Society of Hospital Medicine
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May 27, 2020

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1744-IFC
P.O. Box 8013
Baltimore, MD 21244-1850

Dear Administrator Verma,

The Society of Hospital Medicine, which represents the nation's hospitalists, is pleased to offer comments on the CMS' Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency interim final rule. Hospitalists are front-line clinicians in America's acute care hospitals whose professional focus is the general medical care of hospitalized patients. Hospitalists provide care to millions of patients each year, including a large majority of hospitalized Medicare beneficiaries. As a result of their unique position within the healthcare system, hospitalists are on the frontlines of the novel COVID-19 pandemic.

Each day, hospitalists are putting their health and lives at risk to care for their patients in a high quality and compassionate manner during this pandemic. It is from this perspective that we offer our comments on the Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency interim final rule.

Payment for Medicare Telehealth Services Under Section 1834(m) of the Act

On March 17, 2020, CMS announced a series of relief waivers intended to immediately increase access to telehealth services for Medicare and Medicaid beneficiaries around the country. The expansion of telehealth services throughout the duration of the Public Health Emergency (PHE) has been extremely valuable to reduce the transmission of COVID-19, both between Medicare and Medicaid beneficiaries, as well as between patients and providers. As hospitalists have faced shortages of personal protective equipment (PPE), the expansion of telehealth has helped minimize transmission in the hospital setting. Furthermore, the increased payment rates for telehealth services has helped mitigate financial hardship resulting from the dramatic shifts in patient volumes and healthcare utilization.

Society of Hospital Medicine

Included in these provisions was an expansion of which sites and which patients are eligible for telehealth visits. Additionally, these waivers expanded which technologies can be used to deliver telehealth services. These changes have helped hospital medicine groups continue to provide high quality services in these unprecedented times. Additional blanket waivers were issued on March 30th, which further expanded which services could be billed as telehealth and expanded which services could be furnished via audio-only technologies. The interim final rule has authorized many of these changes.

Expansion of Telehealth Eligible Services

Prior to the March 17, 2020 issuance of blanket waivers and flexibilities related to the PHE, Medicare allowed a limited number of services to be provided via telehealth, dependent on the service furnished, patient's location, and relative access to in-person healthcare. However, the blanket waivers, supplemented by the Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020, dramatically expanded the use and payment of telehealth. These changes allow clinicians to furnish telehealth services to patients located anywhere in the country, including in a patient's place of residence. This relaxed longstanding rules that limited Medicare telehealth coverage to very specific circumstances. CMS recognized the need to minimize contact and transmission, while ensuring beneficiaries maintain uninterrupted access to medical care. In doing so, the expansion of telehealth is keeping both beneficiaries and providers safer. We applaud CMS for instituting these changes during the PHE. We also urge the Agency to use this opportunity to learn about the successes and limitations of telehealth and consider retaining through future rulemaking expanded telehealth access where appropriate.

CMS also relaxed its longstanding policy about what services could be billed as Medicare telehealth services. Notably for hospitalists, these were historically limited to certain subsequent hospitalization and critical care E&M codes. As a response to the PHE, CME granted waivers to greatly expand the number of services that could be furnished via telehealth, enabling the vast majority of hospital-based E&M codes to be billed via telehealth. This is a crucial and lifesaving change for hospitalists as it allows them to structure their practice in ways to efficiently deliver high quality care and be reimbursed accordingly, while limiting patient/provider contact as much as is medically reasonable. We thank CMS for expanding the available telehealth services during the PHE.

Telehealth Payment Rates

The COVID-19 pandemic has caused significant financial hardship to hospitalist groups across the country. Patient volumes are down in many parts of the country, particularly from hospital service lines that hospitalists would typically co-manage with specialty providers. At the same time, prior Medicare telehealth policy paid hospitalists providing telehealth services at a lower "facility rate" to account for Medicare making a payment to both a facility and a provider. In an effort to help mitigate financial hardship during the PHE, CMS is paying the same reimbursement rates for services furnished via telehealth as they would for the same in-person visits. Providers billing telehealth services during the PHE would use the appropriate place of service code as if the visit were conducted in person and using a telehealth CPT modifier (modifier 95). We are highly supportive of this policy during the PHE.

Expansion of Telehealth Platforms

To further ensure a continuity and access of quality medical care, CMS has also relaxed standards on what devices can be used to deliver telehealth services. Prior to the March 17, 2020 waivers, telehealth services could only be conducted via HIPAA-compliant technologies. Now during the PHE, telehealth services can be furnished with "telecommunications technology that have audio and video capabilities that are used for two-way, real time interactive communication," which includes smartphones and iPads. This greatly increased the ability of hospitalists to implement telehealth by using readily available technology and obviates prohibitive start-up costs and lengthy implementation processes associated with the use of HIPAA-compliant technologies and vendors. Additionally, many services can also be provided via audio-only media, which is highly beneficial for patients who are less comfortable with technology.

These changes ensure beneficiaries can continue to access the healthcare they need for the duration of this pandemic. This is particularly true in rural areas where access to broadband and high-speed internet is variable. Enabling providers to use existing tools to provide telehealth services is a welcome change. We thank CMS for expanding the technologies that can be used for telehealth services during the PHE and urge CMS to consider how some of these changes can be incorporated permanently into the Medicare program through future rulemaking.

Ensure Hospitalists Can Utilize G2012 Code

Hospitalists are increasingly practicing beyond the hospital walls, including post-acute care settings and post-discharge clinics. We are supportive of the expanded use of the G2012 code, and we ask that maximum flexibility is established to ensure that hospitals and specialists, including but not limited to hospitalists and intensivists (both physician and APP), can develop workflows that maximize coordination of care, reduce the need for in person visits by multiple providers, and encourage collaboration and communication between providers. Impediments that remain in need of flexibility include limitations on the provider types permitted to bill for the service, reimbursement only when a patient encounter occurs, prescriptive frequency or timing requirements, and limitations on the encounter initiator. Flexibility is needed in this regard for traditional face to face services, but specifically with regard to technology aided visits/telehealth.

For example, patients in skilled nursing facilities often encounter serious clinical needs in the middle of the night. Without maximum flexibility and potential changes to the G2012 code, it is very difficult to provide the real-time assistance needed, support SNF staff for the extended period of time these incidents often require, and facilitate the transition to hospitals (if needed).

For these reasons, it is essential that telehealth be made as fully available to hospitalists as possible. Congress and the Administration have already made important strides in this direction, but further action is needed. Specifically, virtual check-in code G2012 needs to be modified to ensure that hospitalists and intensivists may bill this code for telemedicine consultations and that it may be billed on the same day as an E&M visit.

Future Changes to E&M Billing in Acute Care Hospitals

Hospital medicine is a specialty that almost exclusively bills E&M codes, specifically those associated with inpatient and outpatient hospitalizations. As CMS looks to refine existing billing structures in the Medicare fee for service (FFS) system and to move away from FFS into alternative payment models (APMs), we encourage CMS to rethink facility-based E&M billing. Unlike office-based providers, hospitalists see the same patient multiple times per day in the course of normal care. Under current rules, hospitalists can only bill the E&M once per day, in accordance with restrictions on billing frequency and provider types. This setup is not reflective of hospital medicine practice, meaning clinical visit instances are not reimbursable despite requiring the same physical and cognitive resources as the single billable instance each day. Particularly during the pandemic when COVID patients are requiring intensive, on-going cognitive medicine, CMS needs to update their policy to adequately reimburse hospitalists. We ask CMS to consider a policy of enabling billing of multiple acute care hospital E&M codes per day to better account for the frequency and on-going nature of hospital medicine work.

Conclusion

SHM appreciates the opportunity to provide comments on the Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency interim final rule. If you have any questions or need more information, please contact Josh Boswell, Director of Government Relations, at jboswell@hospitalmedicine.org or 267-702-2632.

Sincerely,

Danielle Scheurer MD

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President
Society of Hospital Medicine