



SUMMARY OF KEY TELEHEALTH AND REMOTE MONITORING PROVISIONS

Centers for Medicare & Medicaid Services

Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

This interim final rule will be effective on its day of publication in the Federal Register. Comments are open for 60 days.

- *Please note that several provisions of this rule do not reflect updated law from the Coronavirus Aid, Relief, and Economic Security Act” or the “CARES Act” signed into law on March 27, 2020. That law altered preexisting relationship requirements for telehealth in Medicare and also altered the telehealth payment structure for Federally Qualified Health Centers, among other things.*

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

To facilitate the use of telecommunications technology as a safe substitute for in-person services, CMS is adding to the list of eligible Medicare telehealth services, eliminating frequency limitations and other requirements associated with particular services furnished via telehealth, and clarifying several payment rules that apply to other services that are furnished using telecommunications technologies that can reduce exposure risks.

- To implement this change on an interim basis, CMS is instructing physicians and practitioners who bill for Medicare telehealth services to report the place of service (POS) code that would have been reported had the service been furnished in person.
- CMS is finalizing on an interim basis the use of the CPT telehealth modifier, modifier 95, which should be applied to claim lines that describe services furnished via telehealth. CMS notes that it is maintaining the facility payment rate for services billed using the general telehealth POS code 02, should practitioners choose, for whatever reason, to maintain their current billing practices for Medicare telehealth during the PHE for the COVID-19 pandemic.
- To enable services to continue while lowering exposure risk, clinicians can now provide the following additional services by telehealth:
 - Emergency Department Visits, Levels 1-5 (CPT codes 99281-99285)
 - Initial and Subsequent Observation and Observation Discharge Day Management (CPT codes 99217- 99220; CPT codes 99224- 99226; CPT codes 99234- 99236)
 - Initial hospital care and hospital discharge day management (CPT codes 99221-99223; CPT codes 99238- 99239)
 - Initial nursing facility visits, All levels (Low, Moderate, and High Complexity) and nursing facility discharge day management (CPT codes 99304-99306; CPT codes 99315-99316)
 - Critical Care Services (CPT codes 99291-99292)
 - Domiciliary, Rest Home, or Custodial Care services, New and Established patients (CPT codes 99327- 99328; CPT codes 99334-99337)
 - Home Visits, New and Established Patient, All levels (CPT codes 99341- 99345; CPT codes 99347- 99350)

- Inpatient Neonatal and Pediatric Critical Care, Initial and Subsequent (CPT codes 99468-99473; CPT codes 99475- 99476)
- Initial and Continuing Intensive Care Services (CPT code 99477- 994780)
- Care Planning for Patients with Cognitive Impairment (CPT code 99483)
- Psychological and Neuropsychological Testing (CPT codes 96130- 96133; CPT codes 96136- 96139)
- Therapy Services, Physical and Occupational Therapy, All levels (CPT codes 97161-97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507)
- Radiation Treatment Management Services (CPT codes 77427)
- Licensed clinical social worker services, clinical psychologist services, physical therapy services, occupational therapist services, and speech language pathology services can be paid for as Medicare telehealth services.

C. Telehealth Modalities and Cost-sharing

- For the duration of the public health emergency as defined in § 400.200 of this chapter, *Interactive telecommunications system* means multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner.”
- OIG previously announced that physicians and other practitioners will not be subject to administrative sanctions for reducing or waiving any cost-sharing obligations Federal health care program beneficiaries may owe for telehealth. OIG’s Policy Statement is not limited to the services governed by § 410.78 but applies to a broad category of non-face-to-face services furnished through various modalities, including telehealth visits, virtual check-in services, e-visits, monthly remote care management, and monthly remote patient monitoring.

D. Communication Technology-Based Services (CTBS)

(Remote patient monitoring and interpretations of diagnostic tests when furnished remotely)

- During the PHE for the COVID-19 pandemic, CMS is finalizing that these services, which may only be reported if they do not result in a visit, including a telehealth visit, can be furnished to both new and established patients.
- CMS is also making clear that the consent to receive these services can be documented by auxiliary staff under general supervision. While consent to receive these services must be obtained annually, it may be obtained at the same time that a service is furnished.
- Several newly announced CY2020 Part B Payment Final code descriptors refer to “established patient,” during the PHE, CMS is exercising enforcement discretion on an interim basis to relax enforcement of this aspect of the code descriptors. Specifically, CMS will not conduct review to consider whether those services were furnished to established patients.
- Clarifying that HCPCS codes G2061-G2063 (specific to practitioners who do not report E/M codes) may be billed by licensed clinical social worker services, clinical psychologist services, physical therapist services, occupational therapist services, or speech language pathologist services, so practitioners that report services in those benefit categories could also report these online assessment and management services.
- Broadening HCPCS codes G2010 and G2012 (remote evaluation of patient images/video and virtual check-ins), recognizing that practitioners such as licensed clinical social workers, clinical

psychologists, physical therapists, occupational therapists, and speech-language pathologists might also utilize virtual check-ins and remote evaluations. Seeking input on other kinds of practitioners who might be furnishing these kinds of services as part of the Medicare services they furnish in the context of the PHE for the COVID-19 pandemic.

E. Direct Supervision by Interactive Telecommunications Technology

- CMS is revising the definition of direct supervision to allow, for the duration of the PHE for the COVID-19 pandemic, direct supervision to be provided using real-time interactive audio and video technology

H. The Use of Technology Under the Medicare Hospice Benefit

- CMS is amending the hospice regulations at 42 CFR 418.204 on an interim basis to specify that when a patient is receiving routine home care, hospices may provide services via a telecommunications system if it is feasible and appropriate to do so.
- To appropriately recognize the role of technology in furnishing services under the hospice benefit, the use of such technology must be included on the plan of care. The inclusion of technology on the plan of care must continue to meet the requirements at § 418.56, and must be tied to the patient-specific needs as identified in the comprehensive assessment and the measurable outcomes that the hospice anticipates will occur as a result of implementing the plan of care.
- Hospices can report the costs of telecommunications technology used to furnish services under the routine home care level of care during the PHE for the COVID-19 pandemic as “other patient care services”

I. Telehealth and the Medicare Hospice Face-to-Face Encounter Requirement

- Amending the regulations at §418.22(a)(4) on an interim basis to allow the use of telecommunications technology by the hospice physician or NP for the face-to-face visit when such visit is solely for the purpose of recertifying a patient for hospice services during the PHE for the COVID-19 pandemic.

J. Modification of the Inpatient Rehabilitation Facility (IRF) Face-to-Face Requirement for the PHE During the COVID-19 Pandemic

- Allows rehabilitation physicians to use telehealth services as defined in section 1834(m)(4)(F) of the Act, to conduct the required 3 physician visits per week during the PHE for the COVID-19 pandemic

L. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

- To facilitate the ability of RHCs and FQHCs to take such measures when appropriate, on an interim basis, CMS is expanding the services that can be included in the payment for HCPCS code G0071, and update the payment rate to reflect the addition of these services.
- *Numerous other changes, that may be rendered obsolete by the CARES Act Passage.*

N. Requirements for Opioid Treatment Programs (OTP)

- CMS is revising § 410.67(b)(3) and (4) to allow the therapy and counseling portions of the weekly bundles, as well as the add-on code for additional counseling or therapy, to be furnished using audio-only telephone calls rather than via two-way interactive audio-video communication technology during the PHE for the COVID-19 pandemic if beneficiaries do not have access to

two-way audio/video communications technology, provided all other applicable requirements are met.

O. Application of Teaching Physician and Moonlighting Regulations During the PHE for the COVID-19 Pandemic

- Allow that all levels of an office/outpatient E/M service provided in primary care centers may be provided under direct supervision of the teaching physician by interactive telecommunications technology. CMS believes use of real-time, audio and video telecommunications technology allows for the teaching physician to interact with the resident through virtual means, and thus would meet the requirement for teaching physician presence for office/outpatient E/M services furnished in primary care centers. Also includes interpretation of diagnostic radiology and other diagnostic tests and psychiatric service.
- Medicare may make payment under the PFS for services billed under the primary care exception by the teaching physician when a resident furnishes telehealth services to beneficiaries under the direct supervision of the teaching physician by interactive telecommunications technology.

Q. Innovation Center Models

- Amending the Medicare Diabetes Prevention Program (MDPP) expanded model to permit certain beneficiaries to obtain the set of MDPP services more than once per lifetime, increase the number of virtual make-up sessions, and allow certain MDPP suppliers to deliver **virtual** MDPP sessions on a temporary basis.

R. Remote Physiologic Monitoring

- RPM services can be furnished to new patients, as well as to established patients.
- Consent to receive RPM services can be obtained once annually, including at the time services are furnished
- Clarifying that RPM codes can be used for physiologic monitoring of patients with acute and/or chronic conditions.

S. Telephone Evaluation and Management (E/M) Services

- Finalizing, on an interim basis for the duration of the PHE for the COVID-19 pandemic, separate payment for CPT codes 98966-98968 and CPT codes 99441-99443 for prolonged, audio-only communication between the practitioner and the patient. Will not conduct review to consider whether those services were furnished to established patients.
- 98966-98968 services may be furnished by, among others, LCSWs, clinical psychologists, and physical therapists, occupational therapists, and speech language pathologists when the visit pertains to a service that falls within the benefit category of those practitioners. Designated as “sometimes therapy” services that would require the private practice occupational therapist, physical therapist, and speech-language pathologist to include the corresponding GO, GP, or GN therapy modifier on claims for these services.

W. Level Selection for Office/Outpatient E/M Visits When Furnished Via Medicare Telehealth

- Revising CMS policy to specify that the office/outpatient E/M level selection for these services when furnished via telehealth can be based on MDM or time, with time defined as all of the time associated with the E/M on the day of the encounter; and to remove any requirements regarding documentation of history and/or physical exam in the medical record.