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The reassignment riddle: Billing Medicare for distant site services

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Can physicians who provide the professional component of telemedicine services reassign their Medicare billing rights to a hospital? I have heard this question countless times from compliance officers, operational managers, and healthcare attorneys alike, yet the telehealth industry seems to be moving toward such billing models.

This question often arises in two different contexts. In the first scenario, the hospital serves as the originating site, and the hospital bills both for the originating site facility fee and for the distant site professional services (which the physician has reassigned to the hospital). The originating site hospital then reimburses the physician, either as an employee or an independent contractor. In the second scenario, the hospital employs or contracts with specialist physicians and serves as a hub. Those specialists are located at the hub hospital, and deliver telehealth services to rural originating sites. The distant site hub hospital submits reassigned claims to payers, and reimburses the physicians providing those professional services. This is known as the "hub and spoke" model.

Both of these are common telehealth billing models. There are already plenty of regulatory and compliance considerations in developing telehealth arrangements (see sidebar), but are there any extra concerns when these models are employed for Medicare payable services?

The regulatory conundrum

To set the stage, in order to be eligible for telehealth services, Medicare beneficiaries must be present in an originating site located in either a rural health professional shortage area or in a county outside of a metropolitan statistical area.[1] Note, however, that Congress recently made exceptions to the geographic requirements for home dialysis ESRD-related clinical assessments (as of January 1, 2019), telestroke services (as of January 1, 2019), and treatment of substance use disorders or co-occurring mental health disorders (as of July 1, 2019).[2] An "originating site" includes, among others, the office of a physician, a hospital, a critical access hospital, and a skilled nursing facility.[3]

The telehealth services must be provided at a distant site by a physician or practitioner, which is "the site where the physician or practitioner, providing the professional service, is located at the time the service is provided via a telecommunications system." Medicare practitioners who are permitted to bill for covered telehealth services include (among others) physicians, nurse practitioners, physician assistants, and clinical psychologists. Other general requirements include that the patient and practitioner communicate via interactive audio-video technology and that the service rendered is named on the list of Medicare telehealth services.[4]

Curiously though, the Centers for Medicare & Medicaid Services (CMS) regulations state that "[o]nly the

physician or practitioner at the distant site may bill and receive payment for the professional service" and "[p]ayments made to the physician or practitioner at the distant site, including deductible and coinsurance, for the professional service may not be shared with the referring practitioner or telepresenter."[5] Similarly, the CMS Medicare Claims Processing Manual lists only individual practitioners (e.g., physicians, nurse practitioners, and physician assistants) who may bill for distant site telehealth services—not hospitals or other facilities—and that "the only claims from institutional facilities" that can be reimbursed by Medicare at the distant site are medical nutrition therapy or in critical access hospitals (CAHs) using a specific billing method.[6]

And unfortunately, both "[a] distant site practitioner or originating site facility may be subject to the applicable sanctions" and penalties, including civil monetary penalties, if the practitioner or facility "[k]nowingly and willfully bills or collects for services in violation of the limitation of [these requirements]."[7]

How, then, are the most common telehealth billing models permitted? How can they be reconciled with a literal reading of CMS's (relatively) clear rules?