New Medicare Payments for Virtual Services
Effective January 1, 2019

Editor’s Note: You may also be interested in:

On November 1, 2018, the Centers for Medicare & Medicaid Services (CMS) published the 2019 Medicare Physician Fee Schedule Final Rule, which includes a significant expansion of Medicare reimbursement for virtual (non-face-to-face) services furnished by physician practices.

In the Final Rule, CMS noted “[i]n recent years, we have sought to recognize significant changes in healthcare practice, especially innovations in the active management and ongoing care of chronically ill patients. . . .” However, CMS’ efforts to promote these innovations have been limited by its interpretation of the statutory restrictions on Medicare reimbursement for telehealth services.

While CMS previously interpreted the geographic and site-of-service restrictions found in Section 1834(m) of the Social Security Act as applying to any virtual service, CMS now recognizes that these rules apply only “to a discrete set of physicians’ services that ordinarily involve, and are defined, coded, and paid for as if they were furnished during an in-person encounter between a patient and a healthcare professional.” By contrast, “services that are defined by, and inherently involve the use of, communication technology” are not subject to the Section 1834(m) restrictions. In making this distinction, CMS opened the door to new payment for remote patient monitoring (RPM), virtual check-ins, and interprofessional internet consultations.

Remote Patient Monitoring

In 2018, CMS began reimbursing for RPM under CPT® 99091[1] as a placeholder until the CPT® Editorial Panel finalized new codes. For 2019, CMS will reimburse for RPM under these new codes (in addition to CPT® 99091):

**CPT® 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® 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® 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.

The first two codes are reimbursement for the practice expense associated with furnishing RPM services; no physician work is required to bill for either code. The reimbursement for CPT® 99453 is approximately $21, $69 for CPT® 99454, and $54 for CPT® 99457. Remember that RPM may be billed for the same patient in the same month as chronic care management services, provided the time spent for CPT® 99457 is in addition to (and not the same as) the time spent for CPT® 99490, 99487, or 99489.

In the Final Rule, CMS summarized the numerous comments it received regarding the new RPM codes, including requests for clarification about the types of technology that meet the requirements for RPM. In response, CMS stated plans “to issue guidance to help inform practitioners and stakeholders on these issues.” CMS offered no timeframe for the publication of such guidance. Without this guidance, providers likely will be unwilling to make investments in RPM programs.

**Virtual Check-Ins**

Historically, CMS has not made separate payment to physicians for patient telephone calls that evaluate whether an office visit or other service is warranted. If the physician decides to see the patient, CMS considers the check-in as bundled into the payment for the resulting visit. If, however, the check-in does not lead to an office visit, the physician goes without payment for the time and effort associated with the call.

Earlier this year, CMS acknowledged the problems this reimbursement model creates:

> 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. 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. Given the evolving technological landscape, we believe this creates incentives that are inconsistent with current trends in medical practice and potentially undermines payment accuracy.

In an effort to address these misaligned incentives, CMS now will pay for virtual check-ins under HCPCS G2012. The reimbursable service is narrowly defined:

> Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified healthcare professional who can report evaluation and management [E/M] 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.

CMS set the reimbursement for this service at approximately $15, citing “low work time and intensity.” For now, there are no frequency limits on this service, although CMS noted it may impose such limits if it detects overutilization.

In the Final Rule, CMS clarified “that telephone calls that involve only clinical staff [cannot] be billed
using HCPCS G2012, since the code explicitly describes (and requires) direct interaction between the patient and the billing practitioner.” Also, CMS elected to require “verbal consent that is noted in the medical record for each billed service” and to limit eligibility to established patients. In addition to reimbursement for synchronous communication, CMS will also pay for—under another new code, HCPCS G2010—remote evaluation of patient-submitted recorded video and/or images. This reimbursable service also is narrowly defined:

Remote evaluation of recorded video and/or images submitted by the patient (e.g., store and forward), including interpretation with 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.

CMS clarified that follow-up may take place “via any mode of communication, including secure text messaging, phone call, or live/asynchronous video chat, so as not to restrict a clinician’s interaction with patients.”

Reimbursement for this service is approximately $13. Again, the provider must document the beneficiary’s consent in the record (regardless of whether such consent is provided verbally, in writing, or by electronic confirmation) and eligibility is limited to established patients.

CMS also created a new HCPCS G0071 for virtual communication services furnished by a rural health clinic (RHC) or federally qualified health center (FQHC). Specifically, an RHC or FQHC may receive reimbursement for “at least 5 minutes of communication technology-based or remote evaluation services” furnished for a patient who has had an RHC or FQHC billable visit within the last year. This service is subject to the same limitations as HCPCS G2012 and G2010 with regard to prior and subsequent in-person visits. Payment for HCPCS G0071 is set at the average of the national non-facility payment rates for HCPCS G2010 and G2012.

CMS expects usage of virtual check-ins will be limited at first, “result[ing] in fewer than 1 million visits in the first year. . . .” However, CMS predicts usage of these services “will eventually result in more than 19 million visits per year. . . .”

**Interprofessional Internet Consultation**

Because specialists receive no reimbursement for time spent consulting with treating practitioners regarding specific patients, specialist input often requires scheduling a separate patient visit when telephonic or internet-based interaction between the specialist and the treating practitioner would suffice. To address this, CMS will begin reimbursing for interprofessional consultations under six codes:

**CPT® 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/requesting physician or other qualified healthcare professional, 5 or more minutes of medical consultative time (reimbursement approximately $34).

**CPT® 99452:** Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified healthcare professional, 30 minutes (reimbursement approximately $34).
CPT® 99446: 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 healthcare professional; 5-10 minutes of medical consultative discussion and review (reimbursement approximately $18).

CPT® 99447: Same as CPT® 99446, except 11-20 minutes (reimbursement approximately $36).

CPT® 99448: Same as CPT® 99446, except 21–30 minutes (reimbursement approximately $54).

CPT® 99449: Same as CPT® 99446, except 31 or more minutes (reimbursement approximately $73).

Because these codes concern services furnished without the beneficiary present, CMS requires the treating practitioner to obtain and document verbal consent in the medical record. CMS notes such consent “includes ensuring that the patient is aware of applicable cost sharing.” Although it did not directly address the matter, it appears CMS expects the consultant to confirm such consent with the treating practitioner and make note of it in the consultant’s record.

Although the reimbursement for these virtual services is relatively small, many providers already are providing several of these services without any additional payment. The challenge, therefore, is to implement internal processes to capture the documentation needed to support the claim for reimbursement.

PYA assists organizations in developing these processes to receive the reimbursement to which they are entitled under CMS rules. For more information, contact one of our PYA executives below at (800) 270-9629.


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