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CMS Broadens Telehealth Access Across the Board, Including Audio-Only Telephone Services

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On April 30, 2020, the Centers for Medicare & Medicaid Services (CMS) issued an interim final rule with comment period (April 30 Interim Rule), building on previous regulatory waivers and other revisions to regulations issued March 31, 2020 in an interim final rule (March 31 Interim Rule) in response to the COVID-19 public health emergency (PHE). Among other changes, the April 30 Interim Rule further broadens access to patient care provided via telehealth and other communication technology-based services and increases reimbursement for some of these services. Highlights of these changes and pertinent background are provided below.

Payment Under the Physician Fee Schedule for Audio-Only Telephone Evaluation and Management Services

Prior to the PHE, a number of services that did not qualify as Medicare "telehealth" services were available for reimbursement to physicians and other practitioners able to furnish evaluation and management (E/M) services to Medicare beneficiaries, including:

- brief audio-only telephone communications called "virtual check-ins" (HCPCS code G2012),
- online digital assessment services called "E-Visits" (CPT codes 99421-99423), and
- the remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward, HCPCS code G2010).

These services could only be provided to established patients. In the March 31 Interim Rule, CMS indicated it would allow these services to be provided to both new and established patients on an interim basis during the PHE.

CMS emphasized that the audio-only virtual check-ins are to be used only where patient needs are not significant enough to require the increased time and attention that is specified in codes for in-person or telehealth visits. However, in the March 31 Interim Rule, in the PHE context, CMS

recognized there were circumstances where prolonged, audio-only communications could be clinically appropriate – but that this would *not* include more complex situations where a face-to-face or telehealth visit would be indicated. To accommodate this, for the duration of the PHE, where two-way audio/video capability "might not be available," CMS decided to allow prolonged, audio-only communication to be reimbursed using existing telephone E/M codes 99441-99443, for practitioners who can bill for E/M services, and codes 98966-98968, for practitioners who cannot separately bill for E/Ms (including, among others, licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists). Prior to the PHE, while these codes existed, they were designated as "noncovered."

CMS provided the following example of a circumstance where prolonged, audio-only communication between the practitioner and the patient could be clinically appropriate, yet not fully replace a face-to-face visit:

an established patient who was experiencing an exacerbation of their condition could have a 25-minute phone conversation with their physician during which the physician determines that an adjustment to the patient's medication would alleviate their symptoms. The use of CPT code 99443 in this situation prevents a similar in-person service.

As CMS stated in the March 31 Interim Rule, these codes can be used during the PHE for audio-only telephone E/M services comprised of medical discussions that do not originate from a related E/M service provided within the previous 7 days or lead to an E/M service or procedure within the next 24 hours (or the soonest available appointment). According to CMS, the codes may be used for both new and established patients during the PHE and it will "not conduct review to consider whether those services were furnished to established patients." The assigned RVU's for reimbursement were .25 for codes 98966 and 99441, .50 for codes 98967 and 99442, and 0.75 for codes 98968 and 99443. CMS also finalized direct PE inputs consisting of 3 minutes of post-service RN/LPN/MTA clinical labor time for each code. However, as of the posting of the March 31 Interim Rule, these audio-only services were *not* considered "telehealth" services.

Prior to the PHE, the provision of telehealth services could not be made using a telephone, even if it had real-time interactive audio and video capabilities. This requirement was waived during the PHE, allowing telephones to be used to provide telehealth services for the duration of the PHE, as long as the telephones had *both* audio and video interactive, real-time communication capabilities. The April 30 Interim Rule provided an additional limited expansion of this waiver.

In the April 30 Interim Rule, CMS said that stakeholders had informed it that the use of audio-only services was more prevalent than previously considered, and in some situations audio-only E/M services were being furnished as substitutes for office/outpatient E/M services. CMS recognized that in those cases the audio-only communications more closely approximated regular face-to-face encounters. Accordingly, CMS decided to recognize the services described by audio-only E/M service codes 99441-99443 as "telehealth" services, and added them to the published list of Medicare telehealth services for the duration of the PHE. CMS did not add codes 98966-98968 to the telehealth services list or increase the payment rates for these codes (audio-only telephone services furnished by non-physician practitioners who cannot independently bill for E/M services).

In order to determine reimbursement during the PHE, CMS cross-walked these codes to the most analogous office/outpatient E/M codes. Specifically, codes 99441, 99442, and 99443 were cross-walked to codes 99212, 99213, and 99214, respectively. For the duration of the PHE, CMS increased the work RVUs from the lower values listed in the March 31 Interim Rule — from .25 to .48 for code

99441; from .50 to .97 for code 99442; and from .75 to 1.50 for code 99443.

CMS cautioned that the E/M service codes should not be used for administrative or other non-medical discussion with the patient. CMS also encouraged practitioners to educate beneficiaries on cost-sharing policies, noting that although practitioners can waive cost-sharing during the PHE, patients are still liable for cost-sharing amounts where practitioners do not waive them.

CMS is seeking comments on how to minimize unexpected cost-sharing, plans to monitor utilization of these services, and said that it will potentially consider refining billing rules, documentation requirements or claims edits in future rulemaking. CMS provided a link to the full list of Medicare telehealth services, including those added during the PHE. CMS indicated it will be issuing a separate 1135(b) waiver under the CARES Act for telehealth services to be able to be provided using audio-only technology in the circumstances described in the Interim Rule preamble.

Revisions to the Process Used to Update the Medicare Telehealth List

CMS has revised 42 CFR § 410.78(f) to specify that, during a PHE, CMS will use a "subregulatory process" to modify the services included on the Medicare telehealth list without notice and comment rulemaking. CMS noted that this could involve posting new services to the web listing of telehealth services when the agency receives a request to add (or identifies through internal review) a service that can be furnished in full, as described by the relevant code, by a distant site practitioner to a beneficiary in a manner that is similar to the in-person service. CMS also stressed that any additional services added using the revised process would remain on the list only during the PHE for the COVID-19 pandemic.

Time Used for Level Selection for Office/Outpatient Evaluation and Management Services Furnished Via Medicare Telehealth

On March 31, CMS had revised its policy to specify that the office/outpatient E/M level selection for office/outpatient E/M services when furnished via telehealth can be based on either medical decision-making (MDM) or time, with time defined as all of the time associated with the E/M on the day of the encounter. CMS provided a link to a public use file containing MDM times. According to CMS, members of the physician community subsequently pointed out that the MDM times in the public use file did not align with the typical times included in the office/outpatient E/M code descriptors. Acknowledging this confusion, CMS changed its policy to provide that, for the duration of the PHE for the COVID-19 pandemic, the times to be used for purposes of level selection for an office/outpatient E/M are those times listed in the CPT code descriptors.

Hospital Services Accompanying a Professional Service Furnished Via Telehealth

Prior to the PHE, CMS paid the billing physician or practitioner at the lower "facility" rate and the POS was designated as code 02 (specific to telehealth), since the facility costs would generally be incurred by the originating site, where the patient was located. On March 31, CMS had instructed physicians, and others furnishing telehealth services to patients in their homes during the PHE, to report the POS on the bill as if they were furnishing the services in person. This meant that, effective March 1, 2020 and for the duration of the PHE, practitioners who ordinarily practice in a hospital outpatient department (HOPD) would submit professional claims for telehealth services using the HOPD POS code. Medicare would pay under the Physician Fee Schedule at the "facility" rate. On

the other hand, a physician who normally sees patients in an office setting (not hospital-based) would use the office POS code and would be paid at the non-facility, office rate for telehealth services. Modifier 95 (telehealth) would be applied to the claims, although CMS noted that payments would still be made where the POS was designated as 02, for practitioners who chose to maintain their prior billing practices during the PHE.

With the patient's home now being allowed as an originating site during the PHE, a hospital would be able to bill the originating site facility fee for a beneficiary who is a registered outpatient — including when the patient is at home — but only when the services are provided after the home is made a provider-based department (PBD) of the hospital – meaning the applicable conditions of participation are met, to the extent they are not waived during the PHE. CMS notes that when a telehealth service is provided to a patient located in an HOPD, "the hospital is presumed to provide administrative and clinical support services."

Opioid Treatment Programs (OTPs)

For patients receiving services for opioid use disorders during the PHE, who do not have access to two-way audio-video communications technology, the March 31 Interim Rule allowed the therapy and counseling portions of the weekly bundle of services, as well as the add-on code for additional counseling or therapy services, to be provided by audio-only communications. The April 30 Interim Rule permits periodic assessments to be furnished by OTPs using two-way interactive audio-video communication technology (or using audio-only telephone calls if there is no access to such two-way audio-video technology), provided all other applicable requirements are met. CMS cautioned OTPs to use clinical judgment to determine whether they can adequately perform the periodic assessment over audio-only phone calls — if not, then the assessment should be performed using two-way interactive audio-video communication technology, or in person as clinically appropriate. CMS noted that SAMHSA offers flexibilities to states to ensure that individuals being treated with medication for opioid use disorders can continue to receive their medication during the PHE for the COVID-19 pandemic, and provides specific guidance online.

Partial Hospitalization Programs (PHPs)

CMS expects PHP services to be furnished using technology involving both audio and video, but acknowledged in the April 30 Interim Rule that some patients may not have access to video communications. For these patients, during the PHE, CMS is permitting certain individual psychotherapy, education, and group psychotherapy services that hospitals or community mental health center (CMHC) staff can furnish to patients in their home or other temporary expansion location that functions as a provider-based department of the hospital or expanded CMHC when the beneficiary is registered as an outpatient. CMS is maintaining a list online of the individual psychotherapy, patient education, and group psychotherapy services that hospitals or CMHCs can provide in such circumstances, and plans to update it periodically. CMS also reminds providers "services that require drug administration cannot be furnished using telecommunications technology."

Additional Flexibility under the Teaching Physician Regulations

For teaching physicians to obtain reimbursement under Medicare, sufficient personal and identifiable physicians' services must be provided to the patient to exercise full, personal control over the management of the portion of the case for which payment is sought. There is an exception for

primary care. Under 42 CFR § 415.174, Medicare reimburses for certain professional services of lower and mid-level complexity furnished by a resident in the primary care setting without a teaching physician being present. Teaching physicians can only direct the care of four residents at a time, must have no other responsibilities at the time, be immediately available (i.e., provide direct supervision), assume management responsibility for the patients seen by residents, ensure that the services furnished are appropriate, and review with each resident during or immediately after each visit the medical history, physical examination, diagnosis, and record of tests and therapies.

In the March 31 Interim Rule, CMS allowed a teaching physician to meet the physical presence requirement through direct supervision by audio/video real-time communications technology. CMS also revised the scope of E/M codes that can be furnished under the primary care exception and amended regulations to allow all levels of office/outpatient E/M services furnished in primary care centers under the primary care exception to be furnished under direct supervision of the teaching physician by interactive telecommunications technology.

In the April 30 Interim Rule, CMS is allowing teaching physicians to direct care furnished by residents, and also review services provided with the resident, during or immediately after the visit, remotely via audio/video real time communications technology.

CMS explained, for example, that “this means that Medicare may make payment under the PFS for teaching physician services when a resident furnishes services permitted under the primary care exception, including via telehealth, and the teaching physician can provide the necessary direction, management and review of the resident’s services using interactive audio/video real-time communications technology.”

The remainder of the requirements continue to apply in that the teaching physician must have no other responsibilities at the time, assume management responsibility for the beneficiaries seen by the residents, ensure that the services furnished are appropriate, and review with each resident during or immediately after each visit the beneficiary’s medical history, physical examination, diagnosis, and record of tests and therapies.

For the duration of the PHE, Medicare will reimburse the teaching physician for the following additional services when furnished by a resident under the primary care exception:

- CPT code 99421-99423, 99441-99443, 99452, 99495–99496
- HCPCS codes G2010 and G2012

CMS also clarified that the office/outpatient E/M level selection for services under the primary care exception when furnished via telehealth can be based on MDM or time, and the requirements regarding documentation of history and/or physical exam in the medical record do not apply. According to CMS, this means that on an interim basis for the duration of the PHE, Medicare will reimburse for teaching physician services when a resident furnishes a service included in the expanded list of services in primary care centers, including via telehealth, and the teaching physician can provide the necessary direction, management and review for the resident’s services using audio/video real-time communications technology.

Payment for Remote Physiologic Monitoring (RPM) Services Furnished During the COVID-19 Public Health Emergency

In the March 31 Interim Rule, CMS updated policies related to payment for Remote Physiologic Monitoring services under the Physician Fee Schedule during the PHE, in order “to eliminate as many unnecessary obstacles as possible to delivering these services as part of the response to the pandemic.” To that end, CMS allowed RPM services to be furnished during the PHE to new patients in addition to established patients; with beneficiary consent to be obtained at the time services are furnished and by auxiliary personnel for physiologic monitoring of patients with acute and/or chronic conditions; and under general supervision. The April 30 Interim Rule establishes a policy for the duration of the PHE to allow RPM monitoring services to be reported to Medicare for periods of time that are fewer than 16 days of 30 days, but no less than 2 days, as long as the other requirements for billing for RPM monitoring are met, and the patient has a suspected or confirmed diagnosis of COVID-19.

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