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Telehealth Services Proposed for Medicare Part B Reimbursements, 2018: Fact Sheet

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Introduction

During the 115th Congress, several bipartisan bills[1] have been introduced that aim to expand the number of *telehealth* services that are covered under Medicare.[2] Telehealth is the electronic delivery of a health care service via a technological method.[3] Health care providers use telehealth to improve patients' access to and quality of care.[4] Under Medicare, these patients are likely to live in rural areas, be under the age of 65, and be disabled.[5]

The Centers for Medicare and Medicaid Services (CMS) administers the Medicare program and makes decisions on telehealth coverage and payment through its annual physician fee schedule rulemaking process.[6] On November 2, 2017, CMS issued a final rule on the calendar year (CY) 2018 Physician Fee Schedule;[7] however, CMS is still finalizing the list of telehealth services to add to the CY2018 list for Medicare reimbursement.[8] The information in this report is current as of November 15, 2017.

To assist Congress as it considers legislation related to expanding telehealth services, this fact sheet

- describes the five conditions that a telehealth service must meet to be covered and paid for under Medicare Part B,
- provides an overview of how the Secretary of the Department of Health and Human Services (HHS) adds telehealth services to Medicare's reimbursable list, and
- includes a table listing the proposed telehealth services to be added to the CY2018 list for Medicare reimbursement.

[1] Examples of bipartisan bills introduced to expand telehealth services under Medicare include the House-passed Medicare Part B Improvement Act of 2017 (H.R. 3178) and the Medicare Telehealth Parity Act of 2017 (H.R. 2550).

[2] See CRS In Focus IF10649, *Telehealth and Medicare*, by Victoria L. Elliott.

[3] Department of Health and Human Services, *Report to Congress: E-health and Telemedicine*, August 12, 2016, pp. 4-5, https://aspe.hhs.gov/system/files/pdf/206751/TelemedicineE-HealthReport.pdf.

[4] Medicare Payment Advisory Commission (MedPAC), *Report to Congress: Medicare and the Health Care Delivery System, Chapter 8 - Telehealth Services and the Medicare Program*, June 2016, http://www.medpac.gov/docs/default-source/reports/chapter-8-telehealth-services-and-the-medicare-program-june-2016-report-.pdf?sfvrsn=0.

[5] MedPAC, *Report to Congress: Medicare and the Health Care Delivery System - Fact Sheet*, June 2016, p. 6, http://www.medpac.gov/docs/default-source/fact-sheets/fact-sheet-on-medpac-s-june-2016-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf?sfvrsn=0.

[6] 42 C.F.R. §410.78(f).

[7] According to CMS, "a fee schedule is a complete listing of fees used by Medicare to pay doctors or other providers/suppliers." CMS, *Fee Schedules - General Information*, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index.html.

[8] CMS, *Final Policy, Payment, and Quality Provisions in the Medicare Physician Fee Schedule for Calendar Year 2018*, November 11, 2017, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-02.html; and CMS, "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program," 82 *Federal Register* 219, November 15, 2017.

Five Conditions for Telehealth Services

A telehealth service must meet all five conditions to be covered under Medicare Part B.[9]

Condition 1: the rendered service is on Medicare's list of covered telehealth services. Under Medicare, not every telehealth service rendered by a health care provider is covered. The Secretary of HHS has the authority to change which telehealth services are covered, and these may be changed annually.[10]

A telehealth service is designated by a Healthcare Common Procedure Coding System (HCPCS) code or a Current Procedural Terminology (CPT) code. CPT codes identify the medical services and procedures that are provided by healthcare providers.[11] A service, supply, or product that is not included within a CPT code is designated by a HCPCS code. As mandated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA; P.L. 104-191), these codes make up the standard coding system for Medicare and other health insurance reimbursements.[12]

Condition 2: the service is delivered via an *interactive telecommunication system*. According to CMS, an interactive telecommunication system is "multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner."[13] Four types of modalities are currently accepted for coverage under Medicare: (1) live video (synchronous), (2) store-and-forward technology (SFT), (3) remote patient monitoring (RPM), and (4) mobile health (mHealth). Each modality is described below.

1. **Live video (synchronous)** allows a provider to communicate with a patient, caregiver, and/or provider in real-time by video, with audio and visual capabilities.
2. **Store-and-forward technology (SFT)** allows a provider to transmit previously recorded videos, captured digital images, and other patient-related documentation to another provider. Store-and forward is reimbursable only during a federal demonstration program whereby the originating site is located in Alaska or Hawaii.[14]
3. **Remote patient monitoring (RPM)** allows a provider to manage a patient's chronic health condition or illness from afar, by collecting information such as the patient's blood pressure and heart rate.
4. **Mobile health (mHealth)** allows a provider to deliver health care services such as education materials through a mobile device.[15]

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[9] CMS, "Medicare Program; Revisions to Payment Policies and Five-Year Review of and Adjustments to the Relative Value Units Under the Physician Fee Schedule for Calendar Year 2002; Final Rule," 66 *Federal Register* 55246, November 1, 2001.

[10] Congress gave the Secretary of HHS authority to change which services are reimbursable under Medicare, under 42 C.F.R. §410.78(f).

[11] CMS, *HCPCS - General Information*, https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html.

[12] See CMS, *Telehealth Services*, November 2016, p. 6, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf.

[13] CMS, "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program," 82 *Federal Register* 219, November 15, 2017.

[14] 42 C.F.R. §410.78(a)(4).

[15] This list was summarized and adapted from HHS, *Report to Congress: E-health and Telemedicine*, August 12, 2016,

Condition 3: the service is provided by an authorized physician or practitioner. An authorized physician is defined as a doctor of medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, or optometry, or as a chiropractor who is legally authorized to perform such services by the state where the services are performed.[16] An authorized practitioner is defined as a physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, certified nurse-midwife, clinical social worker, clinical psychologist, or registered dietitian or nutrition professional.[17]

Condition 4: the service is provided to an eligible telehealth individual. An eligible telehealth individual is a Medicare Part B enrollee who received his or her telehealth service from an *originating site*.[18] An originating site is the place where a telehealth service is rendered to a Medicare beneficiary. The types of Medicare-eligible originating sites are listed below.[19]

- Physician or practitioner's office
- Rural health clinic
- Hospital
- Community mental health center
- Critical access hospital
- Federally qualified health center
- Skilled nursing facility
- Hospital-based or critical access hospital-based renal dialysis center

Condition 5: the eligible telehealth individual is located in a telehealth originating site in a county outside of a metropolitan statistical area (MSA) and/or in a rural health professional shortage area (HPSA).[20] An MSA is a densely populated area of at least 50,000 residents. An HPSA is a rural area that generally has a shortage of mental health, primary care, and dental providers.[21]

Process of Adding Services

CMS, through its physician fee rulemaking process, determines which telehealth services meet the conditions for coverage and payment under Medicare.[22] CMS determines whether a telehealth service qualifies for Medicare coverage by evaluating it against two categories. The first category designates a proposed telehealth service as being "similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services."[23] The proposed telehealth service is compared with existing services in relation, but not exclusively, to the telecommunication interaction between the patient and provider. The second category

p. 5, https://aspe.hhs.gov/system/files/pdf/206751/TelemedicineE-HealthReport.pdf.

[16] 42 U.S.C. §1395x(r).

[17] 42 C.F.R. §410.78(b)(2).

[18] CMS, "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program," 82 *Federal Register* 33970, July 21, 2017. See 42 C.F.R. §410.78(b)(4).

[19] C.F.R. §410.78(b)(3).

[20] The location of an originating site is based on its geographical location as defined on December 31 of the previous calendar year. See 42 C.F.R. §410.78(b)(4).

[21] See U.S. Census Bureau, *Metropolitan and Micropolitan: Glossary*, https://www.census.gov/programs-surveys/metro-micro/about/glossary.html; and HRSA, *Shortage Areas*, https://datawarehouse.hrsa.gov/topics/shortageAreas.aspx.

[22] 42 C.F.R. §410.78(f).

[23] Ibid.

designates a proposed telehealth service as being dissimilar to the current list of Medicare covered telehealth services. CMS determines whether the telehealth service provides a clinical benefit and whether its corresponding HCPCS or CPT code describes such service. The results of CMS's evaluation determine which telehealth services qualify for coverage and payment under Medicare.

This process is based on calendar year cycles. In each cycle, CMS allows the public to request and comment on proposed telehealth services to include for consideration on its Medicare coverage list. For the CY2018 cycle, the public submitted comments from July 13, 2017, to September 11, 2017.[24] The requests for telehealth services that CMS deems as "qualifying" in the CY2018 cycle will be discussed for rulemaking in the CY2020 cycle.[25]

Proposed CY2018 Telehealth Services

Table 1 lists some of the proposed telehealth services that the Secretary of HHS is finalizing to add as new covered services under Medicare.[26] These are some of the services that were requested during the CY2016 cycle. Other telehealth services may initiate a new separate Medicare payment such as for CPT code 99091. According to CMS, CPT code 99091 will be paid for by Medicare when the service includes the "collection and interpretation of physiologic data (e.g., [electrocardiogram], blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, for 2018 pending anticipated changes in CPT coding."[27] Currently, this is a bundled service.[28]

Table 1. Some Proposed CY2018 Telehealth Services for Medicare Reimbursement

Telehealth Service	HCPCS/CPT Code
Proposed Services to Add to the List	
Counseling visit to discuss need for lung cancer screening low-dose computed tomography (LDCT) scan	HCPCS code G0296
Comprehensive assessment of and care planning for patients requiring chronic care management services	HCPCS code G0506
Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation	CPT code 96160

[24] CMS, Proposed Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2018: Fact Sheet, July 13, 2017, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-07-13-2.html.

[25] CMS, "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program," 82 *Federal Register* 33970, July 21, 2017.

[26] CMS has proposed 96 telehealth services for Medicare reimbursement, for CY2018. See CMS, *CY2018 PFS Proposed List of Medicare Telehealth Services*, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/CY2018-PFS-NPRM-Telehealth.zip; and CMS, *Final Policy, Payment, and Quality Provisions in the Medicare Physician Fee Schedule for Calendar Year 2018*, November 11, 2017, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-02.html.

[27] Ibid.

[28] CMS, *Frequently Asked Questions about Physician Billing for Chronic Care Management Services*, January 18, 2017, p. 3, https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment_for_CCM_Services_FAQ.pdf.

Telehealth Service	HCPCS/CPT Code
Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation	CPT code 96161
Interactive complexity	CPT code 90785
Psychotherapy for crisis; first 60 minutes	CPT code 90839
Psychotherapy for crisis; each additional 30 minutes	CPT code 90840

Source: CRS prepared this table based on information from CMS, "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program," 82 *Federal Register* 33970, July 21, 2017; and CMS, "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program," 82 *Federal Register* 219, November 15, 2017.

Notes: HCPCS is the abbreviation of Healthcare Common Procedure Coding System; CPT is the abbreviation of Current Procedural Terminology. For the CY2017 list of covered telehealth services, see CMS, *Telehealth Services*, November 2016, pp. 3-5, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf.

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