



CY 2018 FINALIZED PHYSICIAN FEE SCHEDULE

On November 2, 2017, the Center for Medicare and Medicaid Services (CMS) published their finalized CY 2018 Physicians Fee Schedule (PFS). The final rule includes the addition of several codes to the list of telehealth eligible services, including counseling visits for lung cancer screenings and psychotherapy for crisis situations, as well as four new add-on codes that are expected to reduce administrative burden. CMS has also decided to eliminate the required use of the GT modifier in favor of the new POS code in most circumstances, as well as allow for additional chronic care management services in FQHCs and RHCs and the Shared Savings Program.

ADDITIONAL CODES

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 CY 2018 CMS has added the following CPT Codes to the list of eligible Medicare telehealth services on a Category 1 basis:

- **G0296:** Counseling visit to discuss need for lung cancer screening using low dose CT scan.
- **90839** and **90840:** Psychotherapy for crisis; first 60 minutes and each additional 30 minutes

CMS describes these codes as sufficiently similar to other codes currently on the telehealth list. Specifically for 90839 and 90840, it references the CPT code prefatory language which requires that the provider be able to mobilize resources to defuse the crisis and restore safety. CMS stated in the proposed CY 2018 PFS that they believe that a distant site practitioner would have access to resources at the originating site to allow for this, but if they don't they would not qualify to deliver the service over telehealth. Commenters were supportive of this assumption, and CMS finalized this policy.

The finalized PFS also adds four additional add-on codes on a category 1 basis, even though they were not specific requests. The codes are:

- **90785:** Interactive complexity
- **96160** and **96161:** Administration of patient (or caregiver) focused health risk assessment instrument with scoring and documentation
- **G0506:** Comprehensive assessment of and care planning for patient requiring chronic care management services

CMS notes that adding these codes would ease administrative burden for practitioners who bill these add-on codes with another qualifying telehealth code. These codes would not be considered a Medicare telehealth service if the base code is not an eligible Medicare telehealth code.

In response to a request to allow telehealth coverage of end stage renal procedure codes without an in-person exam of the catheter access site monthly (currently required), in the proposed CY 2018 PFS CMS requested more information about current clinically accepted care practices, the efficacy of telehealth to examine the access site, and clinical standards of care regarding the frequency of evaluation of the access site. Because the requester did not submit evidence according to CMS, they have decided not to implement any changes to the policy regarding the face-to-face encounter requirement with the home dialysis patient, but they remain interested in the subject and will consider alternative options in future rulemaking.

PLACE OF SERVICE

In the CY 2017 PFS, CMS added a new POS code to indicate that a service took place using telehealth. The CY 2018 finalized PFS notes that it is redundant to also have providers report the GT modifier on claims. Therefore, they eliminated the required use of the GT modifier, with the exception of distant site practitioners billing CAH Method II, as they do not use a POS code and therefore can continue to use the GT modifier. Additionally, the federal telemedicine demonstration programs in Alaska or Hawaii will retain the GQ modifier, so that CMS can differentiate between synchronous and asynchronous telehealth services.

In response to concerns surrounding the decrease in payment for some distant site practitioners furnishing services via telehealth in the non-facility setting as a result of the new 02 POS code, CMS states that they will consider this issue further in future rulemaking.

REQUEST FOR ADDITIONAL INFORMATION

In the proposed CY 2018 PFS CMS sought information on ways that they can further expand access to telehealth services within their statutory authority. CMS noted the many responses it received, which included many suggestions around waiving restrictions using demonstration projects. They will carefully review these suggestions and consider them in future rulemaking.

Specifically related to remote patient monitoring, the proposed CY 2018 PFS acknowledged that RPM would generally not be considered eligible for telehealth reimbursement under statute, but that “these services involve interpretation of medical information without direct interaction between the practitioner and beneficiary. As such, they are paid under the same conditions as in-person physician’s services with no additional requirements regarding permissible originating sites or use of the telehealth place of service.” They asked for feedback on the use of CPT code 99091 (currently a bundled code), for separate reimbursement. 99091 is defined as the collection and interpretation of physiologic data digitally stored and/or transmitted by the patient or caregiver to the physician or other qualified health professional, requiring a minimum of 30 minutes of time.

After consideration of the comments received, CMS has decided to unbundle CPT code 99091 in order to facilitate payment for remote patient monitoring (RPM) services in the short term, while the CPT Editorial Board works on developing more appropriate codes for RPM. However, in order to account for concerns raised by some commenters regarding the broad nature of 99091, CMS will apply some of the requirements currently applicable to chronic care management (CCM) services to identify circumstances appropriate for reporting the code.

These include:

- The practitioner must obtain advance beneficiary consent and document it in the patient's record.
- For new patients, or patients not seen by the billing practitioner within the previous year, the service must be initiated during a face to face visit

CMS will also require that the code be reported no more than once in a 30 day period. The code can also be billed once per patient during the same service period as CCM, transitional care management (TCM) and behavioral health integration.

ORIGINATING SITE FACILITY FEE

The facility fee, paid to eligible originating sites for eligible services delivered via telehealth, was increased to \$25.76, up from \$25.40 in 2017.

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 this code, could potentially include telehealth elements. In the CY 2017 finalized PFS, CMS added CCM CPT codes 99487 and 99489 for complex CCM services. At the same time, CMS also added codes for Behavioral Health Integration (BHI) and Psychiatric Collaborative Care Model (CoCM) codes.

FQHCs AND RHCs

CMS has decided to establish two new G codes for use by RHCs and FQHCs that combines elements of the CCM, BHI and CoCM codes in order to ensure their patients have access to new care management services in a manner that is consistent with RHC and FQHC per diem payment methodologies.

RHCs and FQHCs must use the new General Care Management code G0511 when billing for CCM or general BHI services, and the new psychiatric CoCM code G0512 when billing for psychiatric CoCM services, either alone or with other payable services on an RHC or FQHC claim.

SHARED SAVINGS PROGRAM

For purposes of the Shared Savings Program, CMS had previously incorporated CCM code 99490 into the program, but have now finalized the addition of CPT codes 99487, 99489 and G0506 (along with four BHI codes). The codes would be included in the definition of primary care services and could be utilized in the beneficiary assignment methodology under the Shared Savings Program beginning in 2018 for performance year 2019 and subsequent years.

ADDITIONAL COMMENT REQUESTS TO REDUCE ADMINISTRATIVE BURDEN

CMS requested comments in their proposed CY 2018 PFS on reducing the administrative burden associated with evaluation and management (E/M) visit codes. Currently, CMS maintains guidelines that specify detailed information that must be

reported for each level of Medicare payment associated E/M codes, including the history of the present illness, physical examination and medical decision making. CMS wants to reduce the burden this imposes on providers, and to better align E/M coding and documentation with the current practice of medicine. They acknowledge that this will most likely be a multi-year process, and will involve updates to E/M guidelines, as well as changes in technology, clinician documentation practices and workflow. In addition to comments regarding the E/M codes, CMS also requested comments on ways they might further reduce the burden on reporting practitioners for care management services, including stronger alignment between CMS requirements and CPT guidance for existing and potential new codes.

In response to the feedback CMS received, they state that they will consider the best approaches for collaborating with stakeholders prior to implementing any changes, and will take comments into consideration in future rulemaking.

DIABETES PREVENTION PROGRAM

CMS finalized several changes to expand the Medicare Diabetes Prevention Program (MDPP) including the use of virtual visits to complete make-up visits a beneficiary may have missed.

IMPACT & ANALYSIS

The new codes to CMS' list of telehealth reimbursable services are still subject to the geographic and scope of service restrictions defined for telehealth delivered care.

The creation of the counseling and psychotherapy for crisis situations were determined to be sufficiently similar to codes that already exist to allow it to be added to the list. The four proposed add-on codes are expected to reduce administrative burden, and may be reflective of CMS' increased willingness to make it easier for providers to utilize telehealth.

Each year, multiple requests for code additions also get denied because either CMS found no evidence suggesting that the use of telehealth "demonstrated a clinical benefit to the patient," or they are limited by statute from making such an expansion. Among the rejected CPT codes in the CY 2018 PFS, were physical, occupational and speech therapy services, primarily because the majority of the codes are furnished by therapy professionals over 90 percent of the time but are not eligible providers of telehealth services. CPT codes for an initial inpatient consultation were rejected because CMS did not find that they resembled codes that are currently on the telehealth list, and noted that they believe it is critical for the initial hospital visit to be conducted in person to ensure the admitting practitioner can comprehensively assess the patient's condition upon admission, indicating that this needs to be done through an in-person exam. They also refused to consider code 99444 (online evaluation and management services) because it is currently not covered in Medicare generally.

CMS has decided to reimburse for remote patient monitoring by unbundling CPT code 99091. They also indicate their willingness to consider additional or alternative codes being developed by the CPT Editorial Board. Although they place

certain restrictions around the use of the code, it's an indication that CMS may be more open in the future to further expansion of telehealth reimbursement within their statutory authority. CMS does not consider RPM to fall under the telehealth restrictions because it does not require direct interaction between the practitioner and beneficiary.

The changes made to allow for the use of CCM codes in FQHCs, RHCs and in the Shared Savings Program is consistent with CMS' efforts to raise awareness of the availability of non-face-to-face CCM services and expand the codes' utilization across Medicare generally.

The elimination of the GT modifier was not a surprise, as CMS noted that this may occur in their 2017 PFS when they created the new POS code. While a few Medicaid programs have followed suit and also made the changeover to the new POS code, this may push still others to make the transition. However, CMS is not adopting the 95 modifier that the American Medical Association created last year and has been adopted in several state Medicaid programs.

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Prepared by:

