



Re: Proposed CY 2014 Physician Fee Schedule

Impacts Telehealth Services

By: Clinton R. Mikel

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eHealth, Privacy & Security Interest Group

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Yesterday, CMS released a pre-publication proposed rule, [Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule and Other Revisions to Part B for CY 2014 \(2013-16547\)](#) (the "Proposed Rule").

Among other topics of interest to the eHealth IG, including proposed revisions to the EHR Incentive Program, the Proposed Rule contained significant proposed revisions related to Telehealth Services.

Expands/Clarifies Eligible "Originating Site" Locations

By way of brief background, in order to be reimbursed for certain enumerated Telehealth Services by Medicare, providers must meet the primary requirements contained at 42 C.F.R. §410.78 (Telehealth Services). In short summation, these requirements include:

- ***Must use a real time, interactive telecommunications system***
- ***Must be at an eligible "Originating Site" (e.g., remote location where patient presents)***
 - The location where the patient presents must be a: (1) physician office; (2) a hospital (inpatient or outpatient or critical access hospital); (3) a rural health clinic; (4) a federally qualified health center (FQHC); (5) a hospital-based or critical access hospital-based renal dialysis center (including satellites); (6) a skilled nursing facility; or (7) a community mental health center.
 - The location where the patient presents must also be in either a:
 - Rural health professional shortage area (HPSA);
 - A non-Metropolitan Statistical Area (MSA) county; or
 - Entities participating in a Federal telemedicine demonstration project that have been approved by, or receive funding from, the Secretary as of December 31, 2000, qualify as an eligible originating site regardless of geographic location.
 - ***There is no limitation on the location of the physician delivering the remote medical service***
- ***Must be an eligible practitioner***

In particular, the geographic/location requirements of the "Originating Site" definition

have been a primary limiter of Medicare's telehealth reimbursement. Further, the "rural" modifier for the HPSA location criteria has caused practitioners and telehealth providers difficulties. Without going into depth, in the early 2000's, unrelated to Medicare telemedicine reimbursement, HRSA eliminated the "rural HPSA" category, and only continued designating other types of HPSAs. Since then, there has been debate, and conflicting CMS/MAC interpretations, sometimes varying from MAC-to-MAC and entity-to-entity, as to whether reimbursement was proper if the Originating Site was in a mere HPSA. Some, including CMS (non-publicly and inconsistently), took the position that reimbursement was only proper in a non-MSA. This limited interpretation would have the perverse result of making many places that would logically be considered both remote and underserved ineligible for Medicare telehealth reimbursement.

Others believed that this was an overreach since the BBA (Balanced Budget Act of 1997 (Pub. L. 105-33) statutorily included the rural HPSA eligible location *in addition* to the non-MSA eligible location; hence, CMS/HRSA could not unilaterally drop the rural HPSA classification and thereby narrow the potential location-base for telehealth reimbursement. This interpretation was borne out by various MACs' reimbursement policies and informal positions taken by CMS (again, non-publicly and inconsistently, but further evidenced by their reluctance to drop the rural HPSA as an alternative geographic enabler from the actual telehealth reimbursement regulations), whereby they would reimburse for reimbursable telehealth services in an area if it was designated as a HPSA location (regardless of the type of HPSA classification).

Thankfully, in the Proposed Rule, CMS has attempted to bring clarity to this subject, in a manner that clearly expands the potential geographic area for a facility to be considered an "Originating Site". The Proposed Rule, in addition to retaining the non-MSA county eligibility for telehealth reimbursement, proposes that an Originating Site can also be:

- Located in a HPSA (any type) that is either:
 - Outside of a MSA; or
 - Within a rural census tract of an MSA as determined by the Office of Rural Health Policy (ORHP) of HRSA.
 - E.g., utilizing rural-urban commuting area (RUCA) codes (<http://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.aspx#.UdxUEUHVDw9>), with a "rural census tract" being defined as having a value of 4-10 on the 10 point RUCA scale, or having a 2 or 3 RUCA value that is also at least 400 square miles and has a population density of less than 35 people per square mile.

CMS has also proposed that the determination be made based on the Originating Sites' designation as of December 31 of the prior year, so as to avoid mid-year interruptions in service if a location is re-classified.

Anyone providing telehealth services, or running telehealth delivery networks, should evaluate their current geographic footprint to determine whether their "Originating Site" locations will meet the newly proposed RUCA based geographic requirements for Medicare billing purposes. Further, telehealth providers/networks should evaluate what further strategic opportunities may be available to them vis-à-vis the proposed expanded/clarified geographic requirements.

Expands and Clarifies Billable Services

The Proposed Rule would also expand Medicare reimbursable telehealth services to include "transitional care management services". Though not defined in the Proposed

Rules' regulatory text changes to 42 C.F.R. § 414.65 (Payment for Telehealth Services), the commentary in the Proposed Rule defines "transitional care management services" as:

- CPT Code 99495
 - Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of at least moderate complexity during the service period **face-to-face visit**, within 14 calendar days of discharge; and
- CPT Code 99496
 - Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of high complexity during the service period **face-to-face visit**, within 7 calendar days of discharge.

These services are for a patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, longterm acute care hospital), partial hospitalization, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domiciliary, rest home, or assisted living). Transitional care management is comprised of **one face-to-face visit** within the specified time frames following a discharge, in combination with non-face-to-face services that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his or her direction.

CMS's Proposed Rule would allow the face-to-face visit component of 99496 and 99495 to be delivered via telehealth (and, of course, the other service components of the CPT code can be made via non-telehealth communication).

The Proposed Rule also makes technical corrections to 42 C.F.R. § 414.65 (Payment for Telehealth Services) to more closely align it to the similar list of permissible telehealth services at 42 C.F.R. § 410.78 and current telehealth reimbursement policies as reflected in CMS manuals.

Denies Two ATA Requests to Expand Billable Services

The American Telemedicine Association ("**ATA**") had made two requests which CMS denied in the Proposed Rule:

- Requested that CMS add online assessment and E/M services as Medicare telehealth services
 - Denied primarily because the services are currently not covered, regardless of whether they are delivered via telehealth or other means; and
- Remove telehealth frequency limitations for subsequent nursing facility services reported by CPT codes 99307 through 99310
 - Denied primarily because CMS did not find ATA's evidence persuasive and because they believed that periodic in-person, hands-on visits may be appropriate to manage complex care cases.

Comment Period

To be assured consideration, comments must be received no later than 5 p.m. on Tuesday, September 17, 2013.

**We would like to thank Clinton R. Mikel, Esq. (The Health Law Partners, P.C., Michigan Office), for authoring this email alert.*

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 - ***Speaker/Topic TBD*** - free member benefit
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