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CY 2024 Medicare Physician Fee Schedule: Extending Telehealth Flexibilities and Seeking Future Policy Input

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CMS recently released the CY 2024 Medicare Physician Fee Schedule (MPFS) Proposed Rule (Proposed Rule), which included many noteworthy proposals and clarifications related to Medicare telehealth services and other remote services. Since the COVID-19 Public Health Emergency (PHE) terminated on May 11, 2023, providers and practitioners have sought clarity on the end dates of various waivers and telehealth flexibilities. The Proposed Rule removes some ambiguity by extending certain telehealth flexibilities that were within CMS's discretion and implementing statutory extensions that were included in the Consolidated Appropriations Act, 2023 (CAA, 2023). While CMS FAQ Guidance issued at the end of the PHE hinted at some of these extensions, the proposed rule provides more clarity – at least through the end of 2024.

As an overview, the Proposed Rule includes proposals to:

1. Implement all telehealth provisions of the CAA, 2023 which temporarily lifted statutory limitations on coverage of telehealth services through the end of 2024.
2. Pay all claims for telehealth services other than those for services furnished to patients in their homes at the lower MPFS facility rate beginning on January 1, 2024. This applies to any non-home originating sites such as physician offices. In contrast, all telehealth services provided to patients in their homes would paid at the non-facility rate.
3. Allow hospital outpatient departments to continue to bill for outpatient therapy, Diabetes Self-Management Training (DSMT), and Medical Nutritional Therapy (MNT) furnished remotely via telehealth by institutional staff to beneficiaries in urban areas (as opposed to only rural areas) and to beneficiaries in their homes (through the end of 2024).
4. Define direct supervision to permit the presence and immediate availability of the supervising practitioner through real-time audio and visual interactive telecommunications (through the end of 2024).
5. Allow teaching physicians to be virtually present for key and critical portions of services performed with residents in all teaching settings in clinical instances when the service is furnished virtually through telehealth. CMS is exercising enforcement discretion through the end of 2024 to allow teaching physicians to be virtually present through telehealth in clinical instances where the service is not furnished via telehealth.
6. Remove frequency limitations on telehealth services applicable to subsequent inpatient visits, subsequent nursing facility visits, and critical care consultation services (through the end of 2024).
7. Modify its process for making changes to the Medicare Telehealth List. CMS also proposes to add a new code to the Medicare Telehealth List for the administration of a standardized evidence-based social determinants of health risk assessment.
8. Clarify policies and requirements for Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) services. CMS also confirms that these services will only be available for established patients now that the PHE is over and codes that require data collection minimums will go back to requiring 16 days of data collected in a 30-day period.

Comments on the Proposed Rule are due at 5:00 p.m. on September 11, 2023.

Below is a more detailed summary of proposals related to telehealth and remote services including some context related to pre-existing policies and the implications of the proposals.

1. CAA, 2023 Extensions

The Proposed Rule implements all telehealth provisions extended through the end of 2024 by the Consolidated Appropriations Act, 2023. This includes:

- Lifting geographic restrictions and maintaining the expanded list of originating sites including patient's homes.
- Expanding the list of distant site practitioners to include Physical Therapists (PTs), Occupational Therapist (OTs), Speech Language Pathologists (SLPs), and Audiologists. Marriage and family therapists (MFT) and mental health counselors (MHC) will be recognized as telehealth practitioners effective January 1, 2024.
- Extending telehealth to FQHCs and RHCs.
- Delaying until January 1, 2025, the required in-person visit for telehealth mental health services.
- Extending audio-only telehealth.

2. Place of Service for Medicare Telehealth Services

Under COVID-19 PHE flexibilities, physicians and other practitioners have reported the place of service (POS) that would have been reported had the service been furnished in-person. Services were reported with modifier 95 to effectuate this change. The payment impact was services that would have been furnished in person in an office setting could be paid at a higher MPFS non-facility rate when furnished via telehealth. This was never the case before the PHE where all telehealth services were reported with POS 02 and paid at the lower facility rate.

In the CY 2023 MPFS final rule, CMS finalized that following the end of the calendar year in which the PHE ends, practitioners will no longer be able to bill telehealth claims with modifier 95 along with the POS code that would have been applied if the service were furnished in person. Instead, telehealth claims would have to be billed with the following POS indicators:

- POS 02 – Telehealth Provided Other Than in Patient's Home (Descriptor: Patient is not located in their home when receiving health services or health-related services through telecommunication technology).
- POS 10 – Telehealth Provided in Patient's Home (Descriptor: the location where health services and health-related services are provided or received through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence when receiving health services or health-related services through telecommunication technology).

Beginning on January 1, 2024, claims billed with POS 10 will be paid at the non-facility telehealth rate, but all other telehealth claims billed with POS 02 will be paid at the facility rate. This would mean that POS 02 would be reported for any non-home originating site such as physician offices. Accordingly, telehealth services furnished to patients receiving the services in physician offices would be paid at the lower facility rate (i.e., at a rate that is less than if they were furnished in person).

CMS decided that behavioral health services provided to patients when they are in their homes should be valued at the office setting rate even if provided to patients at home because many mental health practitioners see patients in their office and at home so they have to maintain an office as practice expenses even if a

significant portion of the practice's visits are conducted via telehealth. As such, CMS decided the practice expenses for these practices are more accurately reflected by the non-facility rate.

In sum, CMS is proposing that all telehealth services provided to patients who are not in the home (including patients in physician's offices) will be paid at the facility rate starting at the beginning of CY 2024. In contrast, all telehealth services provided to patients in their homes should be reported with POS 10 and paid at the non-facility rate. This could include all Medicare-eligible telehealth services for the period of time that the home is still an originating site for all services (through the end of 2024). Without further legislative changes, when the CAA, 2023 extension of the flexibilities related to originating sites end, the patient's home will not be a Medicare-eligible originating site for services other than mental health and other very limited exceptions. Therefore, most all telehealth claims other than mental health telehealth would be paid at the facility rate. Mental health telehealth services will continue to be paid at the non-facility rate when provided to patients in their homes, but if a mental health practitioner provides telehealth services to a patient in a hospital or facility setting, that would be reported as POS 02 and paid at the facility rate.

3. Extension of Virtual Presence for Direct Supervision

During the PHE, CMS allowed "immediate availability" required for direct supervision of diagnostic tests, physicians' services, and certain outpatient services to allow the supervising professional to be immediately available through virtual presence using two-way, real-time audio/video technology, instead of requiring their physical presence. CMS also allowed immediate availability for direct supervision through virtual presence for purposes of meeting incident-to-billing requirements.

To prevent abrupt changes to practice patterns that CMS acknowledged could limit access to certain services, CMS is proposing to continue to define direct supervision to permit the presence and immediate availability of the supervising practitioner through real-time audio and visual interactive telecommunications through December 31, 2024. CMS believes this will align the timeframe of this policy with the extension of many other telehealth flexibilities. During this extension, CMS is seeking comments on a more permanent extension.

CMS suggests that one potential approach would be to extend or permanently establish the virtual presence flexibility for services that are valued under the MPFS based on the presumption that they are nearly always performed in entirety by auxiliary personnel. This could include any service wholly furnished incident to a physician's or practitioner's professional services as well as Level I office or other outpatient E/M visits for established patients and Level I emergency visits.

4. Virtual Presence of Teaching Physicians

During the PHE, teaching physicians could satisfy teaching physician billing requirements by being virtually present through real-time audio-video telehealth technology for key and critical portions of services performed with a resident. Outside the PHE this was only allowed in rural teaching settings.

CMS is now proposing to allow teaching physicians to continue to have virtual presence in all teaching settings in clinical instances when the service is furnished virtually through telehealth (e.g., a three-way telehealth visit with parties in different locations). This virtual presence policy continues to require real-time observation (not mere availability) by the teaching physician, and excludes audio-only technology.

CMS is exercising enforcement discretion to allow teaching physicians in all residency sites to be present through audio/video real-time communications technology for purposes of billing under the MPFS for services they furnish involving residents through the end of the CY 2024 rulemaking process.

CMS seeks comment on how telehealth services can be furnished in all residency training locations beyond Dec. 31, 2023. This includes other clinical treatment situations that are appropriate to permit the virtual presence of a teaching physician.

5. Extension of Flexibilities that Allow Hospital Outpatient Departments to Bill for Certain Telehealth Services Furnished by Institutional Staff

CMS proposes to allow hospital outpatient departments to bill for telehealth services furnished by therapists through the end of 2024. This includes continuing to allow outpatient therapy, Diabetes Self-Management Training (DSMT) and Medical Nutritional Therapy (MNT) services to be furnished remotely by institutional staff to beneficiaries in their homes when furnished by institutional providers via telehealth.

During the PHE, CMS allowed outpatient therapy services to be furnished and billed by therapists in private practice and also allowed for outpatient therapy services, DSMT, and MNT to be furnished via Medicare telehealth to beneficiaries in urban areas (as opposed to only rural area) and to beneficiaries in their homes.

CMS originally took the position that institutions billing for services furnished remotely by their employed practitioners (where the practitioners do not bill for their own services), would end when the PHE ends along with the end of the Hospitals Without Walls waivers. CMS is now considering whether certain institutions should be able to bill for certain remotely furnished services personally performed by employed practitioners.

While CMS considers how it would implement a more permanent policy, CMS will continue to allow outpatient therapy, DSMT, and MNT services to be furnished remotely by institutional staff to beneficiaries in their homes when furnished by institutional providers via telehealth. To effectuate this, institutional providers will be able to continue to bill for these services when furnished remotely in the same manner they have during the COVID-19 PHE through the end of CY 2024.

CMS also stated that it is exercising enforcement discretion to allow practitioners who would not otherwise qualify as Medicare distant site practitioners to continue to remotely furnish DSMT services as long as they are otherwise qualified to provide the services.

CMS seeks comment on current practice for these services when billed including how and to what degree they continue to be provided remotely to beneficiaries in their homes, as well as relevant authorities to continue to permit billing for these services in future rulemaking. Moreover, CMS has indicated that it plans to broadly consider billing and payment for telehealth services in institutional settings, including when these services are furnished by practitioners who have reassigned their billing rights to an institution (this would include billing arrangements where practitioners reassign billing rights to Critical Access Hospitals (CAHs), and CMS makes payment for the practitioner's services under CAH method II).

6. Frequency Limitations on Telehealth Services

Before the PHE, the following frequency limitations were in place:

- Limit of one telehealth visit every three days for subsequent inpatients visits.
- Limit of one telehealth visit every 14 days for subsequent nursing facility visits.
- Limit on critical care consultations to one telehealth visit per day.

CMS waived the frequency limitations for subsequent inpatient visits, subsequent NF visits, and critical care consultations for the duration of the PHE. Even though the frequency limitations resumed effect beginning on May 12, 2023 (upon expiration of the PHE), CMS used waiver authority to exercise enforcement discretion with respect to these frequency limitations through December 31, 2023.

In the CY 2024 MPFS proposed rule, CMS is proposing to remove telehealth frequency limitations for the duration of CY 2024 for the following codes:

- Subsequent inpatient visit CPT codes (99231, 99232, 99233)
- Subsequent nursing facility visit CPT codes (99307, 99308, 99309, 99310)
- Critical Care Consultation Services - HCPCs Codes: G0508, G0509

CMS is gathering data and seeking comments on a more permanent policy with a focus on ensuring that Medicare beneficiaries are receiving subsequent inpatient and nursing facility visits and critical care services while the temporary policy remains in place post-expiration of the PHE.

7. Telehealth Services List

CMS proposes to clarify and modify its process for making changes to the Medicare Telehealth List. In previous years services were added on a Category 1, Category 2, or Category 3 basis. Now that the PHE is over, CMS proposes to clarify and modify its process for making changes to the Medicare Telehealth List. One goal is to distinguish services that were added to the telehealth list on the basis of COVID-19 PHE-related authorities versus services that were added temporarily on a Category 3 basis, which do not rely on a PHE-related authority.

CMS will assign permanent or provisional status to any service that maps to the service elements of a permanent telehealth service or has evidence of clinical benefit when delivered via telehealth. Once provisional services have enough evidence of clinical benefit, they will be assigned permanent status. For FY 2024, CMS proposes that services currently added on a "temporary Category 2" or Category 3 basis will be assigned to the "provisional" category. Our prior article provides further guidance on the Category assignments for various services on the telehealth list.

CMS proposes to temporarily add health and well-being coaching services to the Medicare Telehealth List for CY 2024. Additionally, CMS proposes to permanently add a new code to the Medicare Telehealth List for the Administration of a standardized evidence-based Social Determinants of Health Risk Assessment as long as the broader proposal for Medicare to pay for such risk assessments is finalized. More specifically, CMS is allowing a face-to-face encounter element of the social determinants of health (SDOH) risk assessment service to be permitted to be performed via two-way interactive audio-video technology as a substitute to in-person interaction as long as the telehealth modality does not affect the accuracy or validity of the results gathered via a standardized screening tool. CMS is also proposing that this service must be furnished by the practitioner on the same date they furnish an E/M visit as the SDOH assessment would be reasonable and necessary when used to inform the patient's diagnosis, and treatment plan established during the visit.

8. Remote Monitoring Services

In the proposed rule, CMS reiterated its longstanding policy that there is a range of services delivered using telecommunications technology that do not fall within the scope of Medicare telehealth services but are separately payable under the MPFS. These include, but are not limited to services that use telemedicine technology to facilitate interactions between the practitioner and the patient, but do not substitute for an in-person encounter. One example of such services includes remote patient monitoring.

In the 2024 proposed MPFS rule, CMS proposes to clarify its payment policies for certain remote monitoring services, specifically remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM). By way of background, in the CY 2020 MPFS final rule, CMS confirmed that the RPM code family (CPT codes 99453,99454, 99457, and 99458) describes chronic care RPM services that involve the collection, analysis, and interpretation of digitally collected physiologic data, followed by a treatment plan and management of the patient under the treatment plan. In the 2024 proposed rule, CMS reiterates that the code family for RTM

services includes CPT codes 98975, 98976, 98977, 98978, 98980, and 98981 which involve the monitoring of program or therapy adherence through a scheduled recording, or program alert, or an interactive communication with the patient or caregiver. In previous rulemaking, CMS confirmed that remote monitoring codes are designated as care management services and the rules for general supervision apply.

New v. Established Patients:

Following the expiration of the PHE, RPM services may be furnished only to established patients, meaning that an initiating visit is required for patients not seen by the practitioner within the last year. During the PHE, CMS waived the requirement of an established patient relationship and allowed practitioners to provide RPM services to both new and established patients without an initiating visit. In the proposed rule, CMS clarifies that patients who received RPM services during the PHE are considered established patients.

Data Collection Requirements:

CMS reminds practitioners that following the end of the PHE on May 11, 2023, the 16-day monitoring requirement for RPM and RTM services was reinstated. This means that monitoring must occur over, at least, 16 days of a 30-day period. The proposed rule seeks to clarify the data collection minimums apply to existing RPM and RTM code families for CY 2024 (the existing RPM and RTM codes are identified above). CMS further seeks to clarify that the following codes require the collection of a minimum of 16 days of data in a 30-day period: 98976, 98977, 98978, 98980, and 98981.

CMS proposes to further clarify that:

- RPM services should be reported once during a 30-day period and only when reasonable and necessary.
- Only one practitioner may bill for CPT codes 99453-99454 and CPT codes 98976, 98977, 98980, and 98981, during a 30-day period, and only when at least 16 days of data have been collected on at least one medical device. This is consistent with CMS's analysis as set forth in the CY 2021 MPFS final rule which provides that even when multiple medical devices are provided to a patient, the services associated with those devices can only be billed once per patient in a 30-day period and only when a minimum of 16 days of data is collected.

Use of RPM, RTM, in Conjunction with Other Services:

CMS reminds practitioners that they may bill for RPM or RTM services, but not both. Either RPM or RTM services may be billed concurrently with certain care management services for the same patient as long as time or effort are not counted twice. Care management services include CCM/TCM/BHI, PCM, and CPM. While the proposed rule seeks to clarify that RPM and RTM may not be billed together, CMS requests feedback regarding practitioner experience with different code sets and services to develop and clarify its payment policies for these services.

Other Clarifications for Appropriate Billing:

CMS is proposing that practitioners may separately furnish and be paid for RPM or RTM services to a beneficiary that received a procedure or surgery which is covered under a payment for a global period. Payment for RTM or RPM services would be separate from the global payment. Similarly, for beneficiaries already receiving RTM or RPM services during a global period, practitioners may receive separate payments for those services as long as they are unrelated to the diagnosis for which the global procedure was performed. In other words, the remote monitoring must relate to an episode of care that is separate and distinct

from the episode of care for the global procedure, i.e., the remote services do not pertain to or address the condition that is related to the global procedure or service.

RPM and RTM Services Provided by RHCs and FQHCs:

Finally, CMS is proposing a policy to include RPM, RTM, Community Health Integration (CHI), and Principal Illness Navigation (PIN) services in the general care management HCPCS code G0511 when these services are provided by RHCs and FQHCs.

Conclusion

The CY 2024 Proposed Rule includes a number of important extensions to telehealth flexibilities and clarifies existing policies related to telehealth and other remote services. While these proposals align with the CAA, 2023 extensions to continue to allow payment for many telehealth arrangements structured during the PHE, most policies allowing significant expansions in Medicare payment (e.g., for services furnished to patients in their homes or by institutional staff of outpatient departments) are only extended through the end of 2024. It will take further legislative action and agency rulemaking to gain more certainty regarding the permanency of these policies. In the meantime, CMS seems open to comments regarding these policies and stakeholder input regarding how to extend flexibilities that would continue to provide expanded access to services through telehealth without compromising clinical care.

If you have questions regarding how CMS's proposals or other regulatory requirements affect existing or planned telehealth arrangements or seek assistance with comments on the proposals, please contact Allison M. Cohen, Alissa D. Fleming, Alex S. Lewis, or any other member of Baker Donelson's Telehealth Team.