

# Navigating the Complexities of Telehealth Reimbursement

For providers building a telehealth business plan, understanding the financial and clinical benefits requires more than looking around to see how others are getting paid. With complicated federal guidelines, ever-changing rules on the state level, and a private payer market that's ready to innovate, the best bet is to create a program that meets your specific goals for leveraging technology to improve patient satisfaction and outcomes, both for your patients and your practice.

That's the opinion of Thomas "T.J." Ferrante, senior counsel for the Foley & Lardner law firm who handles transactional and related regulatory issues for healthcare clients. In a recent [mHealthIntelligence webcast](#), Ferrante outlined an evolving telehealth landscape that (in spite of its complexity) offers hospitals, health systems, and ambulatory providers an avenue to sustainability if they plan properly.

## **NOT A ONE-SIZE-FITS-ALL SORT OF PAYMENT STRATEGY**

"There really isn't a one-size-fits-all sort of payment strategy, and that just because, let's say, you're complying with Medicare rules, (that) doesn't mean you're going to be compliant with Medicaid, or with your commercial payers, or at your other local state-level rules," he said. "So, you're going to have to have a multifaceted payment strategy approach as you tap into other things."

That includes looking beyond reimbursement when planning a business strategy. "Sometimes we get so singularly focused on the 'reimbursement' that we forget about the other opportunities," Ferrante said.

"And because of that, I'm not a big fan of the term reimbursement, particularly in the telehealth context because at least to me, I think that word can connote government-paid-for fee-for-service methodologies alone," he continued. "And anyone espousing alternative payment models or value-based care would agree that while your fee-for-service strategy from the government isn't going away, entirely or anytime soon, it is more of an antiquated program. And we're seeing a lot of pushback in the industry at a number of different levels."

That said, Ferrante outlined a list of payment sources for telehealth programs that begins with Medicare, then filters down to include Medicaid, Medicaid

Managed Care, and Medicare Advantage programs, the commercial insurance industry (including employer-based health plans) and the self-payment market, which includes retail services.

## **MEDICARE COVERAGE AND CHANGES**

At the top is Medicare, still primarily fee-for-service and restrictive in how it allows providers to use telehealth and mHealth.

"Medicare does cover telehealth services, but the patient must be in a qualifying originating site, in a healthcare professional shortage area, or outside of a metropolitan statistical area," Ferrante said.

"That originating site also basically needs to be a medical facility. So it certainly can't be the patient's home," he added. "And at the same time, the technology that can be used can only be your real-time audio-video or synchronous communications, unless you're in Alaska or Hawaii, which have demonstration programs for store-and-forward. Moreover, there's a limited set of covered services. And then finally, the service must be one of the new Meridian CPT or HCPCS codes released every year."

As a result, Ferrante pointed out that Medicare isn't paying a lot of money to hospitals and health systems to use telehealth. But providers are starting to object, and they're getting help from —of all places— Congress.

As part of the bipartisan Budget Act of 2018, the geographic and facility type requirements for telestroke coverage were eliminated, giving providers more leeway to use those services in different locations and urban as well as rural regions. In addition, Medicare expanded coverage for dialysis services to include telehealth platforms run out of the home or independently-run dialysis facilities, as long as the provider meets specific guidelines for in-person check-ups.

In the coming year, the Centers for Medicare & Medicaid Services will change how they cover telehealth in Medicare Advantage plans, by switching connected health services from a supplemental benefit to an essential benefit. In addition, CMS is waiving the originating site requirement for accountable care organizations, opening the door for ACOs to use—and be reimbursed for—telehealth

programs delivered to the patient's home. "That's another big win for ACOs," he said.

With the passage of the SUPPORT Act, Medicare will also now cover telehealth services used in opioid abuse treatment and co-occurring mental health treatment delivered to the home or other remote locations, like a clinic or health center.

Finally, CMS has introduced three new CPT codes to the 2020 Medicare Physician Fee Schedule, allowing providers more opportunities to be reimbursed for the use of telehealth in substance abuse treatment. Those codes will also go into effect beginning next year, pending their inclusion in a final draft due out in November.

Ferrante did note that he was surprised that telehealth advocates didn't ask CMS to add more codes this year.

"CMS made the comment that they didn't receive any requests for new codes from the industry, which is very surprising," he said. "So typically, early in the year - January, February - industry stakeholders usually will submit some proposals for new codes (to CMS). For whatever reason, that didn't happen this year."

Beyond these changes, CMS is altering how it defines telehealth.

Bearing in mind that most changes need Congressional approval and Washington's appetite for wholesale change isn't that good, CMS has been pushing incremental changes to its telehealth rules and carving out a new area called communication technology-based services. These services aren't inherently face-to-face services and can be asynchronous rather than real-time, such as mHealth or remote patient monitoring.

"Instead, CMS is taking the position that they can separately reimburse for these services using new codes under the physician fee schedule," he said. "So it's a little bit of legal gymnastics, but I think it's obviously a very positive move for the virtual care industry."

Those changes include new and revised codes for virtual check-ins, asynchronous remote evaluation, peer-to-peer evaluations, and care management services. They also require patient consent in advance to using these services, though CMS is mulling whether patients should be allowed to give consent once for all these services or give consent before each and every service.

Under what Ferrante calls care management codes, CMS has gathered together reimbursement guidelines for what are commonly known as transitional care management, chronic care management, principal care management, and remote patient monitoring services.

Each of these categories comes with several new or revised codes designed to help providers improve care management for patients once they've left the hospital or doctor's office, and they offer more opportunities to use mHealth and telehealth technologies.

For transitional care management, which covers treatment up to 30 days after a patient is discharged from a hospital, CMS is fine-tuning the 57 codes associated with those services. For chronic care management, the federal agency is reworking how services are rendered for non-complex and complex patients.

For principal care management, a new service identified in the physician fee schedule, CMS is creating a new code to cover care management for patients with one serious chronic condition.

"In the rule, CMS stated they expect most of these services would be built by specialists who are focused on managing patients with a single complex chronic condition that still did require substantial care management," Ferrante pointed out. "And that in most instances, the PCM services would be billed when a single condition is of such complexity that it couldn't be managed as effectively in just a primary care setting. So that's why they think it'll be used quite a bit by specialists."

Finally, there's remote patient monitoring. CMS first identified RPM as a service in 2018, and they did so by unbundling a 16-year-old CPT code to cover a range of mHealth services. Now, the agency has introduced three new codes to replace the antiquated CPT code 99091 and give providers a better chance of securing coverage.

### **MEDICAID PLANS, EACH DIFFERENT IN HOW THEY COVER TELEHEALTH AND mHEALTH**

Beyond all the changes associated with Medicare coverage, there's a puzzling network of state Medicaid plans, each different in how they cover telehealth and mHealth. According to Ferrante (who referenced work done by the Center for Connected Health Policy), every state now provides coverage for real-time audio-video telemedicine services, and 21 states are now covering remote patient monitoring—

but only 11 are covering asynchronous (store-and-forward) telehealth.

Fourteen states now allow the home as an eligible site for telehealth in Medicaid programs. He expects that to increase, as states come to terms with the fact that transportation costs are an important factor in determining healthcare access.

As examples, Ferrante highlighted legislative action taken by three states.

In Wisconsin, a bill making its way through the legislature would not only establish payment and coverage parity for telehealth but would also expand covered modalities to include store-and-forward and RPM and essentially allow telehealth to be provided anywhere, including the home.

In California, new guidelines expand the treatment modalities to include store-and-forward telehealth, but no mention is made of RPM. And in New Hampshire, RPM and store-and-forward are now covered and the patient's home can be an originating site for telehealth, but primary care is restricted to virtual visits and RPM and substance abuse treatment are only covered after an in-person visit.

#### **STATE MANDATES FOR PRIVATE PAYERS AND INCLUDES REMOTE PATIENT MONITORING**

For private payers, roughly 40 states and the District of Columbia now mandate some sort of telehealth coverage. Some mandate that payers cover the same services that are offered in person, while others mandate that telehealth payments be at the same rate as in-person rates.

For examples, Ferrante pointed out that Florida passed legislation this year that “kind of clarifies that contracts signed by insurers with telehealth providers be voluntary, and that have mutually acceptable rates, and that the telehealth provider has to initial any contract provision that would cause telehealth reimbursement to be different than reimbursement for the same services provided in-person—so it really doesn't do anything.”

Georgia and Maine, meanwhile, have passed legislation that expands private payer coverage for some telehealth services.

Finally, Ferrante noted that states are paying more attention to RPM.

“The reason states have started to do this is because RPM by definition is a virtual, distance-based service,” he said.

“And so it really doesn't have an in-person equivalent that would likely already be found in a member's benefit package. So, for example, if the bill or your law reads, ‘Health plans must cover services provided via telehealth to the same extent those services are covered and provided in-person,’ then the language of that law could create an unintended gap or a coverage gap, which would omit RPM, again, because many health plans don't have a coverage of an in-person equivalent to RPM.”

The end-result is states drafting follow-up bills to provide further clarification.

“And so some states have enacted follow-up legislation to expressly expand the scope of the covered telehealth services, even after enacting, at first, a telehealth coverage statute,” he added. “And today there are about 14 states that have done this or have at least expressly have a law that expressly covers RPM. The ones that were recently passed this year were in New Hampshire and Virginia.”

In conclusion, Ferrante noted that telehealth payment laws are complex and, in many cases, overlapping. In some cases, Medicaid programs and private payers are denying telehealth claims or debating paying them. He doesn't recommend just filing a claim to “see what happens,” because that could lead to an audit or federal action.

“Be thoughtful in your revenue strategy,” he concluded, “because there are solutions and strategies that can be implemented to make your program generate revenue to ensure it's sustainable, robust, and scalable.”

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