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Proposed 2019 Payment Rules Contain Notable Changes to Medicare's Telehealth Policy

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CMS has issued proposed payment rules for CY 2019 that hold significant implications for telehealth coverage and reimbursement. In the Proposed 2019 Home Health Prospective Payment System Rule (Proposed HH PPS Rule), published July 12, 2018, CMS proposes to reduce barriers to telehealth services by integrating remote patient monitoring into the home health plan of care. In the Proposed 2019 Physician Fee Schedule (Proposed PFS Rule), published July 27, 2018, CMS proposes changes aimed at modernizing the delivery of health care and specifically physician services, as well as improving the physician-patient relationship.

Comments on the Proposed HH PPS Rule are due August 31, 2018. Comments on the Proposed PFS Rule are due September 10, 2018.

Proposed 2019 Physician Fee Schedule

The Proposed PFS Rule would increase coverage and reimbursement for telehealth services by clarifying how certain communication technology-based services are not considered telehealth under the Medicare program, adding approved telehealth services, and conforming existing regulations to changes in Medicare telehealth policy under the Bipartisan Budget Act of 2018.

Communication Technology-Based Services

CMS discusses how certain communication technology-based services are not considered telehealth under the Medicare program and therefore are not subject to the limitations under Section 1834(m) of the Social Security Act. CMS believes that the misapplied statutory limitations on telehealth coverage and reimbursement may stifle efforts to grow innovation by limiting expansion of services that utilize communication technology and asserts that these services should be payable as other physician services are under the physician fee schedule. CMS proceeds to discuss its proposals for payment for three categories of communication technology-based services.

1. Virtual Check-Ins. Virtual Check-Ins are described as 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. CMS views this service as an effective way to mitigate potentially unnecessary office visits and billable services. CMS believes this service could be utilized as part of a treatment regimen for opioid use disorders and other substance use disorders, two very pressing social issues today. The proposed payment would be lower than an in-person E/M visit to reflect lower work time and intensity and the resulting efficiencies. The check-ins would be available only for established patients but there would be no frequency limitation.

CMS is soliciting comments on various aspects of this service, including what types of technologies (e.g., audio-only communications) may be appropriate for the check-ins and whether patients should consent to such services.

2. Remote Evaluation of Pre-Recorded Patient Information. Use of store and forward technology has been long supported by the telehealth industry as an effective means of triage, diagnosis and treatment. However,

coverage and reimbursement for such technology under the Medicare telehealth benefit has been close to non-existent as it is only covered within certain demonstration programs. Remote Evaluation of Pre-Recorded Patient Information is a physicians' or other qualified health care professionals' evaluation of recorded video or images captured by a patient to determine if an office visit or other service is warranted. CMS again takes the stance that, because these services are not intended to substitute for in-person visits, they are separate from telehealth services.

Both the Check-Ins and Remote Evaluation of Pre-Recorded Information are proposed as stand-alone billable services, *unless* they either (1) originate from an E/M service provided within the prior seven days by the same physician or qualified health care professional or (2) lead to an E/M in-person visit with the same physician or qualified health care professional. In those two instances, the payment for the service would be bundled into the payment for the E/M services.

3. Interprofessional Internet Consultations. CMS also proposes payment for six codes for Interprofessional Internet Consultations, which describe patient assessment and management services conducted through the telephone, Internet or electronic health records (EHR) consults between a treating physician (or other qualified health care professional) and a consulting physician (or other professional). The consulting physician is expected to have expertise in a specialty needed for the diagnosis or management without requiring a face-to-face encounter with the patient. CMS views this proposal as aligned with its past efforts to recognize a more comprehensive patient-centered care management, such as additional codes for chronic care management and transitional care management services.

CMS is soliciting comments on these proposed services, including how to best minimize potential program integrity issues and assure payment is made only for reasonable and necessary services.

New Approved Telehealth Services

Each year, CMS considers the addition of new CPT codes into one of two categories based on submitted requests. Category 1 services are similar to services already included in the list of telehealth services. Category 2 services are not similar but CMS has determined that, based upon submitted clinical evidence, they provide a demonstrated clinical benefit to the patient when furnished via telehealth.

Having reviewed numerous submitted requests, CMS proposes to add two services to Category 1: HCPCS G0513 and G0514, both of which cover prolonged preventive services beyond the typical service time. CMS has declined to add procedures for chronic care remote physiological monitoring based on its view that such procedures are inherently non-face-to-face and therefore not considered telehealth. Accordingly, CMS proposes to add CPT codes 990X0, 990X1 and 990X9 for payment under the standard fee schedule. For similar reasons, and as already discussed above, CMS is not proposing to add Interprofessional Internet Consultation codes, as they were proposed for payment under the regular fee schedule outside the category of telehealth services.

Citing to its consideration and subsequent denial of the same requests with the 2011 Physician Fee Schedule, CMS discusses the addition of initial hospital care services to the list of approved telehealth services. CMS distinguishes between initial inpatient *consultation* services, which are on the telehealth service list, and the initial *hospital care* provided to an acutely ill patient by the admitting practitioner who has ongoing treatment responsibility during the patient's hospital stay. CMS continues to believe that these services must be conducted in-person to ensure the practitioner with ongoing responsibility, who may or may not have seen the patient in the decision-making process regarding hospitalization, comprehensively assesses the patient's condition upon admission.

CMS received requests for the removal of the once-per-three-day limit on subsequent hospital care services rendered via telehealth and the once-per-30-day limit for nursing facility care services provided via telehealth for psychiatric care. With regard to hospital care, CMS echoes its past position that the majority of these visits should be in person to facilitate comprehensive care needed by acute patients. CMS takes a similar position with regard to nursing facility services, asserting concerns related to the complexity and acuity of nursing home patients prevent. In both cases, CMS declines to remove the limitations in place.

Implementation of Bipartisan Budget Act of 2018

The Bipartisan Budget Act of 2018 (BBA) made significant changes to Medicare telehealth policy that could only be achieved through legislation, and the Proposed PFS Rule proposes conforming regulatory changes. To conform to the BBA's expanded access to telehealth for end-stage renal disease (ESRD) patients, CMS proposes to remove the geographic and location limitations for home dialysis from current regulations to allow ESRD patients to receive monthly clinical assessments via telehealth in their home and regardless of geography. With regard to the BBA's expansion of telehealth services rendered for purposes of diagnosis and treatment of acute stroke symptoms, CMS proposes to conform current regulations by removing the geographic location requirement and expanding the permissible originating site for acute stroke telehealth services to include mobile stroke units and other sites determined by the Secretary. CMS also proposes a special modifier to identify such stroke services. The proposed regulatory changes will align with the BBA's January 1, 2019, effective date.

Proposed 2019 Home Health PPS

The Proposed HH PPS Rule would classify costs associated with remote patient monitoring as operating expenses allowed to be reported on a home health agency's cost report.

Under Section 1895(e)(1)(A) of the Social Security Act, Medicare may not pay for services provided to home health patients via telecommunications as a replacement for in-person home health services. CMS notes, however, that the act does not define *telecommunication systems*, nor does it specify that a home health agency (HHA) may not provide services via telehealth, so long as such services are not billed as a home health visit.

To remove barriers to the use of telehealth services, CMS proposes to include expenses related to remote monitoring services as reportable operating expenses for HHAs. Remote patient monitoring is a process whereby health data is collected and securely transmitted to a provider for evaluation. It explicitly need not include direct interaction between a patient and a provider. A key feature is that such monitoring should not displace in-home visits. Rather, in CMS's view, the remote monitoring services should supplement the services provided by the HHA under the care plan.

Implications for Providers

Overall, the Proposed PFS Rule and Proposed HH PPS Rule are promising for the telehealth industry as they appear to equate modernization and progress with increased use of communication-based and non-in-person services, including non-face-to-face services and remote patient monitoring, much of which the industry considers to fall into the population of telehealth services. What is interesting is CMS's approach to such expansion by declaring categories of services to be something other than telehealth. We have seen similar approaches to treatment of remote patient monitoring in the Medicaid program. Industry advocates should consider whether Medicare's restrictive definition of telehealth would apply to other innovative services, thereby rendering those services outside the scope of the telehealth restrictions.

In addition, the Proposed PFS Rule contains significant progression for true telehealth services of which providers should take advantage. ESRD providers and facilities as well as providers servicing acute stroke

patients, such as hospitals and emergency medical services providers, should consider how their telehealth service offerings will need to be modified to incorporate the expanded opportunities for coverage and reimbursement.