TELE HEALTH

FOR VIRGINIA

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REIMBURSEMENTS

FOR MEDICARE

On November 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.

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.

Finally, within the final rule is an interim final rule, which implements changes made by the SUPPORT for Patients and Communities Act, providing exemptions from some of CMS' telehealth requirements for the treatment of substance use disorder (SUD), and providing a 60 day comment period.

FOR PRIVATE PAYERS

Since 2010, Virginia has enacted laws mandating parity in coverage for telehealth-provided services under private health insurance plans, Medicaid, and state employee health plans.

For the most part, telemedicine is defined as "the real-time or near real-time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment." Meaning most Virginia telehealth-provided services must utilize real-time video visits in order to qualify for reimbursement, though some plans allow for asynchronous exchange of information.

With these laws in place, eligible medical professionals can bill and be reimbursed for services provided to their patients via telehealth at the same rate as they would for an in-office visit.

RELAXED REQUIREMENTS AMIDST COVID-19

Under the "Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020", the president has given The Centers for Medicare and Medicaid Services (CMS) unique authority to waive certain restrictions on telehealth services for Medicare individuals in order to better care for a vulnerable population during the COVID-19 outbreak.

	ORIGINAL RESTRICTIONS	COVID-19 POLICY CHANGES
Location	*Patients must be at a qualified originating site to receive telehealth services.*	*Patients may now receive telehealth services regardless of their location (even from home!).*
Relationship	*Patients must have an established relationship with the professional providing care.*	*Patients must have an established relationship with either the professional providing care or another in the same practice.*
Methods	*Telehealth services must utilize a tool that provides two-way real-time audio and visual interaction between patient and provider, but not a telephone.*	*Telephones with two-way real-time audio and visual capabilities can now be used to administer and receive services as long as it leverages a HIPAA-compliant platform.*

Additionally, the Department of Health and Human Services released a bulletin on March 15, 2020 indicating that they would wave any HIPAA penalties, fines, and sanctions incurred during the COVID-19 pandemic. While the media and general public have seen this announcement as permission to implement insecure telehealth tools, it is important to note the actual language of the bulletin, as it applies to a very narrow instance of Covered Entities.

Regardless of its applicability to your business, this temporary waiver does not indicate a reduction in responsibilities to HIPAA compliance for Covered Entities and Business Associates alike. Civil cases, OCR fines, and other regulatory penalties still apply and could adversely affect a business as it is recovering from the impact of COVID-19. Please see below for a summary of the conditions of the HHS' bulletin.

SANCTIONS AND PENALTIES WAIVED:

- *Failure to obtain a patient's agreement to speak with family members or friends*
- *Failure to honor a patient's request to opt out of the facility directory*
- *Failure to distribute a Notice of Privacy Practices*
- *Failure to respect a patient's rights to privacy restrictions*
- *Failure to respect a patient's rights to request confidential communications*

WAVED RESTRICTIONS ONLY APPLY:

- *To hospitals in an area indicated in a public health emergency declaration*
- *To hospitals that have instituted their disaster protocols*
- *For up to 72 hours from the time the hospital implements its disaster protocol*

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BRIEF COMMUNICATIONS TECHNOLOGY-BASED SERVICES e.g. VIRTUAL CHECK-INS

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. Because there was some ambiguity in the proposed rule regarding the types of technology that could fall within a brief communication technology-based service, CMS clarified that it would allow for audio-only real-time telephone interaction in addition to synchronous, two-way audio interactions that are enhanced with video or other kinds of data transmission. CMS also clarified that the code would only be available to practitioners who furnish E/M services, which would exclude clinical staff, such as RNs and physical therapists.

THE FINALIZED CODE (G2012):

"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 G2012. CMS believes that through the check-ins, practitioners would be able to mitigate the need for potentially unnecessary office visits. After reviewing multiple public comments on the issue of informed consent, CMS decided to require verbal consent notated in the patient record because the beneficiary would be liable for sharing in the cost of the services, which necessitated the need to obtain consent to ensure they are aware of the cost. CMS did note that the virtual check-ins could be used as part of a treatment regimen for opioid use disorders and other SUDs to assess whether the patient's condition requires an office visit.

Although CMS is not instituting any frequency limitations on the service, the have limited it to only established patients, partially as a response to MedPAC's concerns regarding an increase in utilization that is not related to ongoing, informed patient care. CMS also states that they will monitor utilization and make future adjustments as necessary.

THE BOTTOM LINE:

How Much: $15.00
What: Virtual Check-Ins
Who: Practitioners who furnish E/M services
Established patients
How: Providers virtually connect with patients in real-time to determine if patient needs to be seen in person
How Often: No limit
How Long: 5-10 minutes

REMOTE EVALUATION OF PRE-RECORDED PATIENT INFO e.g. ASYNCHRONOUS VISITS

CMS finalized a new code to describe remote professional evaluation of patient-transmitted information conducted via pre-recorded "store and forward" video or image technology. These services are not 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.

THE FINALIZED CODE *(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."

In the final rule, CMS clarified that the follow-up within 24 hours that is referenced in the CPT code, could take place via phone, audio/video communication, text messaging, email, or patient portal communication. As is the case for the virutal 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 finalized their valuation of the code to be consistent with CPT code 93793, which in 2018 paid $12.24. CMS notes that this would be distinct from the brief communication technology-based service described earlier, 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. Like the virtual check-ins, reimbursement for remote evaluation will only be available for existing patients and providers will need to obtain verbal or written consent (to ensure they are aware of the cost sharing involved), which can include electronic confirmation that is noted in the patient's medical record for each billed service.

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 has finalized their proposal to allow RHCs and FQHCs to receive payment for communication technology-based services or remote evaluation services when at least 5 minutes of communications-basedtechnology or remote evaluation services are furnished by a RHC or FQHC practitioner to a patient that has been seen in the RHC or FQHC within the previous year. CMS finalized the creation of a new Virtual Communications G0071 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 G2012 for communication technology-based services, and HCPCS code G2010 for remote evaluation services. They also have waived the RHC and FQHC face-to-face requirements for these services.

THE BOTTOM LINE:

How Much: $13.00

What: Asynchronous Visits

Who: Practitioners who furnish E/M services
Established patients

How: Providers review patient-provided material to determine if patient needs to be seen in person

How Often: No limit

How Long: At least 5 minutes

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INTERPROFESSIONAL INTERNET CONSULTATION

Reimbursement for interprofessional internet consultation codes have also been finalized by CMS, which covers consultations between professionals performed via communications technology such as telephone or Internet. This supports a team-based approach to care that is often facilitated by electronic medical record technology.

THE FINALIZED CODE (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 or requesting physician or other qualified health care professional; 5-31 minutes of medical consultative discussion and review (depending on code)."

THE FINALIZED CODE (99452):

"Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional; 30 minutes."

THE FINALIZED CODE (99451):

"Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient's treating or requesting physician or other qualified health care professional; 5 or more minutes of medical consultative time."

Providers are required to obtain verbal consent, which would include making the patient aware of any cost sharing that may be applicable (since the patient would not be present while the service is taking place), in advance of the services, and document the consent in the patient medical record. These codes are limited to only practitioners that can independently bill Medicare for E/M visits.

THE BOTTOM LINE:

How Much: $18 - $73

What: Provider-to-Provider Consultation

Who: Practitioners who furnish E/M services
Oftentimes Specialists

How: Providers virtually connect to discuss the needs and care of a specific patient

How Often: No limit

How Long: 5-31+ minutes

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MEDICARE TELEHEALTH SERVICES e.g. VIDEO VISITS

While the services previously listed (Brief Communications Technology-Based Services, Remote Evaluation of Pre-Recorded Patient Info, and Interprofessional Internet Consultations) are health services delivered using technology, they are not considered "Telehealth" by Medicare, instead they are referred to as "Virtual Medicine." As such, they are not subject to the same geographical restrictions that Medicare places on the formal Telehealth services, listed below.

	RESTRICTION	DETAILS
Originating Site	*Patients must go to a qualified site in a rural or underserved geographic area to receive telehealth services.*	*Physician and practitioner offices, Hospitals, Critical Access Hospitals, Rural Health Clinics, FQHCs, Renal Dialysis Centers, Skilled Nursing Facilities, Community Mental Health Centers, Renal Dialysis Facilities, etc.*
Qualified Providers	*Practitioners must hold a qualified license to furnish and get payment for covered telehealth services.*	*Physicians, Nurse practitioners, Physician assistants, Nurse-midwives, Clinical nurse specialists, Certified registered nurse anesthetists, Clinical psychologists, Clinical social workers, Registered dietitians or nutrition professionals*
Methods	*Practitioners must use an interactive audiovisual telecommunications system to provide telehealth services.*	*Telehealth services must utilize a tool that provides two-way, real-time audio and visual interaction between patient and provider, but not a telephone. The telecommunications system must leverage a HIPAA-compliant platform.*

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 post a significant benefit for the patient. For the CY 2019 PFS, CMS has finalized two requests from commenters to add new codes on a Category 1 basis:

THE FINALIZED CODES *(G0513 and G0514):*

"Prolonged preventative 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 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 will be reimbursed under other sections that would not make them subject to all the restrictions Medicare places on telehealth.

THE BOTTOM LINE:

How Much: $21-$69

What: Prolonged Preventative Services

Who: Practitioners who furnish E/M services Medicare Patients regardless of location

How: Providers virtually connect with patients needs and care of a specific patient

How Often: No limit

How Long: 30-31+ minutes

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