Medicare Remote Patient Monitoring & Telehealth Reimbursement Opportunities

January 25, 2018
AGENDA

- Introduction to the Alliance for Connected Care
- Previous remote monitoring regulatory framework
- New developments in RPM reimbursement
- New developments in telehealth
ALLIANCE ADVISORY BOARD

- Alliance for Aging Research
- Alzheimer’s Foundation of America
- American Academy of Family Physicians
- American Nurses Association
- American Academy of Physician Assistants
- American Heart Association
- American Language-Speech-Hearing Association
- American Osteopathic Association
- Association for Behavioral Health and Wellness
- Children’s Mercy Hospitals and Clinics
- Digestive Disease National Coalition
- Evangelical Lutheran Good Samaritan Society
- Infectious Diseases Society of America
- HealthCare Chaplaincy Network
- Indiana University Health
- Mental Health America
- National Alliance on Mental Illness
- National Association of ACOs
- National Association of Chain Drug Stores
- National Association of Homecare & Hospice
- National Council for Behavioral Health
- National Council of State Boards of Nursing
- National Health IT Collaborative for the Underserved
- National Multiple Sclerosis Society
- National Organization for Rare Disorders
- Parkinson’s Action Network
- Population Health Alliance
- Stanford Health Care
- United Spinal Association
- Visiting Nurse Associations of America
DEFINITIONS

Telemedicine is umbrella term for tools that enable clinicians to reach and engage patients outside of institutional settings, expand access to care, improve population health management and increase care coordination.

Remote Patient Monitoring is asynchronous monitoring of patient biometric data.

Telehealth is a real-time virtual visit between a provider and a patient, mainly by video.
Medicare Beneficiaries, 2017 (millions)

- Medicare Fee-For-Service: 31.3
- Medicare Advantage: 18.6
- ACOS: 8.1

- 58 Million beneficiaries
- 18.6 Million in MA
- 10,000 seniors newly eligible per day
- 25% of new members join Medicare Advantage
REMOTE PATIENT MONITORING
PREVIOUS RPM REGULATORY FRAMEWORK

- Confusing variety of codes
- No discernable regulatory vision from CMS
- Intense focus on evidence, utilization assumptions
- Confusion for Medicare Advantage plans
- No incentives for clinicians to use it
There is no, or limited reimbursement available for:
- Beneficiary data collection
- Smart devices that complement existing DME devices.

Reimbursement is primarily for practitioner time.

CMS does not reimburse for smartphones or devices as DME. (“Smart devices like tablet computers, laptops and smartphones are non-covered by Medicare because they do not meet the definition of DME. That is because they’re not primarily and customarily used for a medical purpose, one of the tests for DME.”)
NEW DEVELOPMENTS IN RPM PAYMENT IMPACT STARTING 2018 & 2019
Physicians paid between $80-$300 for reviewing glucose data that is remotely gathered.

In January, CMS established “therapeutic CGMs” that can bill claims for two different components of reimbursement:

- The DME component
- An all-inclusive supply allowance

Dexcom and Abbott devices are currently only therapeutic CGMs

Medicare does not cover “smart devices” (phones and tablets) as medical devices, so if any part of the supplies covered by the supply allowance are for a smart device, the entire supply allowance would be disallowed.
In order to ensure physicians are not deterred from integrating these important modalities into care delivery because clinical services utilizing new modalities do not have a clear path to payment, a comprehensive strategy was deployed to address the sometimes complex interplay between coding, valuation, and coverage guided by expert opinion, literature, and health care system data on digital medicine deployment.

Assembled in January 2017

Consists of integrated health systems like Kaiser, Cleveland Clinic, Health Partners and UPMC. Also, technology companies like Qualcomm, and Washington associations like the App Association, and cross-enterprise AMA staff.
AMA’s DMPAG submitted three remote monitoring codes to the CPT panel in September. All three were approved.

The codes will be included in the CPT code set and made available to all healthcare professionals starting on January 1, 2019.

- 990X0: set-up and patient education on use of equipment;
- 990X1: device supply with daily recordings or programmed alerts transmission;
- 994X9: remote physiologic monitoring treatment management services.
RVS Update Committee (RUC) met last week to value to codes.

RUC will decide by late spring/early summer.

CPT handbook published in August.

6. Comment Solicitation on Remote Patient Monitoring

In addition to the broad comment solicitation regarding Medicare telehealth services, we are also specifically seeking comment on **whether to make separate payment for CPT codes that describe remote patient monitoring**. We note that remote patient monitoring services would generally not be considered Medicare telehealth services as defined under section 1834(m) of the Act. Rather, like the interpretation by a physician of an actual electrocardiogram or electroencephalogram tracing that has been transmitted electronically, these services involve the interpretation of medical information without a direct interaction between the practitioner and beneficiary. As such, they are paid under the same conditions as in-person physicians' services with no additional requirements regarding permissible originating sites or use of the telehealth place of service code.
IN THE MEANTIME….

CMS ISSUED RFI IN PFS

We are particularly interested in comments regarding CPT code 99091 (Collection and interpretation of physiologic data (e.g., ECG, 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). This code is currently assigned a procedure status of B (bundled). As with many other bundled codes, we currently assign RVUs for this code based on existing RUC recommendations, even though we have considered the services described by the code to be bundled with other services. In addition to comments on the payment status and valuation for this code (the RUC-recommended value, specifically) we are seeking information about the circumstances under which this code might be reported for separate payment.
Response: “We agree with commenters that monitoring services can be a significant part of ongoing medical care and that we should recognize these services for separate payment as soon as practicable….

We believe that activating CPT code 99091 for separate payment under Medicare for 2018 will serve to facilitate appropriate payment for these services in the short term.”
Reimbursement starts January 1, 2018

Allows practitioners to be paid $56.80 per month

Cumulative of 30 minutes reviewing biometric data digitally transmitted by the patient or patient’s caregiver

Code includes time spent accessing the data, reviewing or interpreting the data, and any necessary modifications to the care plan that result, includes communication with the patient and/or her caregiver and any associated documentation.

Requires annual exam by physician who is managing patient care

Requires consent by patient
TELEHEALTH
CURRENT STATUTORY & REGULATORY BARRIERS TELEHEALTH

Medicare payment for telehealth is limited.

Section 1834(m) of Social Security Act limits telehealth reimbursement to rural areas, and can only be conducted from approved originating sites to distant sites with a physician present.

Telemedicine defined as “interactive 2-way telecommunications system (with real-time audio and video).”

Annual process for securing telehealth modifiers on Part B Codes.
limited medicare part b modifiers

This table provides the CY 2017 list of Medicare telehealth services.

<table>
<thead>
<tr>
<th>Services</th>
<th>HCPCS/CPT code</th>
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<tbody>
<tr>
<td>Telehealth consultations, emergency department or initial inpatient</td>
<td>HCPCS codes G0425—G0427</td>
</tr>
<tr>
<td>Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs</td>
<td>HCPCS codes G0406—G0408</td>
</tr>
<tr>
<td>Office or other outpatient visits</td>
<td>CPT codes 99201-99215</td>
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<tr>
<td>Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days</td>
<td>CPT codes 99231-99233</td>
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<tr>
<td>Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30-days</td>
<td>CPT codes 99307-99310</td>
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<tr>
<td>Individual and group kidney disease education services</td>
<td>HCPCS codes G0420 and G0421</td>
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<tr>
<td>Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training</td>
<td>HCPCS codes G0108 and G0109</td>
</tr>
<tr>
<td>Individual and group health and behavior assessment and intervention</td>
<td>CPT codes 96150-96154</td>
</tr>
<tr>
<td>Individual psychotherapy</td>
<td>CPT codes 90832-90834 and 90836-90838</td>
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<tr>
<td>Telehealth Pharmacologic Management</td>
<td>HCPCS code G0459</td>
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<tr>
<td>Psychiatric diagnostic interview examination</td>
<td>CPT codes 90791 and 90792</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment</td>
<td>CPT codes 90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents</td>
<td>CPT code 90963</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents</td>
<td>CPT code 90964</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents</td>
<td>CPT code 90965</td>
</tr>
</tbody>
</table>
IMPACT OF STATUTORY RESTRICTIONS

- **No coverage** for about 80% of Medicare beneficiaries who live in the 1,200 metropolitan counties not included in the definition of “rural.”

- **No coverage** for services originating from a beneficiary’s home (even for the “homebound”), a hospice and other common non-medical locations from which a beneficiary seeks service.

- **No coverage** for most health procedure codes.

- **No coverage** for virtual physical therapy, occupational therapy, speech-language pathology, audiology.
MEDICARE TELEHEALTH EXPENDITURES 2016

- Telehealth: $28M
- The Rest of Medicare: $990B
CHANGING 1834(M) LEGISLATIVE VEHICLES

21st Century Cures, 2015
MACRA, 2015
Chronic Care Act 2017
Medicare “Extenders”
Allowing telehealth to be in the basic benefit of a Medicare Advantage plan
Paying for telestroke
Allowing dialysis patients to consult their physicians through telehealth, either at home or in a dialysis center.
Section 11 of CONNECT for Health Act & HR 3482

Provides 1834(m) waiver authority to Secretary of HHS

CMS Actuary must certify cost reduction or quality improvement

Use of PFS process annually
Evidence-Based Telehealth Expansion Act

115TH CONGRESS
1ST SESSION

H. R. 3482

To amend title XVIII of the Social Security Act to expand the use of telehealth under the Medicare program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JULY 27, 2017

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Blue Button 2.0 will allow “approved” apps to tap into Medicare claims data via API.

Key challenges include increasing the # of Medicare patients with a MyMedicare.gov account, and communicating to beneficiaries about the available data and Blue Button tools.

CMS priorities for ongoing work include:
- Giving health care providers proxy access rights so that they can access data on behalf of their patients.
- Encouraging and possibly requiring MA plans to adopt a Blue-Button like feature for MA beneficiaries (signaled in CY 2019 MA call letter/rate notice).
Primary regulatory vehicles for encouraging interoperability are MACRA (for clinicians) and Meaningful Use (for hospitals).

HHS OIG has ability to levy penalties up to $1 million per instance of “information blocking.” Forthcoming regulations will define what constitutes information blocking (likely this summer).

HHS is implementing a new voluntary, trusted exchange framework whereby participants will be able exchange data if they agree to be governed by principles outlined by HHS. HHS solicited comment on draft principles; stakeholder reaction was mixed.

21st Century Cures Act defines interoperability as “health IT that enables the secure exchange of electronic health information with, and use electronic health information from, other health IT without special effort on the part of the user, and allows for complete access, exchange, and use of all electronically accessible health information for authorized use under applicable State or Federal law.”
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