



Obtaining A Medicare Coverage Decision For New Telehealth Services

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Medicare covers certain telehealth encounters furnished via live video conferencing.¹ The Centers for Medicare and Medicaid Services (CMS) annually updates the scope of covered telehealth services in an open process, allowing a review of how coverage decisions for new services are derived. This article examines the process for obtaining Medicare coverage of new telehealth services and reviews recent CMS coverage decisions to provide guidance in making telehealth coverage requests.

I. Background on Medicare Telehealth Coverage

The Medicare telehealth benefit is a limited one with restrictions on the location of the beneficiary, the eligible telecommunication system, and eligible providers at the remote site. The beneficiary must be present at an originating site located in a rural area,² and the case must be presented from a hospital, rural health clinic, physician office, or federally qualified health center.³ The technology utilized must be interactive (two-way audio and video), excluding email and simple store-and-forward technologies that do not allow real-time communication.⁴ Eligible healthcare professionals at the distant site are physicians and certain nonphysician practitioners who are otherwise eligible to receive Medicare payment for the encounter⁵ and are licensed to provide the service under the law of the state in which the beneficiary is located.⁶ The remote physician or practitioner controls the examination and determines whether a physician or telepresenter at the originating site is medically necessary.⁷

Medicare pays the remote physician or practitioner the Medicare fee schedule amount that would have been paid if the services had been furnished to the beneficiary in a traditional face-to-face encounter.⁸ The telehealth facility fee (\$22.47 in 2006) is payable only to the originating site, which may bill for other covered services furnished on the same day or as requested by the remote physician.⁹

The types of face-to-face encounters eligible for the telehealth benefit are defined by statute but may include additional services as specified by the Secretary.¹⁰ CMS considers the Medicare telehealth benefit as a surrogate service—that is, the interactive technology effectively must substitute for a traditional face-to-face encounter with the beneficiary. In contrast, remote services traditionally not requiring a face-to-face encounter are covered as though delivered on-site under their regular Medicare benefit categories (*e.g.*, interpretations of x-rays, EKGs, and EEGs).¹¹

II. The Telehealth Coverage Review Process

Current telehealth services include common outpatient services, such as office and other outpatient visits, office psychiatry services, ESRD-related services, and individual medical nutrition therapy, as

well as inpatient and outpatient consults and second opinions.¹² CMS has the statutory authority to add telehealth services that Medicare otherwise would cover and has established an analytical framework and open process for annually updating the list of telehealth services.¹³ CMS updates the list during the annual Medicare physician fee schedule (PFS) notice and comment period.

If the request simply is a surrogate delivery mechanism for an existing service, then CMS often will not expect the type of evidence-based assessment demonstrating medical benefit that typically is required for a national coverage determination (NCD).¹⁴ On receiving a request, CMS categorizes the services to determine whether to review evidence-based studies for coverage under the telehealth benefit. CMS begins by reviewing whether the requested service is similar in nature to the telehealth encounters it currently covers. CMS will analyze how the components of the requested encounter compare to the statutorily defined services¹⁵ in terms of the similarity of the beneficiary and professional roles and the interaction between the beneficiary and the distant site practitioner. If CMS determines that the roles and interaction are similar to current telehealth services, then CMS places the request in Category 1 and the service is included in the telehealth benefit without requiring an evidence-based assessment.

CMS places the request in Category 2 if the requested service is not similar to current telehealth encounters; for example, physical therapy, endoscopy, and ICU monitoring. For such requests, CMS then will assess whether using the interactive technology is equivalent to the in-person delivery of the service, based upon a comparative analysis of the telehealth service to the traditional service.

In the comparative analysis for Category 2 requests, CMS is looking for evidence showing that the telehealth service correlates well with in-person encounters in terms of diagnostic findings, therapeutic interventions, and outcomes. Data can include not only clinical trials, but also clinical utilization data and the opinions of physicians and practitioners who furnish telehealth services.¹⁶ If the analysis shows that the use of the interactive technology does not change the diagnosis or treatment plan compared to the in-person encounter and that Medicare beneficiaries are satisfied with the service, then CMS will cover the service as a telehealth service.

On the other hand, if CMS concludes that using a telecommunication system changes the nature of the intervention or the outcome of the service in comparison to face-to-face delivery of the service, CMS views the request as a new service rather than a surrogate method of delivering an existing Medicare encounter. The formal

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process for obtaining a Medicare NCD then would be followed to ensure that the service (i) falls within a defined Medicare benefit category, (ii) is not specifically excluded from coverage, and (iii) is considered reasonable and medically necessary.¹⁷

During the telehealth solicitation process, CMS has received requests for changes in the geographic location (*e.g.*, inclusion of urban areas), facilities eligible to be an originating site (*e.g.*, skilled nursing facilities, home), and the type of technology for delivering telehealth services (*e.g.*, one-way video). CMS has taken the position that it does not have the statutory authority to expand telehealth coverage geographically to include urban areas and beneficiary homes. Nevertheless, CMS has requested public comment regarding these issues and will specifically review whether one-way video is clinically adequate for many specialty consults.

CMS also has solicited comments on the expansion of telehealth services to skilled nursing facilities (SNFs). Section 418 of the Medicare Modernization Act requires the Department of Health and Human Services to evaluate and report to Congress on whether SNFs should be treated as originating sites for telehealth services. Beginning January 1, 2006, Medicare may cover telehealth services furnished to SNF residents if CMS concludes that this is advisable and if safeguards can be developed to ensure that telehealth services do not replace in-person visits by a physician or other appropriate practitioner.

III. Analysis of CMS Decisions

The Medicare Physician Fee Schedule revisions during the past several years illustrate how CMS decides whether a service will be added to the list of covered telehealth services. As a preliminary matter, CMS reviews a service furnished during a telehealth session to determine whether the service is interactive and furnished by eligible practitioners at the distant site—that is, whether the practitioner is eligible under the statutory telehealth benefit and otherwise eligible to receive Medicare payments.

Some requested services have been dismissed outright where the traditional service does not require the beneficiary to be present. For example, case management and medical conferences are furnished outside of the patient's presence, so a telecommunication system can be used to deliver these services under the existing benefit category without the need for a telehealth benefit.¹⁸ CMS also has declined to cover services furnished by practitioners such as speech language pathologists and audiologists at the distant site that are not covered by the telehealth statute.¹⁹

CMS has expanded the list of covered telehealth services based upon similarity to existing telehealth services covered by Medicare. For example, based on its conclusion that the service components were comparable to office visits and consult services under the telehealth benefit, CMS expanded the list of telehealth services to

include psychiatric diagnostic interviews in 2002²⁰ and individual medical nutrition therapy services provided by a registered dietitian or nutrition professional in 2006.²¹

CMS, however, also has declined to add other services—including inpatient hospital care, hospital observation services, and emergency department services—based on the lack of similarity to existing services. In reviewing requests for these services, CMS determined that these interactions were not similar to consults where an onsite physician or practitioner maintains responsibility for ongoing patient management, so it assigned these requests to Category 2. Given the potential risks for misdiagnosis and mismanagement, CMS concluded that it needed comparative data suggesting that these services would be an adequate surrogate for “hands on” patient care in a high acuity environment.²² Without evidence that telehealth would be a good surrogate for the traditional face-to-face service, CMS declined to add hospital and emergency visits to the telehealth list.²³

Similarly, diabetic self-management training services was assigned to Category 2 based on CMS' belief that a different interactive dynamic existed. CMS questioned the merits of teaching patients to self-administer insulin outside of the physical presence of the teaching practitioner in the absence of comparative data on whether telehealth training would be an adequate substitute for in-person diabetic training.²⁴

IV. Preparing a Telehealth Coverage Request

The CMS Division of Practitioner Services receives public requests on an ongoing basis, but requests must be submitted by December 31 of each year to be considered for the upcoming proposed PFS rule. Physicians and practitioners interested in obtaining coverage under the Medicare telehealth benefit first should determine that the traditional service entails a face-to-face interaction with a physician or eligible practitioner. If so, the requester should provide a detailed description of similarities between the service components and existing telehealth services and compile evidence that the encounter is a good surrogate for traditional services.

As with any request for a Medicare coverage determination, the evidence should be accompanied by an explanation of the relevance of the evidence submitted and the benefits to the Medicare population. Pertinent data regarding telehealth services furnished to patients not covered by Medicare may be available to demonstrate equivalency. More than half of the state Medicaid programs provide some type of reimbursement for telehealth services, and several states have enacted laws requiring reimbursement if the service would be covered if furnished in person.²⁵

As these services are furnished, physicians should try to compile equivalency data to compare diagnostic accuracy and outcomes and establish the clinical and scientific evidence for the efficacy of the telehealth service. Medical and scientific literature, the clinical experience of providers, and expert recommendations may provide

additional evidence to support the request. Requests for new Medicare telehealth services also should include beneficiary satisfaction studies. Finally, as CMS considers suggestions for additional settings, geographic areas, and practitioners appropriate for telehealth services, requesters should monitor CMS' recommendations in its forthcoming reports to Congress.

Endnotes

¹ See 42 U.S.C. § 1395m(m) (statutory benefit); 42 C.F.R. § 410.78 (conditions of payment); 42 C.F.R. § 414.65 (reimbursement).

² 42 C.F.R. § 410.78(b)(4). The originating site must be located in a county outside a Metropolitan Statistical Area or MSA, in a rural health professional shortage area or HPSA, or provided by a qualifying federal telemedicine demonstration participant.

³ 42 C.F.R. § 410.78(b)(3).

⁴ Asynchronous store and forward technology may be used to deliver telehealth services originating from federal telemedicine demonstration programs in Alaska and Hawaii. 42 C.F.R. § 410.78(d).

⁵ Eligible non-physician practitioners include nurse practitioners, physician assistants, nurse midwives, clinical nurse specialists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals. 42 C.F.R. § 410.78(b)(2).

⁶ See 66 Fed. Reg. 55283-55284 (discussing applicable licensure).

⁷ 42 C.F.R. § 410.78(c), (d).

⁸ 42 C.F.R. § 414.65(a)(1).

⁹ 42 C.F.R. § 414.65(b). See also 66 Fed. Reg. 55284 (Nov. 1, 2001) (regarding billing for services preceding or subsequent to a telehealth service).

¹⁰ 42 U.S.C. § 1395m(m)(4)(F).

¹¹ 66 Fed. Reg. 55283 (Nov. 1, 2001).

¹² 42 C.F.R. § 414.65(a)(1).

¹³ See 67 Fed. Reg. 79988 (Dec. 31, 2002). CMS has described analytical approach on its website. See www.cms.hhs.gov/physicians/telehealth.

¹⁴ 67 Fed. Reg. 79989 (Dec. 31, 2002).

¹⁵ 67 Fed. Reg. 43862-43863 (June 28, 2002).

¹⁶ 69 Fed. Reg. 66278 (Nov. 15, 2004).

¹⁷ See 68 Fed. Reg. 55634 (Sept. 26, 2003) (final rule on NCD process).

¹⁸ 69 Fed. Reg. 66278 (Nov. 15, 2004).

¹⁹ 67 Fed. Reg. 79989 (Dec. 31, 2002).

²⁰ 67 Fed. Reg. 43863 (June 28, 2002).

²¹ 70 Fed. Reg. 45787 (Aug. 8, 2005).

²² 69 Fed. Reg. 66276-66277 (Nov. 15, 2004).

²³ 69 Fed. Reg. 66276-66277 (Nov. 15, 2004).

²⁴ 70 Fed. Reg. 45787-45788 (Aug. 8, 2005).

²⁵ See Center for Telemedicine Law, *Telemedicine Reimbursement Report*, at 2 (Oct. 2003).