WHO PAYS? THE PROMISE OF TELEHEALTH, PART II IN A SERIES ADDRESSING THE ROLE OF TELEHEALTH IN THE DELIVERY OF HEALTH CARE IN NEW YORK

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Telehealth: Who Pays? *Part II in a Series Addressing Telehealth in the Delivery of Health Care in New York*

Advances in telecommunications, including improvements in high resolution imaging and access to broadband, are accelerating the availability of telehealth. Still, an important question remains: who pays for telehealth services? The answer depends on a host of factors, including the type of health care provider, the service involved and, depending on the payor source, even the location of the patient at the time of the service. In Part II of our telehealth series, we offer an overview of the primary approaches, starting with Medicare.

Medicare Fee-for-Service

Medicare provides fee-for-service payments for providing telehealth services to an eligible Medicare beneficiary (i) in a rural area; (ii) at an eligible originating site; (iii) by an eligible distant site practitioner; (iv) via an interactive (real-time) audio and video telecommunications system; (v) for a service on the list of Medicare-covered codes. One rural location, eight types of facilities, ten eligible professionals, and one technology, for an eligible telehealth service: this is the formula for Medicare telehealth reimbursement.

The originating site is the location of the eligible Medicare beneficiary at the time of the service. By statute, the originating site must be located in a rural area, that is, either (i) in a county that is outside a Metropolitan Statistical Area; or (ii) in a Health Professional Shortage Area within a rural census tract. HRSA, the Health Resources and Services Administration, maintains a web-based Medicare Telehealth Payment Eligibility Analyzer, available here, with guidance on whether a particular site is eligible for Medicare telehealth payment.

The originating site must be one of the following types of facilities: (i) a physician or practitioner office, (ii) a critical access hospital, (iii) a rural health clinic, (iv) a federally qualified health center, (v) a hospital, (vi) a hospital-based or critical access hospital-based renal dialysis center or satellite, (vii) a skilled nursing facility, or (viii) a community mental health center. Independent renal dialysis facilities are not

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originating sites.

The categories of eligible telehealth providers are: (i) physicians, (ii) physician assistants, (iii) nurse practitioners, (iv) clinical nurse specialists, (v) certified registered nurse anesthetists, (vi) nurse-midwives, (vii) clinical social workers, (viii) clinical psychologists, (ix) registered dietitians and (x) nutrition professionals. Physical therapists and occupational therapists are not eligible telehealth providers.

When these requirements are met, Medicare pays for services on an approved telehealth list, based on Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes. CMS publishes an annual Telehealth Services Medicare Learning Network fact sheet, currently available here, which lists the Medicare-approved telehealth service CPT/HCPCS codes. The practitioner bills upon the physician fee schedule, and eligible originating sites may bill for an originating site fee.

Medicare Advantage

Aside from Medicare FFS payments, Medicare Advantage managed care plans cover the same telehealth services as Medicare fee-for-service, although not necessarily with the same coverage restrictions.

Changes on the Horizon

Significant changes are on the horizon. Under the Bipartisan Budget Act of 2018, enacted in February 2018, Congress expanded Medicare telehealth policy by incorporating provisions of the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act. Specifically, the new law:

- eliminates, beginning in 2019, geographic restrictions on telestroke consultation services;
- expands, beginning in 2020, telehealth coverage for Medicare Advantage enrollees by allowing the plan to offer additional, clinically appropriate, telehealth benefits beyond the services that currently receive payment under Part B;
- gives Accountable Care Organizations more flexibility to use telehealth services; and
- adds, beginning in 2019, the patient's home and freestanding dialysis facilities, without geographic restriction, to the types of originating sites from which a beneficiary receiving dialysis can have a telehealth assessment with the nephrologist (without a separate originating site payment if the service is furnished in the home).

These policy changes offer expanded opportunities for healthcare providers to improve access and quality of care for Medicare beneficiaries by implementing the use of telehealth.

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In our next alert, we examine the rules for telehealth reimbursement under New York Medicaid. And stay tuned for further alerts addressing the emerging role of telehealth as it relates to the delivery of health care in New York. Click here to view the previous article of the series.

If you have any questions regarding the information contained in this alert, please contact Jane Bello Burke at jbburke@hodgsonruss.com.

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