

CY 2017 Final Fee Schedule

November 2016

Introduction

On November 2, 2016, the Center for Medicare and Medicaid Services (CMS) published their finalized CY 2017 Physicians Fee Schedule (PFS). The final rule includes the addition of several codes for reimbursement regarding end-stage renal disease related services for dialysis; advance care planning; and critical care consultations furnished via telehealth using new Medicare G-codes. CMS has also a new policy related to the use of a place of service (POS) code specifically designated to report services furnished via telehealth, and added new chronic care management (CCM) codes.

Additional Codes

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 pose a significant benefit for the patient. For the FY 2017, CMS has chosen to add the following CPT Codes to the list of eligible Medicare telehealth services on a Category 1 basis:

- 90967-90970: End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day. The proposed fee schedule notes that there is a required clinical examination of the catheter access site which must be furnished face-to-face “hands on”.
- 99497-99498: Advance care planning including the explanation and discussion of advance directives such as standard forms, by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), or surrogate.

Analysis

The addition of the ESRD and advance care planning codes to CMS’ telehealth approved list of telehealth reimbursable services are still subject to the same geographic and other statutory restrictions that apply to all telehealth services in Medicare.

Creation of Code

CMS created new codes in the CY 2017 PFS to adequately reflect the resource costs of providing critical care consultation services remotely to critically ill patients. They will make payments through new codes (G0508 and G0509) for initial and subsequent services, used to specifically describe critical care consultations furnished via telehealth.

These services will be limited to once per day per patient. These codes, like all of the codes Medicare currently covers via telehealth would be subject to the same geographic and other statutory restrictions that apply to telehealth services.

Analysis

The creation of the critical care codes comes after several years of requesting inclusion of critical care evaluation and management codes for reimbursement if the service was provided via telehealth. Each year, those requests have been denied because CMS found that there is “no evidence suggesting that the use of telehealth could be a reasonable surrogate for the face-to-face delivery of this type of care.” However, CMS did find that several studies showed some critical care services provided via telehealth had clinical benefit but did not fall under the current critical care E/M codes. Additionally, CMS recognized that there may be greater resource costs in providing these services that would not be covered under currently existing telehealth consultation codes. The creation of the critical care consultation services codes specific to telehealth may set a precedent for CMS and others such as the American Medical Association (AMA) to create additional telehealth specific codes that more adequately reflect the value of some of the unique elements involved in a telehealth encounter. However, while it is a recognition that current codes may not be adequate to reflect telehealth delivered services, creation of new codes may also serve to separate out telehealth as a distinct service rather than as a tool to deliver a service.

Place of Service (POS)

Currently, providers report the POS code of the originating site for telehealth services. CMS has adopted a new telehealth specific POS code (02), that starting January 1, 2017, will be used by providers at the distant site to indicate that the service took place via telehealth. CMS indicates that it is their hope the new POS code will help “track telehealth utilization and spending”. CMS also indicated that since the new POS code would serve to identify telehealth services under 1834(m) of the Social Security Act, they believe that they should consider eliminating the required use of GT and GQ telehealth modifiers, and will revisit this question through future rulemaking. They will use the facility PE RVUs to pay for the telehealth services reported by physicians or practitioners with the telehealth POS code. CMS does not anticipate that this will result in a significant change in the total payment for the majority of services on the telehealth list. But they also state that they will consider the concerns and monitor telehealth utilization, and welcome information from stakeholders regarding any potential unintended consequences of the payment rate. The POS code would not apply to originating sites billing the facility fee.

Regulatory changes consistent with this include:

- Change to regulation Section 414.22(b)(5)(i)(A) addressing the PE RVUs – amends section to specify that the facility PE RVUs are paid for practitioner services furnished via telehealth under 410.78.
- Delete Section 414.32 that refers to the calculating of payment for certain services prior to 2002.

Analysis

As CMS notes in their discussion on the proposed telehealth specific POS code, many providers are currently confused about the correct POS code (originating or distant site) to use when they are billing for a telehealth service. CMS believes the use of this new telehealth POS code, which will utilize the facility PE RVUs, would improve payment accuracy and submission claims. The addition of this new code would be an adjustment for telehealth providers and may generate additional confusion.

Chronic Care Management Codes

In the CY 2015 PFS CMS approved non-face-to-face chronic care management code 99490, which includes at least 20 minutes of clinical staff time directed by a physician or other qualified health professional, per calendar month for beneficiaries with multiple chronic conditions that meet specific criteria specified by CMS. Some of the non-face-to-face activities that fall under this code, could potentially include telehealth elements. In the CY 2017 finalized PFS, CMS added CCM CPT codes 99487 and 99489 for complex CCM services. CMS also finalized several changes to the scope of services included under the CCM codes, including elements under the following areas:

- The initial visit
- 24/7 access to care and continuity of care
- Format and sharing of the care plan and clinical summaries
- Beneficiary receipts of the care plan
- Beneficiary consent and documentation

For a complete overview of the scope of services included under CCM codes, see Table 11, located on page 311 of the finalized CY 2017 PFS.¹

Analysis

Although some view the non-face to-face CCM codes as providing an opening for the reimbursement of virtual and asynchronous remote monitoring of chronic conditions, telehealth is not directly referenced in any of the descriptions. By not defining it as a “telehealth” service, however, it does allow the CCM codes to not be subject to the restrictions other telehealth services currently face, such as geographic and location limitations and prohibitions on the use of asynchronous technology in most cases.

¹“CY 2017 PFS.” Department of Health and Human Services. Nov 2016. < https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-26668.pdf?utm_source=Telehealth+Enthusiasts&utm_campaign=2d7865f7a9-EMAIL_CAMPAIGN_2016_11_08&utm_medium=email&utm_term=0_ae00b0e89a-2d7865f7a9-267651241>