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1. Brief Communication Technology-Based Service, e.g. Virtual Check-In (HCPCS Code G2012)

The traditional office visit codes describe a broad range of physicians' services. Historically, we have considered any routine non-face-to-face communication that takes place before or after an in-person visit to be bundled into the payment for the visit itself. In recent years, we have recognized payment disparities that arise when the amount of non-face-to-face work for certain kinds of patients is disproportionately higher than for others, and created coding and separate payment to recognize care management services such as chronic care management and behavioral health integration services (81 FR 80226). We now recognize that advances in communication technology have changed patients' and practitioners' expectations regarding the quantity and quality of information that can be conveyed via communication technology. From the ubiquity of synchronous, audio/video applications to the increased use of patient-facing health portals, a broader range of services can be furnished by health care professionals via communication technology as compared to 20 years ago.

Among these services are the kinds of brief check-in services furnished using communication technology that are used to evaluate whether or not an office visit or other service is warranted. When these kinds of check-in services are furnished prior to an office visit, then we would currently consider them to be bundled into the payment for the resulting visit, such as through an evaluation and management (E/M) visit code. However, in cases where the check-in service does not lead to an office visit, then there is no office visit with which the check-in service can be bundled. To the extent that these kinds of check-ins become more effective at addressing patient concerns and needs using evolving technology, we believe that the overall payment implications of considering the services to be broadly bundled becomes more problematic. This is especially true in a resource-based relative value payment system. Effectively, the better practitioners are in leveraging technology to furnish effective check-ins that mitigate the need for potentially unnecessary office visits, the fewer billable services they furnish. Given the evolving technological landscape, we believe this creates incentives that are inconsistent with current trends in medical practice and potentially undermines payment accuracy.

Therefore, we proposed to pay separately, beginning January 1, 2019, for a newly defined type of physicians' service furnished using communication technology. We stated this service would be billable when a physician or other qualified health care professional has a brief non-face-to-face check-in with a patient via communication technology, to assess whether the patient's condition necessitates an office visit. We understand that the kind of communication technology used to furnish these kinds of services has broadened over time and has enhanced the capacity for medical professionals to care for patients. We solicited comment on what types of communication technology are utilized by physicians or other qualified health care professionals in furnishing these services, including whether audio-only telephone interactions are sufficient compared to interactions that are enhanced with video or other kinds of data transmission.

The following discussion summarizes particular definitions and billing rules for these services, as proposed, and more detailed comments we received regarding these aspects of the proposal. Our responses below include information regarding the service definitions and billing requirements applicable for CY 2019.

Comment: Many commenters supported the proposal to pay for these kinds of services. Many commenters offered specific suggestions regarding the service definitions and associated billing rules, which we describe in detail below. Several

commenters urged CMS to take a cautious approach in paying for these services, given concerns these commenters stated regarding potential overutilization, while some noted that potential overutilization would be mitigated by Medicare's requirements for the visit to be reasonable and medically necessary/appropriate. Specific aspects of these comments are detailed below.

Response: Based on the broad support for the proposal, we are creating coding and finalizing our proposal to make separate payment for this service. We note that in the proposed rule we referred to this service as HCPCS code GVCI1, which was a placeholder code. The code will be described as HCPCS code G2012 (Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion).

We appreciate commenters' concerns regarding the potential for overutilization of these services. We plan to monitor utilization with the intention of determining whether changes, such as a frequency limitation on the use of this code, are warranted. We would consider proposing such changes in future rulemaking. We note that, like all other physicians' services billed under the PFS, each of these services must be medically reasonable and necessary to be paid by Medicare.

Comment: Many commenters suggested that we not be overly prescriptive regarding the types of communication technology that are utilized by physicians or other qualified health care professionals in furnishing these services. The commenters noted that technology is evolving at a rapid pace and would require us to have to update our policies frequently. Several commenters suggested that we permit the use of email and Electronic Health Record (EHR) patient portals to qualify. A few commenters stated that audio-visual communication is ideal. Others acknowledged that not all patients have the same level of connectivity and therefore recommended allowing audio-only communication.

Response: We are persuaded by the comments advising us not to be overly prescriptive about the technology that is used, and are finalizing allowing audio-only real-time telephone interactions in addition to synchronous, two-way audio interactions that are enhanced with video or other kinds of data transmission. We note that telephone calls that involve only clinical staff could not be billed using HCPCS code G2012 since the code explicitly describes (and requires) direct interaction between the patient and the billing practitioner.

We further proposed that in instances when the brief communication technology-based service originates from a related E/M service provided within the previous 7 days by the same physician or other qualified health care professional, that this service would be considered bundled into that previous E/M service and would not be separately billable, which is consistent with code descriptor language for CPT code 99441 (Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion), on which this service is partially modeled. We proposed that in instances when the brief communication technology-based service leads to an E/M service with the same physician or other qualified health care professional, this service would be considered bundled into the pre- or post-visit time of the associated E/M service, and therefore, would not be separately billable. We also noted that this service could be used as part of a treatment regimen for opioid use disorders and other substance use disorders to assess whether the patient's condition requires an office visit.

We proposed pricing this distinct service at a rate lower than current E/M in-person visits to reflect the low work time and intensity and to account for the resource costs and efficiencies associated with the use of communication technology. We expect that these services will be initiated by the patient, especially since many beneficiaries would be financially liable for sharing in the cost of these services. For the same reason, we believe it is important for patients to consent to receiving these services. Therefore, we specifically solicited comment on whether we should require, for example, verbal consent that will be noted in the medical record for each service.

Comment: Many commenters stated that it would be burdensome to obtain consent from the patient prior to each occurrence of this service. Some commenters suggested that the patient be informed through the use of a service agreement which could be signed once and kept on file. Several commenters expressed concern about the cost to beneficiaries, especially since they may have previously received this service without financial liability, and therefore recommended requiring verbal consent that is documented in the medical record.

Response: We understand the potential burden regarding obtaining consent for each occurrence of this service. However, we are persuaded by those commenters who suggest that unexpected cost to beneficiaries would be particularly problematic. We note that under our current policy for several types of care management services, verbal consent is required to be obtained and documented in the medical record. The consent policy was implemented, in part, based on feedback we received from practitioners reporting the care management services, to alleviate burdens of alternative approaches, such as requirements for written consent or completion of particular forms. Consequently, we believe the same requirement could be applied here, without imposition of significant burden. We are finalizing requiring verbal consent that is noted in the medical record for each billed service.

We also proposed that this service can only be furnished for established patients because we believe that the practitioner needs to have an existing relationship with the patient, and therefore, basic knowledge of the patient's medical condition and needs, in order to perform this service.

Comment: Many commenters were supportive of our proposal to limit this service to established patients, while several commenters noted that there would be instances when it would be appropriate to bill this service for new patients. MedPAC noted particular concern regarding potential increases in volume that are not related to ongoing, informed patient care. A few commenters requested that CMS clarify that established patients include those patients who have been seen by a practitioner within the same group practice.

Response: After considering the comments, we are finalizing our proposal to limit this service to established patients, given the concern expressed by commenters regarding the degree to which these services can be furnished without familiarity and experience with individual patients, and in light of MedPAC's concerns regarding increases in utilization that are not related to ongoing, informed patient care. In response to the request for clarification about what constitutes an established patient, we defer to CPT's definition of this term. CPT defines an established patient as one who has received professional services from the physician or qualified health care professional or another physician or qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past 3 years. We also emphasize that payment for this service would not preclude a physician or other qualified health care professional from having communication via phone or other modalities with any patient, new or existing, for a variety of reasons. We believe that much of the pre- and post- work associated with, and included in the valuation of existing in-person services that are paid under the PFS can include some types of interactions with patients that are not in-person.

We did not propose to apply a frequency limit on the use of this code by the same practitioner with the same patient, but we want to ensure that this code is appropriately utilized for circumstances when a patient needs a brief non-face-to-face check-in to assess whether an office visit is necessary. We solicited comment on whether it would be clinically appropriate to apply a frequency limitation on the use of this code by the same practitioner with the same patient, and on what would be a reasonable frequency limitation.

Comment: Many commenters were opposed to creating a frequency limitation, suggesting we wait and monitor utilization. Others noted that it could be clinically appropriate to utilize this service multiple times in a week. A few commenters stated that this service could be utilized in behavioral health treatment, and cited an example of assessing suicidal risk, in which case they suggested the frequency should not be limited since routine virtual check-ins would be clinically warranted in some cases. Some commenters suggested a frequency limit of three times per week whereas others suggested a limit of once per week.

Response: After considering these comments, we are not implementing a frequency limitation for CY 2019. However, we plan to monitor utilization with the intention of determining whether such a limitation is warranted. In that case, we would consider proposing a limitation in future rulemaking. We note that, like all other physicians' services billed under the PFS, each of these services must be medically reasonable and necessary to be paid by Medicare.

We also solicited comment on the timeframes under which this service would be separately billable compared to when it would be bundled. We believe the general construct of bundling the services that lead directly to a billable visit is important, but we are concerned that establishing strict timeframes may create unintended consequences regarding scheduling of care. For example, we do not want to bundle only the services that occur within 24 hours of a visit only to see a significant number of visits occurring at 25 hours after the initial service. In order to mitigate these incentives, we solicited comment on whether we should consider broadening the window of time and/or circumstances in which this service should be bundled into the subsequent related visit. We noted that these services, like any other physicians' service, must be medically reasonable and necessary in order to be paid by Medicare.

Comment: Several commenters suggested that we remove the language in the code descriptor that states “or soonest available appointment.” A few commenters suggested we extend the timeframe to 48 hours following the virtual check-in, while others suggested it would be reasonable to expand the limit to 14 days before and 72 hours after the service. Several commenters stated concerns that it might be difficult to document that a subsequent visit was not the “soonest available appointment.” Several commenters expressed concern about the potential for overutilization of this code.

Response: We agree with commenters that urged caution regarding overutilization of this service and believe that the language stating, `or soonest available appointment' in the code description may serve to reduce potential perverse payment incentives to delay seeing patients to ensure payment for this code. We appreciate the concerns regarding potential difficulty in proving that a particular visit was not the “soonest available.” We agree that in each individual case, it might be challenging to prove whether or not other appointments were available prior to the visit, especially since beneficiary convenience is also presumably a factor for when appointments are scheduled. However, we believe that, as written, the code description could help to guard against the potential for abuse that would be present if we instead adopted a purely time-based window for bundling of this service. We also believe that “soonest available appointment” might allow for clinically appropriate flexibility. Therefore, after consideration of the public comments, we are finalizing the code descriptor for HCPCS code G2012 as proposed. However, we plan to monitor this service with the intention of determining whether changes are necessary to the timeframes under which this service would be separately billable compared to when it would be bundled. We would consider any such changes in future rulemaking.

We solicited comment on how clinicians could best document the medical necessity of this service, consistent with documentation requirements necessary to demonstrate the medical necessity of any service under the PFS.

Comment: A few commenters stated that documentation for this service should be consistent with the requirements for an in-person encounter and requested appropriate documentation requirements to ensure that the check-in is fully incorporated into the individual's medical history. Other commenters urged us not to be overly prescriptive.

Response: We appreciate the commenters' input. We do not want to impose undue administrative burden likely to discourage appropriate provision of these services, and are therefore not requiring any service-specific documentation requirements for this service. We note again that these services, like any other physicians' service, must be medically reasonable and necessary in order to be paid by Medicare.

Comment: Several commenters stated that the proposed payment rate would be inadequate for modalities that are both audio- and visual-capable, whereas others stated that the proposed valuation was appropriate. One commenter suggested we create a second code for a virtual check-in that only utilizes synchronous audio/video technology, with a higher reimbursement rate associated with the increased complexity of technology.

Response: As discussed in section II.H of this final rule, we are finalizing the valuation for HCPCS code G2012 as proposed. We believe this valuation reflects the work time and intensity of the service relative to other PFS services and accounts for the resource costs and efficiencies associated with the use of communication technology. We recognize that the valuation of this service is relatively modest, especially compared to in-person services, however, we believe that the proposed valuation accurately reflects the resources involved in furnishing this service. We plan to monitor the utilization of this code and note that we routinely address recommended changes in values for codes paid under the PFS.

Comment: A few commenters requested that CMS allow licensed physical therapists to furnish these services. Additionally, a few commenters requested that we allow other clinical staff, such as registered nurses, to furnish this service.

Response: We are finalizing maintaining this code as part of the set of codes that is only reportable by those that can furnish E/M services. We believe this is appropriate since the service describes a check-in directly with the billing practitioner to assess whether an office visit is needed. We agree that similar check-ins provided by nurses and other clinical staff can be important aspects of coordinated patient care. We note that these kinds of non-face-to-face services by other medical professionals and clinical staff continue to be included in the RVUs for other codes, including those that describe E/M visits, and for procedures with global periods. We also note that non-face-to-face services provided by clinical staff can be explicitly and separately paid for as part of several care management services, many of which we have introduced over the past several years. However, this service is meant to describe, and account for the resources involved, when the billing practitioner directly furnishes the virtual check-in.

Comment: Several commenters requested that CMS waive the beneficiary co-payment for this service.

Response: We appreciate the commenters' request; however, we do not have the statutory authority to make specific changes to the requirements regarding beneficiary cost sharing for this service.

In summary, we are creating coding and finalizing our proposal to make separate payment for brief communication technology-based services. The code will be described as G2012 (Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion). We are finalizing allowing real-time audio-only telephone interactions in addition to synchronous, two-way audio interactions that are enhanced with video or other kinds of data transmission. We are finalizing our proposal to limit this service to established patients.

We are finalizing that if the service originates from a related E/M service provided within the previous 7 days by the same physician or other qualified health care professional, that this service would be considered bundled into that previous E/M service and would not be separately billable. In instances when the service leads to an E/M service with the same physician or other qualified health care professional, we are finalizing that this service would be considered bundled into the pre- or post-visit time of the associated E/M service, and therefore, would not be separately billable. We plan to monitor this service with the intention of determining whether changes are necessary to the timeframes under which this service would be separately billable compared to when it would be bundled. We would consider any such changes in future rulemaking.

We are finalizing requiring verbal consent from beneficiaries that is noted in the medical record for each service. We are not implementing a frequency limitation for CY 2019, however, we plan to monitor utilization with the intention of determining whether such a limitation is warranted. In that case, we would consider that for future rulemaking.

We are finalizing the valuation for HCPCS code G2012 as proposed. We will monitor the utilization of this code and consider any potential adjustments to billing rules or valuation for this service through future rulemaking. We note that cost sharing for these services will apply.

For details related to developing utilization estimates for this service, see section VII. of this final rule, Regulatory Impact Analysis. For additional details related to valuation of this service, see section II.H. of this final rule, Valuation of Specific Codes.