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Telemedicine reimbursement challenges in 2018 and beyond

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Telemedicine has rapidly become a massively popular offering by leading healthcare organizations due to its potential to generate revenue and reach patients beyond the geographic footprint of the healthcare system. The rapid rise in telehealth services is most evident in those healthcare services for which it seems to be tailor made, such as mental health services and online second opinions. As providers become more accepting of leveraging technology, telemedicine has become a way for healthcare institutions to expand their reach and generate additional revenue.

Federal and state regulators, as well as commercial payers, have begun to further clarify how they reimburse for telehealth services. As more providers seek to provide telehealth services, compliance professionals should make sure they are familiar with the rules for reimbursement.

Medicare reimbursement for telemedicine

In response to the rapid rise of telemedicine, Health and Human Services Office of Inspector General (HHS OIG) has announced a major audit of the federal payments made for these services, with a report due in 2019.[1] HHS OIG describes its new telehealth review project as follows:

> Medicare Part B covers expenses for telehealth services on the telehealth list when those services are delivered via an interactive telecommunications system, provided certain conditions are met (42 CFR § 410.78(b)). To support rural access to care, Medicare pays for telehealth services provided through live, interactive videoconferencing between a beneficiary located at a rural originating site and a practitioner located at a distant site. An eligible originating site must be the practitioner's office or a specified medical facility, not a beneficiary's home or office. We will review Medicare claims paid for telehealth services provided at distant sites that do not have corresponding claims from originating sites to determine whether those services met Medicare requirements.[2]

In preparation for HHS OIG's increased attention to telemedicine, it is critical that compliance officers and their teams ensure they have created and implemented policies, procedures, and processes for compliance with the 42 CFR § 410.78(b).

Specifically, for providers who bill Medicare for telehealth services, compliance teams must ensure that written policies and procedures exist, and that these set forth the Medicare coverage requirements for telehealth services. For most services, Medicare will not reimburse for telehealth services unless all of the following five general requirements are met:

1. The beneficiary is located in a qualifying rural area at the time of the consult.
2. The beneficiary is located at an "originating site," which requires the patient to be located at one of the specifically designated facilities at the time of the consult.
3. The telehealth services are provided by a "distant site practitioner," who is a specifically designated professional deemed eligible to receive Medicare payment for telehealth services.
4. The beneficiary and distant site practitioner communicate via an interactive audio and video telecommunications system that permits real-time communication between the beneficiary and the distant site provider.
5. The CPT/HCPCS code for the service being provided is named on the current year list of covered Medicare telehealth services.[3] ,[4]

The patient must be located at a specific rural site defined as a Health Care Professional Shortage Area and cannot be located at home. This effectively means that urban hospitals cannot provide telehealth services to Medicare patients. Please note you can look up whether you are eligible for Medicare coverage of telehealth services via the web site at http://bit.ly/2JsxxBP.

However, compliance professionals should also be aware that the Centers for Medicare & Medicaid Services (CMS) is beginning to recognize that these strict rules for reimbursement should be loosened. With the Bipartisan Budget Act of 2018 (Budget Act), Congress has given clues that it may loosen the geographic and facility-type restrictions for certain types of services effective January 1, 2019.

Telestroke services

Pursuant to Section 50325 of the Budget Act, beginning January 1, 2019, the geographic requirements will no longer apply, and the facility-type requirements were altered for the purposes of diagnosis, evaluation, or treatment of the symptoms of acute stroke. Specifically, telemedicine services may be delivered without a geographic limitation at sites which HHS will define at a later time, and could include a patient's home.

Dialysis services

Section 50302 of the Budget Act changes the geographic and facility-type requirements for dialysis services provided to patients located at home or in independent dialysis facilities. Patients with end-stage renal disease who receive home dialysis may conduct physician visits via telehealth from their home, although the patient must receive in-person visits at least once a month during the first three months of home dialysis, and then at least once every three months thereafter.

Medicare Advantage Plans

Section 50323 of the Budget Act provides that Medicare Advantage Plans will be allowed to offer telehealth services as part of their basic benefit package. At the time of writing, it is unclear what types of services will qualify, but it could be that the plans allow for telehealth services to be delivered at home rather than in a facility, and outside of a rural geographic area. The change to Medicare Advantage Plans will not go into effect until 2020.

Medicare Shared Savings Program

Also starting in 2020, pursuant to the Budget Act, providers participating in certain Accountable Care

Organizations (ACOs) will be able to offer telehealth services to patients in their homes. Like the Medicare Advantage Plans, the types of services available have not been decided yet. These changes will: (1) eliminate the rural geographic originating site requirement, and (2) allow beneficiaries of certain ACOs to receive certain telehealth services in the home. The ACO providers will only be allowed to deliver telehealth services as set forth in Medicare's physician fee schedule.

With respect to the changes in Medicare requirements that may allow telemedicine to be delivered in the home, it is important to note that only physician fees will be reimbursable. This makes sense when you consider that patients receiving services in their home will not be located in a facility where fees could be charged.