



Medicare Telehealth & Connected Care Policies for 2019

I. Background

According to the [Medicare Payment Advisory Commission \(Medpac\)](#), telehealth visits per beneficiary increased by 79% between 2014 and 2016, yet the existing Medicare reimbursement structures only allowed for \$27 million in telehealth-related services reimbursements in 2016. When compared to the \$672.1 billion in Medicare spending for 2016, this represents less than 1% of overall Medicare spending.

Several [conditions](#) must be met for Medicare to make payments for telehealth services under the Physician Fee Schedule (PFS) rule, as outlined in Section [1834\(m\)](#) of the Social Security Act.

1. The service must be furnished via an interactive telecommunications system. CMS' interpretation of the requirement that the services be performed using an interactive telecommunications system is that this must be a two-way, real-time interactive communication using audio and video equipment between the patient and distant site provider;
2. The service must be furnished by a physician or other authorized practitioner;
3. The service must be furnished to an eligible telehealth individual; and
4. The individual receiving the service must be located in a telehealth originating site (mostly rural).

While the law allows CMS to annually add to the list of services which may be performed via telehealth under the above outlined conditions, the statute does not permit the agency to waive the aforementioned conditions.

II. New Telehealth Services for 2019

Prolonged Services

CMS' willingness to consider expanding the types of services which may be reimbursed using telehealth (and thus meeting the above conditions) has been gradual. Over the past several years, CMS has slowly added more services to the list of telehealth services they will reimburse according to requirements outlined in Section 1834(m). For example, in 2019 they added prolonged preventive services (HCPCPs codes G0513 and G0514) and in 2018 they added five additional types of services to the list.

Substance Abuse

Additionally, coming as a result of the recent passage of the Substance Use-Disorder Prevention and Communities (SUPPORT) Act passed October 24, 2018, **CMS has proposed in the form of an interim final rule (the expectation is that will be finalized) that, beginning July 1, 2019, traditional geographic restrictions on telehealth be waived for purposes of treatment of substance use disorder or a co-occurring mental health disorder.**

End-Stage Renal Disease & Acute Stroke

Further, CMS finalized policies to implement the requirements of the Bipartisan Budget Act of 2018 for telehealth services related to beneficiaries with end-stage renal disease (ESRD) receiving home dialysis and beneficiaries with acute stroke effective January 1, 2019.

Specifically, CMS finalized the addition of renal dialysis facilities and the homes of ESRD beneficiaries receiving home dialysis as originating sites, and to not apply originating site geographic requirements for hospital-based or critical access hospital-based renal dialysis centers, renal dialysis facilities, and beneficiary homes, for purposes of furnishing the home dialysis monthly ESRD-related clinical assessments.

CMS also finalized policies to add mobile stroke units as originating sites and not to apply originating site type or geographic requirements for telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.

III. Remote Patient Monitoring

Also, starting in 2018, in addition to adding more types of services that are paid under 1834(m) telehealth policies, CMS began reimbursing clinicians for remote patient monitoring (RPM) - collection and interpretation of physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional requiring a minimum of 30 minutes of time - which CMS says they do not consider to be telehealth services under 1834(m). RPM involves a clinician monitoring and interpreting medical information (i.e. ECG, blood pressure, glucose monitoring) without a direct interaction between the practitioner and beneficiary. Until 2018, these services were bundled with other services. Now clinicians may bill for these services separately using CPT code 99091. Starting in 2019, CMS is also paying for Chronic Care Remote Physiologic Monitoring (CPT Codes 99453, 99454 and 99457), services which are inherently not face-to-face. Many stakeholders have requested feedback from CMS on what types of technology would be permitted for reimbursement under these codes. CMS has said they plan on issuing more guidance soon. Below is a quick overview of each code:

- 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).

IV. Connected Care Services New for 2019

Starting 2019, as announced in their [physician fee schedule rule](#), CMS is taking a big step forward and is going even further. The agency will be reimbursing for services they say are not telehealth but can be delivered remotely.

Specifically, effective January 1, 2019 Medicare will pay for what they are calling “technology-based services.” **CMS will reimburse clinicians when;**

- 1. A clinician checks in with a patient (a service that has typically been bundled with other services and would now be separately billable); and**
- 2. When a patient sends an image or video to a clinician (often referred to as “store-and-forward”).**

The agency makes clear reimbursement of these services are not meant to be a substitute for in-person visits separately payable under the PFS. Therefore, they are distinct from the telehealth services described under section 1834(m).

Although each proposal has restrictions around what would be paid, the finalization of these provisions mark a significant step forward in Medicare’s connected care and telehealth payment policies. Notably, CMS says they do not consider these services to be a replacement for care delivered in person and which is separately reimbursable.

V. Technology-based Services

1) Brief Communication Technology-based Service (HCPCS code G2012); otherwise known as “Virtual Check-in”

This type of service refers to a brief non-face-to-face check-in with a patient via communication technology including assessing whether a patient is in need of an office visit. For many years, any non-patient-facing communication between provider and patient was considered to be bundled with a visit, itself. However, CMS recognizes that as

technology has become more innovative, more information and data can be exchanged away from the brick-and-mortar facility than in past; leading to greater potential for quality patient care away from the office. Therefore, if a virtual check-in occurs without leading to an in-office appointment, it should be unbundled and separately paid for. CMS has this to say about scenarios where the virtual check-in does not lead to an office visit:

To the extent that these kinds of check-ins become more effective at addressing patient concerns and needs using evolving technology, we believe that the overall payment implications of considering the services to be broadly bundled becomes more problematic. This is especially true in a resource-based relative value payment system. Effectively, the better practitioners are in leveraging technology to furnish effective check-ins that mitigate the need for potentially unnecessary office visits, the fewer billable services they furnish. Give the evolving technological landscape, we believe this creates incentives that are inconsistent with current trends in medical practice and potentially undermines payment accuracy.

It's also noted within the PFS that "this service could be used as part of a treatment regimen for opioid use disorders and other substance use disorders, since there are several components of Medication Assisted Treatment (MAT) that could be done virtually, or to assess whether the patient's condition requires an office visit."

Coding:

The proposed code for this unbundled service will be HCPCS code G2012 or "Brief Communication Technology-Based Services." Much like the new proposed code for "store and forward" technologies, there are time limitations regarding when it can be unbundled from the standard E/M visits. These restrictions will allow for unbundling of the virtual check-in if it's 5-10 minutes of medical discussion and it's not related to an E/M visit that happened within the last seven days within 24 hours or soonest available appointment. It's worth noting in instances when the brief communication technology-based service originates from a related E/M service with the same clinician, that this service would be considered bundled into that previous E/M service and would not be separately billable, which is consistent with code descriptor language for CPT code 99441.

2) Remote Evaluation of Pre-Recorded Patient Information (HCPCS code G2010); otherwise known as "Store and Forward" or "asynchronous transmission of health care information."

This type of service is referenced under 1834(m) as communication technology that provides for the "asynchronous transmission of health care information." Stakeholders have long requested that CMS make a separate Medicare payment for this service in order to remotely evaluate a patient's condition but up to this point, due to statutory limitations like geographic restrictions, billing for these services has only been permitted under federal telemedicine demonstration programs conducted in Alaska or Hawaii. However, similar to the virtual check in services that will now be reimbursable, CMS has

said they will pay for the review of pre-recorded images when the purpose is to determine whether an office visit is needed and because it is not intended to replace in-person visits.

CMS expressed that pre-recorded patient-generated still or video images are to be included in this category and involve clinician review of the data and subsequent response to the patient. Other forms of patient-generated health data (PGHD) coming from devices that collect patient health marker data could potentially be reported with CPT codes that describe remote patient monitoring. This new code will hold the same standards as virtual check-in regarding patient initiation, consent and use within an existing patient-clinician relationship.

Coding:

The final code for this service would be described as 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).

- **Additional Information for Billing Technology-based Services Permissible technology:**
 - **Virtual check in:** CMS will allow physicians or other qualified healthcare professionals to perform the virtual check using audio-only real-time telephone interactions, as well as, synchronous two-way audio interactions enhanced with video or other kinds of data transmission.
 - **NOTE:** Phone calls by clinical staff who are not the ones billing the services cannot be billed using HCPCS code G2012 since the code requires the direct interaction between the patient and billing practitioner.
 - **Remote evaluation:** Can occur using phone, audio / visual communications, secure text message, email, or patient portal. Where image quality is too poor for a clinician to interpret, the service cannot be billed.
- **Pricing:** CMS is pricing virtual check in as a distinct service at a rate lower than existing E/M in-person visits to reflect the low work time and intensity and to account for the resource costs and efficiencies associated with the use of communication technology.
- **Initiated by patient:** CMS expects that these services would be initiated by the patient, especially since many patients would be financially liable for sharing in the cost of these services.
- **Consent:**
 - **Virtual checkin:** CMS requires clinicians patient's verbal consent and that this is document in the medical record.

- **Remote evaluation:** Patient consent can be obtained verbally or in writing and must be documented in the medical record.
- **Established patients:** These services are limited to established patients.
- **Frequency limitations:** CMS has not imposed any limits to the number of times virtual check ins can be billed by the same practitioner for the same patient.
- **Medical necessity:** Billing for these codes must meet a Medicare's medical necessity requirements.
- **HIPAA:** All privacy and security rules must be met.

VI. Home Health

In Medicare's [Home Health final rule](#) for 2019, they finalized a proposal to define remote patient monitoring under the Medicare home health benefit as "the collection of physiologic data (for example, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient or caregiver or both to the home health agency." However, visits to a beneficiary's home for the sole purpose of supplying, connecting, and/or training the patient on the remote patient monitoring equipment, without the provision of another skilled service are not separately billable.

Also, CMS finalized their proposal to include the costs of remote patient monitoring as an allowable administrative cost (that is, operating expense), if remote patient monitoring is used by the HHA to augment the care planning process. They said they believe the doing so, "is a necessary first step in determining the cost and frequency in which HHAs are currently utilizing this technology and whether the use of such technology improves health outcomes for home health patients." They furthermore add, "home health visits would not qualify for payment under the home health benefit. We plan to closely monitor remote patient monitoring costs and the impact that such technology may have on patient outcomes under the traditional Medicare home health benefit and we will consider ways to more broadly support such technology as part of home health."