PUBLICATION

Key Telehealth Provisions in the Calendar Year 2022 Physician Fee Schedule Final Rule

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On November 2, 2021, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2022 Medicare Physician Fee Schedule (PFS) final rule (Final Rule), which finalized several noteworthy policies related to telehealth and other remote services. Some highlights include extending the period that an expanded list of Medicare covered telehealth services will be covered beyond the COVID-19 public health emergency (PHE) and implementing Consolidated Appropriations Act of 2021 (CAA) provisions that permanently remove geographic originating site restrictions on telehealth services used for purposes of diagnosis, evaluation, or treatment of mental health disorders. Finalizing these policies will allow mental health services to be furnished through telehealth to beneficiaries in their homes if certain prerequisites are satisfied. These and other key telehealth provisions are summarized in more detail below.

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 PFS (the Medicare Telehealth List). On an annual basis, CMS considers proposals to add services to the Medicare Telehealth List on a Category 1 basis. This means that the proposed services are similar to the professional consultations, office visits, and office psychiatry services that are already covered on the list. Additionally, CMS may add services to the Medicare Telehealth List on a Category 2 basis if there is evidence of clinical benefit when the services are provided through telehealth. Finally, in the CY 2021 PFS final rule, CMS established a new Category 3 to add services to the Medicare Telehealth List on a temporary basis through the end of the year in which the COVID-19 PHE expires. Category 3 services must have a likely clinical benefit when furnished via telehealth, though there is not yet sufficient evidence to consider these services for permanent addition on a Category 1 or Category 2 basis.

In response to the COVID-19 pandemic, CMS added 135 services to the Medicare telehealth list in CY 2020 on an interim basis through the March 31 COVID-19 interim final rule with comment period (IFC) and through a sub-regulatory process established in the May 8 COVID-19 IFC . CMS has now finalized retaining services added to the Medicare Telehealth List on a Category 3 basis until December 31, 2023, to ease the transition from the expanded list of services added to the Medicare Telehealth List during the COVID-19 PHE. During this time period CMS will evaluate whether the services should be permanently added to the Medicare Telehealth List after the COVID-19 PHE has terminated. These Category 3 services and their related Current Procedural Terminology (CPT) codes include the following:

- 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 (96130-96133; 96136-96139)
- Therapy Services, Physical, Speech/Hearing, and Occupational Therapy, All levels (97161-97168; 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507)
- Hospital Discharge Day Management (99238-99239)
- Inpatient Neonatal and Pediatric Critical Care, Subsequent (99469, 99472, 99476)
- Continuing Neonatal Intensive Care Services (99478-99480)
- Critical Care Services (99291-99292)
- End-Stage Renal Disease Monthly Capitation Payment codes (90952, 90953, 90956, 90959, 90962)
- Subsequent Observation and Observation Discharge Day Management (99217, 99224-99226)

CMS also is extending the inclusion of certain outpatient cardiac rehabilitation, and intensive cardiac rehabilitation codes (CPT codes 93797 and 93798, and Healthcare Common Procedure Coding System (HCPCS) codes G0422-G0423) through the end of CY 2023.

The Medicare Telehealth List (including the Final Rule additions) is available on the CMS website here.

Expansion of Medicare Coverage for Telehealth Services for Diagnosis, Treatment and Evaluation of Mental Health Disorders

To implement Section 123 of the CAA, CMS finalized that the geographic restrictions under the Medicare statute (section 1834(m)(4)(c)(i) of the Social Security Act) will not apply, and the patient's home will be a permissible originating site for telehealth services furnished for the purpose of diagnosis, evaluation, or treatment of a mental health disorder. CMS clarified that the definition of "home" in this context can include temporary lodgings such as hotels and homeless shelters, as well as locations a short distance from the beneficiary's home to which the beneficiary has traveled for privacy or other personal reasons. Section 123 of the CAA required that an in-person, non-telehealth service must be provided to the beneficiary within six months prior to the initial telehealth service, but left it to CMS to establish the frequency of subsequent in-person visits. CMS finalized that the in-person service must be furnished at least once within 12 months of each subsequent telehealth service, with exceptions to the in-person visit requirement permitted based on beneficiary circumstances (with the reasons documented in the medical record). This requirement may be met by another physician or practitioner of the same specialty and subspecialty in the same group as the physician or practitioner who furnishes the telehealth service if the physician or practitioner who furnishes the telehealth service is not available. More frequent in-person visits are also permitted based on clinical need. This expanded coverage will take effect for services furnished on or after the end of the PHE for COVID-19 provided that an in-person, non-telehealth service has been provided by the physician or practitioner furnishing mental health telehealth services within six months prior to the initial telehealth service and at least once every 12 months thereafter. These initial and periodic in-person visit requirements do not apply if the telehealth service would have been covered without the new CAA amendment.

CMS finalized allowing audio-only technology for these mental health telehealth services only when the beneficiary does not consent to or is unable to use audio/video technology. The expansion to allow audio-only telehealth services is limited to mental health telehealth services that meet the requirements of the new amendment (e.g., in-person service furnished within the past six months) and when the home is the originating site. Additionally, the practitioner still must have the capacity to furnish the service using interactive two-way, real-time audio/video communication technology. CMS finalized a service-level modifier to identify these

specific mental health telehealth services that could be furnished to a beneficiary using audio-only technology. Finally, CMS clarified that mental health services can include treatment of substance use disorders (SUDs).

Permanent Adoption of an Extended Virtual Check-in

CMS finalized permanent adoption of coding and payment for extended virtual check-ins (HCPCS code G2252). Originally adopted on an interim basis in the CY 2021 PFS final rule, HCPCS Code G2552 describes 11-20 minutes of medical discussion to determine the medical necessity of an in-person visit. This G-code is not an Evaluation and Management (E/M) code but instead is better described as a longer virtual check-in with a higher value. This code allows audio-only interactions to be used for a longer medical discussion to determine the necessity of an in-person visit. Additionally, 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 technology-based service subject to the same billing requirements as HCPCS code G2012 (e.g., if the service originates from a related E/M service provided in the previous seven days or leading to an E/M service or procedure within the next 24 hours or soonest available appointment, it will be bundled into that in-person service).

Remote Therapeutic Monitoring (RTM)

CMS finalized five new Remote Therapeutic Monitoring/Treatment Management (RTM) codes (CPT codes 98975-98977, 98980-98981) that go into effect on January 1, 2022. The RTM codes include three direct practice expense-only (PE-only) codes, 98975-98977, and two professional work codes, 98980-98981. Similar to remote physiologic monitoring (RPM) services, the RTM codes reflect staff and physician work, but the nature of the data collected and how it is collected differs from RPM services. Specifically, RTM services differ from RPM services because the requirements for RTM services allow: 1) non-physiologic data to be collected, and 2) data to be self-reported as well as digitally uploaded. According to the code descriptors, RTM codes are meant to monitor health conditions, including musculoskeletal status respiratory system status, therapy (medication) adherence, and therapy (medication) response. The devices used to collect RTM data must meet the FDA definition of a medical device described in section 201(h) of the Federal Food, Drug, and Cosmetic Act (FFDCA).

Under the Proposed Rule, RTM codes could not be billed by physical therapists or any other practitioners that are not authorized to furnish and bill "incident to" services. The Final Rule finalizes a policy that would permit therapists and other qualified health care professionals to bill the RTM codes. However, CMS noted that, where the practitioner's Medicare benefit does not include services furnished incident to the professional services, the items and services described by the RTM codes must be furnished directly by the billing practitioner or a therapy assistant under the physical therapist's or occupational therapist's supervision.

Chronic Care Management (CCM) Services, including Complex Chronic Care Management (CCCM) and Principal Care Management (PCM)

For CY 2022, the RVS Update Committee (RUC) resurveyed the CCM code family and added five new CPT codes: 99437, 99424, 99425, 99426, and 99427. As a result, the CCM/CCCM/PCM code family now includes five sets of codes, each with a base code and an add-on code. The sets vary by the degree of complexity of care, who furnishes that care (clinical staff or physician/non-physician practitioners (NPP)), and the time allocated for the services. CMS reviewed the RUC-recommended values for the ten codes in the CCM/CCCM/PCM family and is adopting the recommended work values for these codes, as well as the RUC recommended PE inputs without refinements. The Final Rule finalizes the same values for professional PCM and CCM services.

Under the Proposed Rule, CMS sought comments on the level of supervision necessary to obtain beneficiary consent when furnishing CCM services. Commenters would like to continue obtaining beneficiary consent

under the general supervision of the treating physician or NPP, as is currently permitted during the COVID-19 PHE. CMS stated that it would consider the stakeholder comments in future rulemaking.

Take-Aways

Within the bounds of CMS's authority, the Final Rule extends or finalizes several policies that have facilitated broader use of telehealth during the COVID-19 PHE. This includes providing more certainty that services temporarily added to the Medicare telehealth list will be covered through the end of 2023, finalizing a longer audio-only virtual check-in, and implementing the CAA provisions that will allow for broader coverage of telehealth services used to treat and diagnose mental health disorders even beyond the PHE. While CMS was constrained by the statutory requirement of an in-person service six months before mental health telehealth services can be provided to patients in their homes, CMS did extend the intervals for subsequent in-person visits from six to twelve months. CMS also expanded coverage of other virtual services by adding new codes for extended virtual check-ins, RTM services, and CCM/CCCM/PCM services.

While these changes take incremental steps to expanding Medicare coverage for telehealth and other virtual services, any permanent changes to some of the more restrictive limitations (e.g., the originating site requirements that generally apply) will require further legislative action.

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