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Telehealth Scores a Win: CMS Proposes Expanded Coverage

It's not hyperbole to say that telemedicine is changing the way healthcare is delivered. And earlier this month, the Centers for Medicare & Medicaid Services (CMS) took another step to throw its weight behind telehealth. Although the proposal isn't a blank check written to telehealth providers, it does expand what's allowed under Medicare and Medicaid.

In a phone call with reporters, CMS Administrator Seema Verma said, "Today is a huge win for patients and providers as CMS is proposing historic changes to modernize Medicare and restore the doctor-patient relationship."

The proposed rule addresses telehealth, interoperability, and documentation requirements. For example, acceptable telehealth services under Medicare Part B would be broadened to include dialysis facilities, the residences of end-stage renal disease patients, and mobile stroke units as telemedicine originating sites. Another change is that CMS would begin covering "brief check-ins" between doctor and patient that occur via a telehealth platform. Additionally, remote evaluation of images captured by patients would fall under the covered umbrella.

CMS wants to "provide new access points for patients."

"Under this proposal, Medicare will start paying for virtual check-ins, meaning patients can connect with their doctor by phone or video chat," Verma said. "Many times this type of check-in will resolve patient concerns in a convenient manner that gets them the care that they need and avoids unnecessary cost to the system. This is a big issue for our elderly and disabled population where transportation can be a burden to care as well as to caregivers. We're not intending to replace office visits but rather to augment them and provide new access points for patients."

In another break with traditional telemedicine payment requirements, the new rule proposes that providers be allowed to submit claims for a telehealth visit that does not follow or precede an in-person visit.

Verma explained: "There are going to be many situations where a physician might say 'I'm going to need to see you in my office' but it could be a check-in where they come in for a visit and they want to talk to their doctor about the medication that they're taking and how it's impacting them, and [this gives] the ability for them to not have to come in physically to have that conversation with the doctor, but to be able to have that remotely."

In the future, established relationships might not be required

The rule still stipulates that a previously established physician-patient relationship must be in place, which would exclude platforms like Teladoc that are growing in popularity. That thinking may change in the future, however, as evidenced from wording in the proposal: "We are seeking comment as to whether these services should be limited to established patients; or whether there are certain cases, like dermatological or ophthalmological services, where it might be appropriate for a new patient to receive these services."

The new rule also proposes changes to the Merit-based Incentive Payment System (MIPS), specifically, the "Promoting Interoperability" performance category with the intent of giving patients increased access to their own health information. Changes in that category would also bring MIPS in line with the Office of Innovation's MyHealthEData Initiative.

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The proposal also has something to say about documentation requirements that demand so much time from providers:

“Doctors should not be spending time typing information into a computer simply in order to bill a certain level of code. They should focus on documenting the material that’s needed to capture the patient’s health data. Therefore we are proposing to move from a system with four kinds of documentation requirements to a system with one set of documentation requirements. There will still be four distinct code levels, but the differences will be meaningless. There will be one set of documentation requirements.”

CMS’s new rule has an eye toward getting electronic health record developers to create patient-centric tools, rather than merely billing-centric ones. CMS says that the proposed changes in code standardization may save practitioners well over $2 million each year, and tens of thousands of hours.

CMS Administrator Seema Verma qualified the proposed Physician Fee Schedule and Qualified Payment Program updates as one of “the most significant reductions in provider burden undertaken by any administration.”