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CMS Continues to Support Telehealth and Virtual Care Policies in the CY 2021 Medicare Physician Fee Schedule Final Rule

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On December 1, 2020, CMS released the Calendar Year (CY) 2021 Medicare Physician Fee Schedule (MPFS) Final Rule (Final Rule), which includes several policies to extend or make permanent certain policies to support expanded coverage of telehealth services and remote monitoring beyond the COVID-19 public health emergency (PHE). Examples include adding services to the Medicare list of covered telehealth services, finalizing new payment codes for virtual services such as a longer audio-only virtual check-in, modifying certain frequency limitations and other requirements associated with particular services furnished via telecommunications technology, and clarifying payment rules applicable to other services.

While statutory limitations prevent CMS from making changes to some of the most restrictive telehealth coverage requirements (including those that prevent Medicare reimbursement for telehealth services furnished to beneficiaries in urban areas or in their homes), several policies in the Final Rule build upon and clarify coverage of other virtual services, such as remote physiologic monitoring. The ongoing expansion of coverage of remote services, paired with new exceptions and safe harbors in the regulations recently released in connection with HHS's Regulatory Sprint to Coordinated Care, will allow for innovative uses of telecommunications technology to better support patients throughout the care continuum even after the COVID-19 PHE ends.

Temporary and Permanent Additions to the Medicare Telehealth Services List

Before the COVID-19 PHE, Medicare only covered certain services furnished via telehealth, including (1) professional consultations, (2) office medical visits, (3) office psychiatry services, and (4) any additional service specified by the HHS Secretary when furnished via an interactive telecommunications system. These services are all included on a list that is amended and published annually in the MPFS (the Medicare Telehealth List).

CMS finalized the permanent addition of the following services that were all proposed to be added to the Medicare Telehealth List on a Category 1 basis. This means that these services are similar to the professional consultations, office visits, and office psychiatry services that are already covered on the list.

- Group Psychotherapy (90853)
- Neurobehavioral Status Exam (96121)
- Care Planning for Patients with Cognitive Impairment (99483)
- Domiciliary, Rest Home, or Custodial Care Services, Established Patients (99334-99335)
- Domiciliary, Rest Home, or Custodial Care services (99335)
- Home Visits, Established Patient (99437 and 99438)
- Visit Complexity Inherent to Certain Office/Outpatient E/Ms (HCPCS code G2211)
- Prolonged Services (HCPCS code G2212)

CMS also finalized extending the addition of several services temporarily added to the Medicare Telehealth List during the COVID-19 PHE. On a newly created Category 3 basis, the following list of services (which is

notably longer than the list included in the Proposed Rule) will be temporarily added through the end of the calendar year in which the PHE ends:

- Domiciliary, Rest Home, or Custodial Care Services, Established Patients (99336, 99337)
- Home Visits, Established Patient (99349, 99350)
- Emergency Department Visits, Levels 1-5 (99281-99385)
- Nursing Facilities Discharge Day Management (99315, 99316)
- Psychological and Neuropsychological Testing (96130-96133, 96136-96139)
- 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)
- Hospital Discharge Day Management (CPT codes 99238-99239)
- Inpatient Neonatal and Pediatric Critical Care, Subsequent (CPT codes 99469, 99472, 99476)
- Continuing Neonatal Intensive Care Services (CPT codes 99478-99480)
- Critical Care Services (CPT codes 99291-99292)
- End-Stage Renal Disease Monthly Capitation Payment codes (CPT codes 90952, 90953, 90956, 90959, 90962)
- Subsequent Observation and Observation Discharge Day Management (CPT codes 99217, 99224-99226)

Audio-only Virtual Check-ins

CMS has received substantial positive feedback regarding the audio-only telephone (E/M) services that were established on a temporary basis during the COVID-19 PHE. While CMS did not find it consistent with Section 1834(m) Medicare telehealth coverage requirements to finalize codes for audio-only E/M telehealth services beyond the PHE, CMS instead established payment on an interim final basis for a new HCPCS code G2252 describing 11-20 minutes of medical discussion to determine the medical necessity of an in-person visit. The new G-code is not actually an E/M code, but instead is better described as a longer virtual check-in with a higher value. This new code will allow audio-only interactions to be used for a longer medical discussion to determine the necessity of an in-person visit. Notably, this code is not a telehealth service that falls under the statutory payment restrictions of Section 1834 (m) of the Social Security Act. Rather, this longer audio virtual check-in is a communication-based technology service subject to the same billing requirements as HCPCS code G2012 (e.g., if the service originates from a related E/M service or procedure within the next 24 hours or soonest available appointment, it will be bundled into that in-person service).

Remote Physiologic Monitoring (RPM) Services

In the Final Rule, CMS clarified existing payment policies related to RPM services represented by CPT codes 99453, 99454, 99091, 99457, and 99458, and made permanent two temporary COVID-19-related modifications to RPM services.

CMS finalized as a permanent policy the temporary COVID-19-related flexibility that a beneficiary's consent to receive RPM services may be obtained at the time of the services. While CMS has allowed RPM services to be furnished to new patients in response to the COVID-19 PHE, the Final Rule clarifies that once the PHE ends, RPM services may only be furnished to patients with an established physician-patient relationship.

The Final Rule also includes CMS's proposed clarification that the medical device supplied to a patient as part of an RPM service (e.g., CPT 99454 − remote monitoring of physiologic parameter(s) that includes instructing a patient and/or caregiver about using one or more medical devices) must meet the FDA definition of a medical device included in Section 201(h) of the Federal Food, Drug, and Cosmetic Act. The device must be reliable and valid, and the patient's physiologic data must be automatically and electronically collected and transmitted, not self-recorded or self-reported by the patient.

With respect to remote physiologic monitoring treatment management services described by CPT 99457 and 99458, CMS clarified that an "interactive communication" is a conversation that occurs in real time and includes synchronous, two-way audio interactions "capable of being enhanced with video or other kinds of data transmission," as described by HPCS Code G2012. Further, the 20 minutes of time required to bill for these CPT codes is not limited to the required interactive communication, but may also include time for furnishing care management services.

Even though there was some indication in the past that RPM services were limited to patients with chronic conditions, the Final Rule clarifies that practitioners may furnish RPM services to patients with acute conditions when medically necessary.

CMS clarified that only physicians and nonphysician practitioners (NPPs) eligible to furnish E/M services may order and bill for RPM services. At the same time, CMS finalized its proposal to allow auxiliary personnel (including leased or contracted employees) to furnish the RPM services described by CPT codes 99453 and 99454 incident to the billing practitioner's services and under his/her supervision. CMS also clarified that 16 days of data must be collected and transmitted every 30 days to meet the requirements of these codes after the PHE ends.

Smart Phones as Interactive Telecommunication Systems

CMS finalized a technical amendment to existing Medicare telehealth regulations at 42 CFR § 410.78(a)(3) to remove the language that provides that "[t]elephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunication system." Under the Final Rule, the revised definition of "interactive telecommunication systems" will mean any "multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication." This is designed to remove outdated references to specific technology to resolve confusion, and confirm that equipment such as smart phones may qualify as an interactive telecommunication system for purposes of satisfying Medicare coverage requirements for telehealth services, even though such equipment may be used as a telephone.

Direct Supervision via Telemedicine

Based on positive feedback regarding a temporary policy implemented in response to the COVID-19 PHE, CMS finalized its proposal to allow the necessary presence of a physician for direct supervision to include virtual presence through real-time audio and video technology through the later of the end of the calendar year in which the PHE for COVID-19 ends or December 31, 2021.

Incident To Services

Consistent with clarifications made in the May 8 COVID-19 Interim Final Rule, CMS has now confirmed that services provided incident to the professional services of an eligible distant site physician or practitioner could be reported when they meet direct supervision requirements at both the originating and distant site through the virtual presence of the billing physician or practitioner. Therefore, services that may be billed incident to may be provided via telehealth incident to a physician's (or authorized NPP's) service and under the direct supervision of the billing professional.

Payment for Teaching Physician Services Furnished Using Interactive Telecommunications Technology

CMS finalized a policy allowing teaching physicians in teaching settings outside of a metropolitan statistical area (MSA) to use interactive real-time audio/video technology for purposes of meeting the requirement that they be present for key and critical portions of the service. This new policy is also applicable when the teaching physician involves the resident in furnishing Medicare telehealth services. Also, for residency training sites in teaching settings outside of an MSA, CMS finalized a permanent policy to allow teaching physicians to provide

the necessary direction, management, and review of residents' services as needed to satisfy the primary care exception, using real-time audio/video technology. For primary care centers in these sites, CMS has also finalized an expanded list of services that can be furnished under the primary care exception, including communications technology-based services (such as virtual check-ins) and inter-professional consults.

Virtual Services Furnished by LCSWs, PTs, OTs, and SLPs

The Final Rule includes CMS's clarification that licensed clinical social workers (LCSWs), clinical psychologists, physical therapists (PTs), occupational therapists (OTs), and speech language pathologists (SLPs) can furnish brief online assessment and management services, virtual check-ins, and remote evaluation services as clinical practitioners. CMS also established two new HCPCS codes to allow these practitioners to bill for remote evaluation of virtual check-ins and visual images and video submitted by patients. Given that these services do not fall under Medicare's statutory definition of "telehealth" services, this expansion of practitioners who may furnish these services could be made without changing the statutory definition of "distant site practitioner."

Services Furnished via Telecommunications Technology to Patients in the Same Location as the Physician/Practitioner

CMS also reiterates in the Final Rule that the telehealth rules do not apply when the individual physician or practitioner is in the same location as the beneficiary even if audio/video technology is used when furnishing the service (e.g., a physician or practitioner is in the hospital providing services through telecommunications technology to a patient in a different part of the same hospital in order to reduce risks of exposure). These same location services should be billed as if they were provided in person even if telecommunications technology is used.

Frequency Limitations

Before COVID-19, subsequent hospital care services (inpatient and nursing facility visits) were limited to one telehealth visit every three days for hospital inpatients and one visit every 30 days for patients in a nursing facility. CMS temporarily removed these frequency limitations for the duration of the COVID-19 PHE.

Based on stakeholder feedback, CMS proposed to revise the frequency limitation for subsequent nursing facility visits from one visit every 30 days to one visit every three days. Citing concerns that this could create a disincentive to in-person care and taking into account the fact that nursing facility patients often have longer lengths of stay, CMS decided to finalize a frequency limitation for subsequent nursing facility telehealth visits of one visit every 14 days.

Electronic Prescribing of Controlled Substances

Pursuant to section 2003 of the Support Act, the prescribing of a Schedule II, III, IV or V controlled substance under Medicare Part D must be done electronically in accordance with an electronic prescription drug program, subject to HHS-specified exceptions. CMS solicited feedback through a July 30 Request for Information (RFI) and the CY 2021 MPFS Proposed Rule on whether it should impose penalties for noncompliance. In the Final Rule, CMS finalized that effective January 1, 2021, prescribers are required to use the National Council for Prescription Drug Programs (NCPDP) SCRIPT 2017071 standard for EPCS prescription transmissions, but the deadline is January 1, 2022, to allow more time for compliance with the mandate.

Take-Aways

Waivers and flexibilities issued to facilitate broader access to telehealth in response to the COVID-19 PHE resulted in a broader adoption of telehealth services and virtual care. This has allowed providers and practitioners to gain a better understanding of the best clinical applications and to provide CMS with feedback on proposed telehealth policies. Taking into account this input, CMS finalized policies to expand coverage of telehealth and communication technology-based services in contexts in which remote services have proven to

enhance patient care. CMS also has clarified and temporarily extended coverage for certain services beyond the end of the COVID-19 PHE. More comprehensive expansions of coverage will require Congressional action to remove statutory Medicare telehealth reimbursement requirements. In the meantime, the Final Rule provides further insights into telehealth reimbursement beyond the pandemic and will ensure that providers that have implemented telehealth solutions have more clarity regarding the time period during which they may rely on coverage for certain telehealth services, virtual supervision, and remote care.

For more information, please contact Allison Cohen or any member of Baker Donelson's Telehealth team.