



PROPOSED CY 2019 PHYSICIAN FEE SCHEDULE

On July 12, 2018, the Center for Medicare and Medicaid Services (CMS) published their CY 2019 proposed revisions related to the Physicians Fee Schedule (PFS). Comments on the proposals are due no later than 5 pm on September 10, 2018. The proposal 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. 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 limits 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 proposed rule, expresses concern that these requirements may be limiting the coding for new kinds of services that utilize communication technology. The proposed 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 is proposing reimbursement 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.

PROPOSED CODE:

GVCII - 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 GVCII and paid \$14 under the proposal. CMS believes that through the check-ins practitioners would be able to mitigate the need for potentially unnecessary office visits. Only established patients would be eligible for this service. CMS does not propose any frequency limits on the code.

SPECIFIC COMMENT REQUESTS

- The types of communication technology that can be utilized by physicians or other qualified health care professionals in furnishing these services, including whether audio-only telephone interactions are sufficient compared to interactions that are enhanced with video or other kinds of data transmission
- Whether or not CMS should require verbal consent that would be noted in the medical record for each service.
- Whether it would be clinically appropriate to apply a frequency limitation on the use of this code by the same practitioner with the same patient, and what would be a reasonable frequency limitation.
- Timeframes under which this service would be separately billable compared to when it would be bundled.
- How clinicians could best document the medical necessity of this service.

REMOTE EVALUATION OF PRE-RECORDED PATIENT INFORMATION

CMS proposes creating a specific new code to describe remote professional evaluation of patient-transmitted information conducted via pre-recorded “store and forward” video or image technology. These services would not be 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.

PROPOSED CODE:

GRAS1 - 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.

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 plans to value the service by a direct crosswalk to 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.

SPECIFIC COMMENT REQUESTS

- Code descriptor and valuation for HCPCS code GRAS1
- Whether these services should be limited to established patients; or whether there are certain cases, like dermatological or ophthalmological services, where it might be appropriate for a new patient to receive these services.

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 proposes RHCs and FQHCs 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 proposes to create a new Virtual Communications G 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 GVCI1 for communication technology-based services, and HCPCS code GRAS1 for remote evaluation services. They also propose to waive the RHC and FQHC face-to-face requirements for these services.

INTERPROFESSIONAL INTERNET CONSULTATION

The addition of interprofessional internet consultation codes would cover consultations between professionals performed via communications technology such as telephone or Internet. This would support a team-based approach to care that is often facilitated by electronic medical record technology. They propose to pay separately for each code and requests that the Relative Value Scale (RVS) Update Committee (RUC) at the American Medical Association assists in establishing values for the six CPT codes.

PROPOSED 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).*

994X0 - *Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes.*

994X6 - *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 would be required to obtain verbal consent, which would include making the patient aware of any cost sharing that may be applicable, in advance of the services and document the consent in the patient medical record.

SPECIFIC COMMENT REQUESTS

- CMS' assumption that these are separately identifiable services, and the extent to which they can be distinguished from similar services that are nonetheless primarily for the benefit of the practitioner.
- How best to minimize potential program integrity issues.

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 proposal of the virtual check-ins, remote evaluation of pre-recorded patient information and interprofessional internet consultations. **A few notes CCHP made on the above sections include:**

- It is not clear whether a live video connection is needed to qualify as a communication-based technology service or if other forms of communication may qualify. CMS asks for comments about whether or not a telephone conversation should qualify, but does not specifically reference the potential to use secure email (i.e. conversation through a medical provider's portal between a patient and provider where the patient describes their symptoms and communicates with a provider about their care), though patient health portals are referenced in an acknowledgement by CMS that there is increasing use of them. Under the remote evaluation topic area, CMS makes the distinction between a communication based technology service and a remote evaluation of pre-recorded information indicating that the virtual check-ins occur in real time while the latter does not. If this is the case, an email conversation would not qualify as communication based technology service. While the email would qualify if the patient sent an image or video under the remote evaluation service area, it would not if there were no images and simply a description of symptoms.
- In the section on the remote evaluation of pre-recorded patient information, CMS seeks comments on whether or not it would be appropriate to allow payment for non-established patients for specific conditions, such as dermatology or ophthalmology. If such a policy were to be finalized it could prove to be beneficial to the direct-to-consumer telehealth apps whose model of care often include patients sending pre-recorded images and having providers assess and diagnose the patient without prior contact. It is also unclear whether CMS would also consider this type of interaction to be sufficient to establish a patient-provider relationship.

IMPACT AND ANALYSIS, CONT.

- 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, there is no discussion regarding if or how they might get paid for an interprofessional internet consultation.

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 proposals 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 proposed PFS, CMS has accepted 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 are proposed to 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 is proposing to amend 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.

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. CMS is seeking comments on other possible appropriate originating sites for telehealth services furnished for the diagnosis, evaluation, or treatment of symptoms of an acute stroke. Any additional sites would be adopted through future rulemaking.

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 proposed payment for.

The codes include:

CPT code 990X0 - *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 990X1 - *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 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.*

IMPACT AND ANALYSIS

994X9 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 health-care 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 proposed CY 2019 PFS, the CPT Editorial Panel created yet another CCM code, listed below:

CPT code 994X7- 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.

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.

SPECIFIC COMMENT REQUESTS

- Whether a bundled episode-based payment would be beneficial to improve access, quality and efficiency for SUD treatment.

- Development of coding and payment for a bundled episode of care for treatment for SUDs that could include overall treatment management, any necessary counseling, and components of a MAT program such as treatment planning, medication management, and observation of drug dosing.
- The typical number of counseling sessions as well as the duration of the service period, which types of practitioners could furnish these services, and what components of MAT could be included in the bundled episode of care.
- How to define and value this bundle and what conditions of payment should be attached.
- Whether the concept of a global period, similar to the currently existing global periods for surgical procedures, might be applicable to treatment for SUDs.
- Whether the counseling portion and other MAT components could also be provided by qualified practitioners “incident to” the services of the billing physician who would administer or prescribe any necessary medications and manage the overall care, as well as supervise any other counselors participating in the treatment.
- Regulatory and sub-regulatory changes to help prevent opioid use disorder and improve access to treatment under the Medicare program.
- Methods for identifying non-opioid alternatives for pain treatment and management, along with identifying barriers that may inhibit access to these non-opioid alternatives including barriers related to payment or coverage.

CMS indicates that comment will be considered in future rulemaking.

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