care. By reimbursing for asynchronous image reviews, the new code exemplifies CMS' renewed vision and desire to bring the Medicare program into the future of clinically-valid virtual care services.

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