



FINALIZED CY 2019 PHYSICIAN FEE SCHEDULE

On Nov. 1, 2018, the Center for Medicare and Medicaid Services (CMS) published their finalized CY 2019 Physicians Fee Schedule (PFS). The final rule aims to modernize the healthcare system and help “restore the doctor-patient relationship” by reducing administrative burden. The changes related to telehealth are significant, as it not only expands Medicare telehealth services, but communicates a new interpretation by CMS of the applicability of their statutory requirements for reimbursement of remote communication technology as separate from telehealth, and adds new services based on this interpretation. Additionally, CMS adds new codes to the Medicare telehealth list, as well as new codes for chronic care management and remote patient monitoring and expands telehealth reimbursement for end stage renal disease and acute stroke based on requirements in the Bipartisan Budget Act of 2018. Finally, within the final rule, is an interim final rule, which implements changes made by the SUPPORT for Patients and Communities Act, providing exemptions from some of CMS’ telehealth requirements for the treatment of substance use disorder (SUD), and providing a 60 day comment period. Each of these elements is discussed in detail below.

CMS PAYMENT FOR REMOTE COMMUNICATION TECHNOLOGY

Telehealth delivered services under Medicare are limited in statute by 1834(m) of the Social Security Act which restricts the use of telehealth to certain services, providers, technology (mainly live video) and patient locations (needing to be in certain types of healthcare facilities in rural areas). CMS, in their final rule, expresses concern that these requirements may be limiting the coding for new kinds of services that utilize communication technology. The final rule expresses CMS’ belief that their obligation to impose those restrictions only apply to “the kinds of professional services explicitly enumerated in the statutory provisions, like professional consultations, office visits, and office psychiatry services.” These are services that are paid for as if they were furnished during

an in-person encounter between a patient and health care professional. Certain other kinds of services that do not typically fall into the aforementioned categories and are furnished remotely using communications technology are not considered “Medicare telehealth services” and are not subject to the restrictions. This includes interactions between a medical professional with a patient via remote communication technology. Thus, CMS has finalized their reimbursement policy for virtual check-ins, remote evaluation of pre-recorded patient information and interprofessional internet consultation, which CMS believes fall outside the scope of Medicare telehealth services.

Each is described below:

BRIEF COMMUNICATION TECHNOLOGY-BASED SERVICE, E.G. VIRTUAL CHECK-IN

Brief communication technology-based service would include check-in services used to evaluate whether or not an office visit or other service is necessary. This service would be billable when a physician or other qualified health care professional has a brief non-face-to-face check-in with a patient via communication technology to assess whether the patient's condition necessitates an office visit and when it does not result in an office visit. Because there was some ambiguity in the proposed rule regarding the types of technology that could fall within a brief communication technology based service, CMS clarified that it would allow for audio-only real-time telephone interaction in addition to synchronous, two-way audio interactions that are enhanced with video or other kinds of data transmission. CMS also clarified that the code would only be available to practitioners who furnish E/M services, which would exclude clinical staff, such as RNs and physical therapists.

FINALIZED CODE:

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 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.*

For instances when the brief communication technology-based service originates from a related E/M service provided within the previous 7 days by the same physician or other qualified health care professional, the service would be considered bundled into the previous E/M service and would not be separately billable. Likewise, if the service leads to an E/M in-person service with the same provider within 24 hours or the next available appointment it would also be bundled into the pre-visit time. However, if no visit is associated with the interaction it would be separately billable under G2012. CMS believes that through the check-ins practitioners would be able to mitigate the need for potentially unnecessary office visits. After reviewing multiple public comments on the issue of informed consent, CMS decided to require verbal consent notated in the patient record because the beneficiary would be liable for sharing in the cost of the services, which necessitated the need to obtain consent to ensure they are aware of the cost. CMS did note that the virtual check-ins could be used as part of a treatment regimen for opioid use disorders and other SUDs to assess whether the patient's condition requires an office visit.

Although CMS is not instituting any frequency limitations on the service, they have limited it to only established patients partially as a response to MedPAC's concerns regarding an increase in utilization that is not related to ongoing, informed patient care. CMS also states that they will monitor utilization and make future adjustments as necessary.

REMOTE EVALUATION OF PRE-RECORDED PATIENT INFORMATION

CMS finalized a new code to describe remote professional evaluation of patient-transmitted information conducted via pre-recorded "store and forward" video or image technology. These services are not subject to the Medicare telehealth restrictions because they could not substitute for an in-person service currently payable separately under the PFS. These services may be used to determine whether or not an office visit or other service is warranted.

FINALIZED CODE:

G2010 - *Remote evaluation of recorded video and/or images submitted by the patient (e.g., store and forward), including interpretation with verbal 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.*

In the final rule, CMS clarified that the follow-up within 24 hours that is referenced in the CPT code, could take place via phone, audio/video communication, text messaging, email or patient portal communication. As is the case for the virtual check-ins described previously, in instances when the brief communication technology-based service originates from a related E/M service provided within the previous 7 days by the same physician or other qualified health care professional, the service would be considered bundled into the previous E/M service and would not be separately billable. Likewise, if the service leads to an E/M in-person service with the same provider within 24 hours or the next available appointment it would also be bundled into the pre-visit time. If neither of these scenarios occurs, then the service is a stand-alone service that is separately billed. CMS finalized their valuation of the code to be consistent with CPT code 93793 which in 2018 paid \$12.24. CMS notes that this would be distinct from the brief communication technology-based service described above in that this service involves the practitioner's evaluation of a patient-generated still or video image, and the subsequent communication of the resulting response to the patient, while the brief communication technology-based service describes a service that occurs in real time and does not involve the transmission of any recorded image. Like the virtual check-ins, reimbursement for remote evaluation will only be available for established patients and providers will need to obtain verbal or written consent (to ensure they are aware of the cost sharing involved), which can include electronic confirmation that is noted in the patient's medical record for each billed service.

FEDERALLY QUALIFIED HEALTH CLINICS (FQHCs) & RURAL HEALTH CENTERS (RHCs)

Because of the different way RHCs and FQHCs are reimbursed under the RHC AIR or FQHC PPS rate, when costs are not associated with a billable visit, they are not eligible for payment. Therefore, special billing procedures have been formulated for FQHCs and RHCs in order to allow them to still bill for the communications-based technology and remote evaluation services. CMS has finalized their proposal to allow RHCs and FQHCs to receive payment for communication technology based services or remote evaluation services when at least 5 minutes of communications-based technology or remote evaluation services are furnished by an RHC or FQHC practitioner to a patient that has been seen in the RHC or FQHC within the previous year. CMS finalized the creation of a new Virtual Communications G0071 code for use by RHCs and FQHCs only, with a payment rate set at the average of the PFS national non-facility payment rates for HCPCS code G2012 for communication technology-based services, and HCPCS code G2010 for remote evaluation services. They also have waived the RHC and FQHC face-to-face requirements for these services.

INTERPROFESSIONAL INTERNET CONSULTATION

Reimbursement for Interprofessional internet consultation codes have also been finalized by CMS, which covers consultations between professionals performed via communications technology such as telephone or Internet. This supports a team-based approach to care that is often facilitated by electronic medical record technology.

FINALIZED CODES:

99446 - 99449 - *Interprofessional telephone/Internet 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; 5-31 minutes of medical consultative discussion and review (depending on code).*

99452 - *Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes.*

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, 5 or more minutes of medical consultative time.*

Providers are required to obtain verbal consent, which would include making the patient aware of any cost sharing that may be applicable (since the patient would not be present while the service is taking place), in advance of the services and document the consent in the patient medical record. These codes are limited to only practitioners that can independently bill Medicare for E/M visits.

IMPACT AND ANALYSIS

This new interpretation of statute by CMS, that not all kinds of services where a medical professional interacts with a patient via remote communication technology falls under the statutory restrictions that Medicare telehealth services are subject to, is a significant development for CMS telehealth policy. It may usher in a new era of telehealth reimbursement by Medicare where services that don't directly substitute for an in-person visit should be reimbursed. This is what they have done with the finalization of the virtual check-ins, remote evaluation of pre-recorded patient information and interprofessional internet consultations.

While a method of payment for FQHCs and RHCs is discussed in terms of virtual check-ins and remote evaluation of pre-recorded patient information, CMS stated that since the RHC All Inclusive Rate (AIR) and FQHC Prospective Payment System (PPS) rate includes all costs associated with a billable visit, consultations with other practitioners are not a billable service. Therefore, FQHCs and RHCs will not be able to bill for the interprofessional consultations.

In an impact section later in the document, CMS discusses the impact that these additional services will have on Medicare expenditures. They state that although they expect the changes to increase access to care in rural areas, they estimate there will be only a negligible impact on expenditures. This is consistent with payment that has occurred for non-face-to-face chronic care management codes since they were first allowed for payment in 2015, where Medicare found very little uptake in utilization of the codes. These new remote communication services are utilized to avoid unnecessary visits that would presumably lead to more efficient use of the provider's time and potentially cost savings for Medicare as they would pay only \$14 per visit for the virtual check-ins, which would have otherwise been a \$92 visit, if the patient had to physically visit the provider.

ADDITION OF MEDICARE TELEHEALTH SERVICES

CMS has an established process for adding codes to the list of Medicare telehealth services eligible for reimbursement. The process includes assigning qualifying requests to either one of two categories. Category 1 is reserved for services that are similar to services already approved on the Medicare telehealth list such as professional consultations, office visits and office psychiatry services. Category 2 (which entails a more extensive qualification process) is for services that are not similar to current telehealth services on the Medicare list, but pose a significant benefit for the patient. For the CY 2019 PFS, CMS has finalized two requests from commenters to add new codes on a Category 1 basis:

HCPCS codes G0513 and 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; first 30 minutes or for each additional 30 minutes*

Medicare chose not to add to the list codes for chronic care remote physiologic monitoring, interprofessional internet consultation, and initial hospital care; or to change the requirements for subsequent hospital care or subsequent nursing facility care. However it should be noted that chronic care remote physiologic monitoring and interprofessional internet consultation will be reimbursed under other sections that would not make them subject to all the restrictions Medicare places on telehealth.

CHANGES BASED ON THE BIPARTISAN BUDGET ACT OF 2018

Based on changes made by the Bipartisan Budget Act of 2018, CMS has finalized their regulations to reflect the required changes in telehealth reimbursements, to commence on Jan. 1, 2019. These changes are specifically related to the treatment of end stage renal disease (ESRD) and acute stroke, and include the following:

ESRD-RELATED ASSESSMENTS

- Add renal dialysis facilities and the home of an individual as Medicare telehealth originating sites for the purpose of the home dialysis monthly ESRD-related clinical assessment. An individual must have a face-to-face visit, without the use of telehealth, at least monthly in the case of the initial 3 months of home dialysis and at least once every 3 consecutive months after the initial 3 months.
- No originating site facility fee would apply when the originating site for these services is the patient's home.
- The rural geographic requirement will not apply to originating sites that are hospital-based or critical access hospital-based renal dialysis centers, renal dialysis facilities, or the patient's home.

ACUTE STROKE

- Allows for the treatment of acute stroke through telehealth in any hospital, critical access hospital, mobile stroke units (as defined by the Secretary), or any other site determined appropriate by the Secretary without application of the geographic requirement. A new modifier is created to identify acute stroke telehealth services.
- Only sites that meet the usual Medicare telehealth services criteria would be eligible for the facility fee.
- CMS proposes to create a new modifier that would be used to identify acute stroke services delivered via telehealth. The practitioner, and where appropriate the originating site, would use this modifier to the HCPCS code for billing or the originating site facility fee.

In both circumstances other Medicare telehealth requirements not explicitly addressed would still apply, such as limitations related to the provider types eligible for reimbursement and the services that can be reimbursed.

CHRONIC CARE REMOTE PHYSIOLOGIC MONITORING

In the CY 2018 Finalized PFS, CMS allowed reimbursement for remote monitoring code CPT code 99091 but acknowledged the need for additional codes that more accurately describe remote monitoring services and indicated that there is new coding forthcoming from the CPT Editorial Panel and the Relative Value Scale (RVS) Update Committee (RUC). In September 2017, the CPT Editorial Panel created three new codes to describe remote physiologic monitoring and management, which CMS has finalized payment for.

The codes include:

CPT code 99453 - *Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment.*

CPT code 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.*

CPT code 99457- *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.*

In response to commenters seeking clarity on the elements in the scope of service and code descriptors, including the modalities that could be included, CMS responded that they plan to issue guidance to help inform practitioners and stakeholders on this issue. They also clarified that 99457 describes professional time and therefore cannot be furnished by auxiliary personnel incident to a practitioner's professional service. The term "other qualified healthcare professionals" in the code descriptor is defined by CPT and found in the CPT codebook.

IMPACT AND ANALYSIS

99457 will be especially useful in clarifying the types of providers that can monitor and interact with the patient regarding their monitored information, as it specifies that it can be clinical staff, a physician, or other qualified healthcare professional. This was a concern with CPT code 99091 throughout 2018 because the code's description only allows for data review by a physician or another qualified health care professional and it was unclear which types of practitioners (i.e. registered nurses) fall under that definition.

CHRONIC CARE MANAGEMENT (CCM)

In the CY 2015 PFS CMS approved non-face-to-face chronic care management code 99490, which includes at least 20 minutes of clinical staff time directed by a physician or other qualified health professional, per calendar month for beneficiaries with multiple chronic conditions that meet specific criteria specified by CMS. Some of the non-face-to-face activities that fall under chronic care management could potentially include telehealth elements. In the CY 2017 finalized PFS, CMS also added CCM CPT codes 99487 and 99489 for complex CCM services, and in 2018 clarified how FQHCs and RHCs could be reimbursed for CCM services. In the finalized CY 2019 PFS, the CPT Editorial Panel created yet another CCM code, listed below:

CPT code 99491 - Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.

This new code is meant to describe situations when the billing practitioner is doing the care coordination work that is attributed to clinical staff in CPT code 99490.

CHANGES BASED ON SUPPORT FOR PATIENT AND COMMUNITIES ACT

The SUPPORT for Patient and Communities Act required CMS to adjust their reimbursement policy of telehealth for treating individuals with SUDs or a co-occurring mental health disorder. Specifically, it removed the originating site geographic requirements for telehealth services on or after July 1, 2019 for any existing Medicare telehealth originating site (except for a renal dialysis facility). Additionally, the home was made an eligible originating site for purposes of treating these individuals, however the home would not qualify for the facility fee.

CMS has issued an interim final rule with comment period to implement these requirements. They note that the normal telehealth service code limitations still apply. Practitioners would also be responsible for assessing whether individuals have a SUD diagnosis and whether it would be clinically appropriate to furnish the telehealth services for the treatment. Comments on the interim final rule are due within 60 days of the rule's publication (Nov. 23).

MEDICARE PAYMENT FOR CERTAIN SERVICES FURNISHED BY OPIOID TREATMENT PROGRAMS – REQUEST FOR INFORMATION

The SUPPORT Act also established a new Medicare benefit category for opioid use disorder treatment furnished by OTPs starting Jan. 1, 2020. This would include FDA approved opioid agonist and antagonist treatment medications, the dispensing and administration of such medication, SUD counseling, individual and group therapy, toxicology testing and other services determined appropriate. Along with the comments on the previous proposal related the SUPPORT Act, CMS is also requesting comments on the services furnished by OTPs, payments for these services and additional conditions for Medicare participation for OTPs that stakeholders believe may be useful.

MANAGEMENT AND COUNSELING TREATMENT FOR SUBSTANCE USE DISORDER

CMS is considering developing separate bundled payment for an episode of care for treatment of Substance Use Disorders (SUD), which can include elements of Medication Assisted Therapy (MAT), including potentially web-based routine counseling. They reason that “creating separate payment for a bundled episode of care for components of MAT ... under the PFS could provide opportunities to better leverage services furnished with communication technology while expanding access to treatment for SUDs.” It could also help alleviate the need for more acute services and prevent hospital readmissions. During the comment period for the CY 2019 PFS proposed rule, CMS requested comments on various aspects of this proposal.

CMS agreed with commenters that there is a wide variability in patient needs for treatment of SUDs and ongoing treatment is often necessary. Their intention is to increase access to necessary care and that any potential bundled payment would be developed in consideration of that. CMS has invited additional comments in the 60 day window for public comments for the other SUD related proposals, on payment structure and amounts for SUD treatment that account for ongoing treatment and wide variability in patient needs.

THEY ARE ALSO REQUESTING COMMENTS ON:

- Regulatory and sub-regulatory changes to help prevent opioid use disorder and improve access to treatment under Medicare.
- Methods for identifying non-opioid alternatives for pain treatment and management, along with identifying barriers that may inhibit access to non-opioid alternatives including barriers related to payment or coverage.

CMS indicates that comment will be considered in future rulemaking.

FACILITY FEE RATE

The originating site facility fee has been updated to be 80 percent of the lesser of the actual charge or \$26.15.

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