Medicare Proposes (and Rejects) New Telehealth Services for 2019

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The telemedicine industry was pleased to learn CMS recently proposed adding new services to its list of Medicare-covered telehealth services. But what may be more interesting are the services CMS declined to add, and why. This article summarizes the newly-proposed additions as well as the services CMS rejected, explores some reasons for CMS’ decisions, and describes how industry advocates can submit comments to CMS and make their voice heard on these new proposals. The public comment period is open through September 10, 2018.

Medicare Telehealth Services

Under Medicare, the term “telehealth services” refers to a specific set of services practitioners normally furnish in-person, but for which CMS will make payment “when they are instead furnished using interactive, real-time telecommunication technology.” The Social Security Act governs what telehealth services are, and are not, covered under Medicare. Generally, there are five statutory conditions required for Medicare coverage of telehealth services:

1. The beneficiary is located in a qualifying rural area;
2. The beneficiary is located at one of eight qualifying originating sites;
3. The services are provided by one of ten distant site practitioners eligible to furnish and receive Medicare payment for telehealth services;
4. The beneficiary and distant site practitioner communicate via an interactive audio and video telecommunication system that permits real-time communication between them; and

So long as the distant site practitioner complies with each of the above requirements, the telehealth service furnished via a telecommunication system will substitute for an in-person encounter, and it should meet the requirements for Medicare coverage assuming other standard coverage provisions are met.

How Does CMS Assess New Telehealth Services?

There is a specific process to request additions or deletions from the list of covered telehealth services. Initially, CMS assigns each proposed code to one of two buckets: Category 1 and Category 2. Category 1 includes services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services. Category 2 includes services that are not similar to those on the current list of telehealth services. Proposals that fall into Category 2 undergo a more exacting review, including whether the proposed service will produce demonstrated clinical benefit for patients. When submitting a proposal to request coverage of a new service/code, be sure to understand which category the service falls under, so you can best know the type of clinical and nonclinical support documentation CMS expects to accompany your submission.

When Does CMS Accept Requests for New Telehealth Services?
Historically, CMS has accepted requests for additions or deletions to the Medicare telehealth services list until December 31 of each calendar year. However, for 2019 and onward, CMS proposed changing the deadline to February 10 of each year. This change is designed to better align with the deadline for receipt of code value recommendations from the Relative Value Scale Update Committee.

**What Telehealth Services Did CMS Add for 2019?**

For 2019, CMS proposed adding two codes to the covered Medicare telehealth service list:

1. **HCPCS 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 services; first 30 minutes;” and
2. **HCPCS G0514** “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; each additional 30 minutes.”

Both of these services are sufficiently similar to services already on the list of Medicare telehealth services, so CMS classified them as Category 1. Accordingly, they enjoyed the streamlined review process. Subject to public comment, these services are expected to be added to the list of Medicare telehealth services when the final rule is published in November.

**What Telehealth Services Did CMS Reject for 2019?**

**Chronic Care Remote Physiologic Monitoring**

Requestors proposed to add the following “Chronic Care Remote Physiologic Monitoring” codes to the list of Medicare telehealth services for 2019:

1. **CPT 990X0** (Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education of use of equipment);
2. **CPT 990X1** (Remote monitoring of physiologic parameter(s) (eg, weight, blood, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days); and
3. **CPT 994X9** (Remote 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).

However, because these codes can be furnished without the beneficiary's face-to-face presence and using any number of non-face-to-face means of communication, CMS did not propose adding them to the list of Medicare telehealth services. **CMS did propose covering these new RPM codes** under the Physician Fee Schedule, albeit not as telehealth services. These new codes are intended as a follow-up and expansion to CMS’ **current coverage of CPT 99091** (Remote Patient Monitoring).

Note: CPT codes that contain an ‘X’ (e.g., 994X9) are placeholder codes that are intended, through the first three digits, to give readers an idea of the proposed placement in the code set of the potential code changes. These codes will not be used for claims reporting and will be removed and not retained when the final CPT Datafiles are distributed on August 31st of each year. To report the services for ‘X’ codes, be sure to refer to the actual codes as they appear in the CPT Datafiles publication distributed on or before August 31st of each year.

**Interprofessional Internet Consultations**

CMS similarly rejected requests to cover “Interprofessional Internet Consultation” codes (CPT 994X0, 994X6) as telehealth services, noting how these codes describe services that are inherently non-face-to-face. Fortunately, CMS did propose covering these codes under the Physician Fee Schedule, just not as telehealth services. That means **these new codes are not subject to the same statutory restrictions** of rural geography or qualified originating site as Medicare “telehealth services.”

**Initial Hospital Care Services**

Advocates asked CMS to add “Initial Hospital Care” CPT codes to the Medicare telehealth service list, something that has been requested (and rejected) in prior years. The requested codes were:

1. **CPT 99221** (Initial hospital care, per day, for the evaluation and management of a patient, which requires 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of
care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient’s and/or family needs. Usually the problem(s) requiring admission are of low severity.);

2. CPT 99222 (for moderate complexity and moderate severity); and

3. CPT 99223 (for high complexity and high severity).

CMS rejected adding these as covered telehealth services. The explanation was because CMS believes “it is critical that the initial hospital visit by the admitting practitioner be conducted in person to ensure that the practitioner with ongoing treatment responsibility comprehensively assesses the patient’s condition upon admission to the hospital through a thorough in-person examination.”

Hospitals, health systems, and telemedicine companies delivering inpatient hospital services should pay particular attention to this, as there is a material difference between these CPT codes and, for example, the telehealth consultation G-codes (which are covered by Medicare). With the cost-effectiveness, quality and access improvement, and high provider and patient satisfaction levels of telemedicine services, we have seen a continued expansion of this technology in the hospital setting (both emergency department and inpatient units).

Hospitals should take the time to understand when CMS allows telehealth services to be delivered to hospital inpatients, the billing and reimbursement implications, and how to build a compliant operational workflow (both under federal law, such as EMTALA and Medicare Conditions of Participation, but also state laws, such as scope of practice, supervision, and facility licensure). This is particularly true as Medicare Administrative Contractors are expected to implement billing audits of telehealth services in the wake of the recent OIG report finding that 31% of telehealth claims did not meet the Medicare conditions for payment for telehealth services and should not have been paid. A companion OIG report auditing state Medicaid payments for telemedicine services remains in the works, and is expected to be released next year.

Frequency Limitations on Subsequent Hospital Care Services and Subsequent Nursing Facility Care Services

CMS also rejected requests to remove the frequency limitations on certain telehealth services already covered by Medicare. They are:

1. CPT codes 99231, 99232, and 99233 (Subsequent Hospital Care Services);
2. CPT codes 99307, 99308, 99309, and 99310 (Subsequent Nursing Facility Care Services).

Unlike the initial hospital care services described above, Medicare does cover certain subsequent hospital care services delivered via telemedicine. However, there are frequency limits on these services (once every three days for hospital inpatient, and once every thirty days for skilled nursing facility resident). CMS rejected requests to remove the three day frequency limitation for Subsequent Hospital Care Services because CMS “continues to believe that admitting practitioners should continue to make appropriate in-person visits to all patients who need such care during their hospitalization.” Similarly, CMS refused to lift the thirty day frequency limitation for Subsequent Nursing Facility Care Services because CMS “continues to have concerns regarding the potential acuity and complexity of [skilled nursing facility] inpatients.”

Expanding the Use of Telehealth under the Bipartisan Budget Act of 2018

The Bipartisan Budget Act of 2018 made five important statutory changes to telehealth services under the Medicare program. CMS’ proposed rule addressed implementation of two of these changes as follows:

End-Stage Renal Disease Services: Patients at Home

The Act allows an individual determined to have end-stage renal disease receiving home dialysis to choose to receive certain monthly end-stage renal disease-related clinical assessments via telehealth. CMS proposed including renal dialysis facilities and the home of a renal dialysis individual as Medicare telehealth originating sites for the purpose of meeting required conditions for Medicare Part B payment. Should this change be adopted (and we anticipate it will), providers can deliver these services to patients in their homes and Medicare will reimburse for it. However, there would be no originating site facility fee paid when the originating site is the patient’s home.

Telestroke Services: New Modifier and Mobile Stroke Units

The Act added special rules for telehealth services for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke, including removing any restriction on the geographic locations and the types of originating sites where acute stroke telehealth services can be furnished. This means telestroke will be covered by Medicare at hospitals in rural and urban areas, alike (which is a great improvement because patients living in cities also need stroke care).
In order to accommodate this change, CMS proposed creating a new modifier that would be used to identify acute stroke telehealth services. The industry might be disappointed or frustrated to learn they need to (again) reprogram their EMR and billing software to create yet another telehealth modifier, particularly as CMS just last year eliminated the requirement to use the GT modifier and instead requires providers to bill using Place of Service Code 02.

In addition, CMS proposed adding “mobile stroke units” as a new originating site for acute stroke telehealth service. The proposed rule defines mobile stroke unit defined as “a mobile unit that furnishes services to diagnose, evaluate, and/or treat symptoms of an acute stroke.” In many regards, it appears that a telemedicine-augmented ambulance might meet the definition of a mobile stroke unit, and companies interested in exploring this new option may want to submit comments to CMS now and seek clarification or further details on how CMS expects billing to be conducted for telehealth services delivered while the patient is in a mobile stroke unit.

**How to Submit Comments**

Telemedicine industry advocates, entrepreneurs, and healthcare providers have the opportunity to comment on the proposed rule until 5 p.m. September 10, 2018. Anyone may submit comments – anonymously or otherwise – via electronic submission at this link. Alternatively, commenters may submit comments by mail to:

- **Regular Mail:** Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1693-P, O. Box 8016, Baltimore, MD 21244-8016.
- **Express overnight mail:** Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1693-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

If submitting via mail, please be sure to allow time for comments to be received before the closing date.

Olivia King contributed to this piece.

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