

CMS FINALIZED TELEHEALTH CHANGES TO PHYSICIAN FEE SCHEDULE CY 2019



On Nov. 1, 2018, the Center for Medicare and Medicaid Services (CMS) released their CY 2019 finalized revisions related to the Physician Fee Schedule (PFS). The final policy 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. For a more detailed analysis of these new policies, visit CCHP's website at cchpca.org.



Brief Communication Technology-based Service, e.g. Virtual Check-in

- 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
- Reimbursed at \$14
- Code G2012
- Copays apply
- Not labeled telehealth, therefore not subject to telehealth restrictions
- FQHC/RHCs will receive own code for this service
- Informed consent required

Asynchronous Remote Evaluation of Pre-Recorded Patient Information

- Remote professional evaluation of patient-transmitted information conducted via pre-recorded “store and forward” video or image technology
- Must be an established patient
- Code G2010
- Copays apply
- Not labeled telehealth, therefore not subject to telehealth restrictions
- FQHC/RHCs will receive own code for this service
- Informed consent required

Interprofessional Internet Consultation

- Cover consultations between professionals performed via communications technology such as telephone or Internet
- 99446-99449, 99451, 99452
- Verbal consent and acknowledgement of cost sharing from patient required
- Limited to practitioners that can independently bill Medicare for E/M visits
- Not allowed for FQHC/RHC because AIR and PPS rates already includes costs of consults with other practitioners

Additional Changes

- Add HCPCS codes G0513 and G0514 as codes to be reimbursed if telehealth is used. Would be subject to the telehealth restrictions
- Made changes required by Bipartisan Budget Act of 2018
- For remote physiological monitoring: codes created and finalized to be reimbursed: 99453, 99454 and 99457
- For chronic care management: new code for reimbursement 99491

INTERIM FINAL RULE ON CHANGES BASED ON SUPPORT FOR PATIENT AND COMMUNITIES ACT

The SUPPORT for Patient and Communities Act required CMS to remove 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) for purposes of treating substance use disorder or co-occurring mental health disorder. 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. CMS also is continuing to accept comments regarding the development of a 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. Comments on the interim final rule and bundled payments are being accepted for 60 days following this rule's publication (Nov. 23).