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CMS: Many Telehealth Codes Are Here to Stay, But First Visit Will Be in Person Post-PHE

By Nina Youngstrom

A top CMS official said Nov. 17 that the expansion of telehealth is the "most transformative of things" it has done in the past 10 months since the declaration of the COVID-19 public health emergency (PHE). That statement may explain why Medicare coverage of telehealth services will stay in place to some degree when the PHE is over.

"I can safely say when it comes to telehealth, we will be keeping a lot of those services," Kimberly Brandt, CMS's principal deputy administrator for operations and policy, said at the Health Care Compliance Association's virtual Healthcare Enforcement Compliance Conference.[1]

Eventually, however, Medicare will require physicians to see new patients in person the first time, she said. Although physicians and other practitioners are now permitted to bill Medicare for services delivered by telehealth even without an established relationship, that will end with the PHE. "We want to make sure we get back to aligning the initial visit to something in person," Brandt explained. "We are conscious of the fact that it is something that potentially could be a bit of a fraud issue."

Brandt described how the pandemic was the inflection point for telehealth. "It has really been one of the things we have had to change our entire thinking about to ensure the continuity of treatment for Medicare beneficiaries." Brandt said 26% of Medicare fee-for-service beneficiaries are now using telemedicine, a 1,100% increase since CMS on March 6 expanded telehealth services and the types of providers who can deliver them in the first of four COVID-19 interim final rules[2] with comment periods. She said 146 CPT codes have been added to the Medicare telehealth services list, 89 of which are approved for audio-only delivery.

Waivers: There May Be 'Grace Period' After PHE

Eventually the PHE will come to an end, probably sometime in 2021, and with it some or all of the waivers and flexibilities. But hospitals and other providers won't lose them overnight, even though "technically there is no official grace period" when the PHE ends, Brandt said. "There is an intent to provide a little grace period," she explained. "I can't speak to what exactly will happen because there may be a change in leadership. A lot depends on what the leadership at CMS says."

She also said CMS is using administrative claims and encounter data to track the utilization of COVID-19-related services in Medicare and Medicaid. In terms of program integrity, CMS is monitoring the use of waivers "and how they are utilized" and whether hospitals are billing Medicare appropriately for patients with a COVID-19 diagnosis. Medicare's 20% bonus for COVID-19-related MS-DRGs, which require documentation of a positive coronavirus test, is a focus of Medicare auditors.

On a Nov. 17 CMS stakeholder call, Ronald Hirsch, M.D., vice president of R1 RCM, asked CMS officials about the proof they require for positive tests, because sometimes patients present at the hospital without documentation although they have tested positive elsewhere (e.g., at drive-through test sites or nursing homes). Will that fly

with Medicare reviewers, or should hospitals repeat the test to protect their 20% bonus? "We would be looking in the medical records for the clinician stating there was a positive result" versus relying on the say-so of the beneficiary, said Connie Leonard, acting director of the Provider Compliance Group in CMS's Center for Program Integrity. "As long as there is detail from the clinician, it would probably be enough." But Leonard said this will be discussed internally, and CMS will decide whether to update providers on a subsequent call or in answers to frequently asked questions.

On an unrelated note, Brandt said CMS plans to finalize its overhaul of the Stark Law regulations by the end of the year.