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## PROPOSED RULE CHANGES TO MEDICARE PROGRAM July 12, 2013

On July 8, 2013, proposed rule changes impacting telehealth services in Medicare were released and are scheduled to be published in the Federal Register on July 19, 2013. The changes are proposed by the Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS). The proposed language will specifically modify:

1. Geographical designation of an eligible originating site for telehealth services in the Medicare program.
2. Eligible codes for reimbursement in Medicare for services delivered via telehealth.

Comments on the proposed changes must be submitted no later than 5 pm on September 6, 2013, for consideration. CMS will respond to them in a final rule with comment period to be issued on or about November 1, 2013. To read the full proposed change filing, please go to:

<https://s3.amazonaws.com/public-inspection.federalregister.gov/2013-16547.pdf>

### **Current Law Defining an Original Site**

For telehealth delivered services to be eligible for reimbursement under Medicare, the patient must physically be located at an originating site in one of three possible geographical locations:

- The originating site is located in a county that is not a Metropolitan Statistical Area (MSA);
- The originating site is located in an area that is designated as a rural health professional shortage area (HPSA) under section 332(a)(1)(A) of the Public Health Service Act (PHSA); **OR**
- The site is participating in a federal telemedicine demonstration project as of December 31, 2000.<sup>i</sup>

However, Section 332(a)(1)(A) of the PHSA does not provide a definition for what classifies as a “rural” HPSA. Absent this definition in law, CMS has defined “rural” for the purposes of determining eligibility to mean any area that is not located in an MSA. This interpretation has resulted in severely limiting the number of areas across the country that could qualify as originating sites, thus significantly reducing the number of Medicare recipients’ who can access services delivered via telehealth.

### **Proposed Geographical Designation of Eligible Originating Site**

CMS is proposing to modify its regulations regarding originating sites to define rural HPSAs as those located in rural census tracts *as determined by the Office of Rural Health Policy (ORHP)*. CMS believes that defining “rural” to include geographic areas located in rural census tracts within MSAs would allow for the appropriate inclusion of additional HPSAs as areas for telehealth originating sites. This more precise definition of “rural” for this purpose would expand access to health care services for Medicare beneficiaries located in rural areas.

Unlike the current CMS policy of considering “rural” to mean not located in an MSA, ORHP employs the Rural Urban Commuting areas (RUCAs) to determine rural areas which can also be within MSAs. RUCAs rely on a census tract-based classification that considers a variety of elements to determine rural and urban status including work commuting information.<sup>ii</sup> The classification contains 10 primary codes and 30 secondary codes.

Census tracts with RUCA codes of 4 through 10 refer to areas with a primary commuting share outside of a metropolitan area. ORHP considers census tracts with RUCA codes 4 through 10 to be rural, even if they are located in an MSA county. Census tracts with RUCA codes 2 and 3 that are at least 400 square miles and have a population density of less than 35 people per square mile are also considered by ORHP to be rural.

Additionally, CMS is proposing that geographical eligibility would be maintained on an annual basis to reduce the likelihood of mid-year changes to geographic designations. This would reduce the potential for sudden disruptions of Medicare beneficiaries’ services and other unexpected changes in geographic eligibility for originating sites.

**Adding Services to the List of Medicare Telehealth Services**

Each year CMS considers deleting or adding additional telehealth delivered services that are reimbursable by Medicare.<sup>iii</sup> The process allows the public to submit requests for adding services or CMS may add services as well. The requests fall into one of two categories for consideration:

Category 1: Services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services. The request is evaluated on the similarities between the services already eligible for reimbursement and that of the requested service.

Category 2: Services that are not similar to the current list of telehealth services. The assessment will be on whether the service is accurately described by the corresponding code when delivered via telehealth and whether the use of a telecommunications system to deliver the services produces a demonstrated clinical benefit to the patient. Supporting documentation should be included.

The following are for consideration during this current period:

SUBMITTED BY	REQUEST	CMS DECISION & EXPLANATION
<b>American Telemedicine Association (ATA)</b>	Add CPT code: <b>98969</b> Online assessment and management service provided by a qualified non-physician health professional to established patient, guardian or health care provider not originating from a related assessment and management service provided within the previous 7 days using Internet or similar electronic networks.	CMS rejects this request.  The service is not a currently covered Medicare service if provided in-person. Therefore it will not be covered if delivered via telehealth.
<b>ATA</b>	Add CPT code: <b>99444</b> Online evaluation and management service provided by a physician to an established patient, guardian, or health care provider not originating from a related E/M service provided within the previous 7 days, using Internet or similar electronic communications network.	CMS rejects this request.  The service is not a currently covered Medicare service if provided in-person. Therefore it will not be covered if delivered via telehealth.

SUBMITTED BY	REQUEST	CMS DECISION & EXPLANATION
CMS	Add CPT code: <b>99495</b> Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of at least moderate complexity during the service period face-to-face visit, within 14 calendar days of discharge.	CMS proposal to add.
CMS	Add CPT code: <b>99496</b> Transitional care management services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of high complexity during the service period face-to-face visit, within 7 calendar days of discharge.	CMS proposal to add.
ATA	Removal of the frequency limitation for subsequent nursing facility services report by CPT codes 99307-99310.  Currently telehealth services are limited to one telehealth subsequent nursing facility service every 30 days. ATA notes that due to recent federal telecommunications policy changes and recent studies, the value of telehealth to patients has been demonstrated.	CMS rejects this request.  CMS did not find that the information provided showed a benefit to patients resulting from an increased frequency of telehealth delivered services in a 30 day period.

<sup>i</sup> Social Security Act, Section 1834(m)(4)(C)(i)(I-III).

<sup>ii</sup> For a comprehensive description go [www.ers.usda.gov/data-products/rural-urban-commuting-area-codes/documentatin.aspx#.UcsKfZwzZKE](http://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes/documentatin.aspx#.UcsKfZwzZKE).

<sup>iii</sup> Social Security Act, Section 1834(m)(4)(F)(ii).

The National Telehealth Policy Resource Center project is made possible by Grant #G22RH20214 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS.