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Noteworthy Telehealth and Remote Services Provisions in the CY 2023 Medicare PFS Final Rule

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On November 1, 2022, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2023 Medicare Physician Fee Schedule (PFS) Final Rule. This article highlights noteworthy provisions of the Final Rule related to telehealth and other remote services. Of particular note, the Final Rule contains provisions extending Medicare coverage to additional telehealth services, requiring new telehealth service modifiers after the COVID-19 public health emergency (PHE), and permitting Remote Therapeutic Monitoring (RTM) services to be furnished under general supervision.

The Final Rule goes into effect on January 1, 2023. Key provisions of the Final Rule are summarized in more detail below.

Changes to Medicare's Telehealth Policies Post-PHE

Implementation of Consolidated Appropriations Act (CAA), 2022 Telehealth Flexibilities. CMS finalized implementing CAA provisions that extend certain telehealth flexibilities 151 days after the PHE terminates. The policies that will be extended include:

- Medicare coverage of telehealth services furnished to beneficiaries outside of originating sites (i.e., in any geographic area and the patient's home).
- Allowing the following practitioners to continue to serve as distant site practitioners whose telehealth services are covered by Medicare: physical therapists, occupational therapists, speech-language pathologists, and audiologists.
- Medicare coverage of telehealth services furnished on audio-only technology.
- Delaying the periodic in-person visit requirement for mental health telehealth services furnished to Medicare beneficiaries outside of originating sites (including in patients' homes).
- Medicare coverage of telehealth services furnished by FQHCs and RHCs.

Services Added to the Medicare Telehealth Services List

Before the COVID-19 PHE, Medicare only covered certain telehealth services, including:

1. professional consultations,
2. office medical visits,
3. office psychiatry services, and
4. additional services specified by the HHS Secretary.

These services are all included on a list that is amended and published annually in the PFS (the Medicare Telehealth Services List). CMS annually considers proposals to add services to the Medicare Telehealth Services List on a Category 1 basis. Category 1 services must be similar to professional consultations, office visits, and/or office psychiatry services that are currently on the Medicare Telehealth Services List. CMS may add services to the Medicare Telehealth Services List on a Category 2 basis if there is evidence of clinical benefit when the services are provided through telehealth. CMS has also established a Category 3, under which it may temporarily add services to the Medicare Telehealth Services List. Category 3 services must have

a likely clinical benefit when furnished via telehealth, even though there is not yet sufficient evidence to consider these services for permanent addition on a Category 1 or Category 2 basis.

In its CY 2022 PFS final rule, CMS provided that Category 3 services would be retained until December 31, 2023, to ease the transition from the expanded list of services added to the Medicare Telehealth Services List during the COVID-19 PHE. During this time period CMS will evaluate whether the services should be permanently added to the Medicare Telehealth Services List after the COVID-19 PHE has terminated.

Category 1 Additions

The Final Rule adds five services to the Medicare Telehealth Services List on a Category 1 basis. Table 13 of the Final Rule lists the added Category 1 services, which include certain E/M services and monthly Chronic Pain Management and Treatment services.

Category 3 Additions

The Final Rule adds fifty-nine Category 3 services to the Medicare Telehealth Services List. Table 12 of the Final Rule provides a list of the added services. The services fall within the following general categories:

5. adaptive behavior treatment and behavior identification assessment;
6. audiologic;
7. behavioral health;
8. cognition;
9. electronic analysis of implanted neurostimulator pulse generator/transmitter;
10. ophthalmologic;
11. speech therapy;
12. therapy; and
13. home ventilator management supervision.

Coverage of Temporary Telehealth Services. During the COVID-19 PHE, CMS temporarily added telehealth services to the Medicare Telehealth Services List on an interim basis during the PHE, but did not add them on Category 1, 2, or 3 basis. A list of the temporary telehealth services is located in Table 14 of the Final Rule. This Table includes, but is not limited to, codes for new patient eye exams, ventilation management services, observation care services, initial nursing facility care, home visits for new patients, and neonatal and pediatric critical care services. The Final Rule provides that Medicare will cover temporary telehealth services for 151 days after the end of the COVID-19 PHE. This differs from the Category 3 services which will remain on the Telehealth List through December 31, 2023 (or 151 days after the PHE, if later). On the 152nd day after the end of the PHE, payment for Medicare telehealth services will once again be limited by the requirements of section 1834(m) of the Social Security Act, and codes for services that were temporarily added, but not on a Category 1, 2, or 3 basis, will be removed from the list, and telehealth claims for these services will be denied.

Coverage of Audio-Only Telehealth Services. CMS declined to keep telephone E/M Services on the Medicare Telehealth Services List after the 151-day post PHE extension period. CMS acknowledges that in certain circumstances, audio-only technology may be used to furnish mental health services to patients in their homes after the PHE ends. Outside this context, two-way audio-visual communications technology will continue to be the appropriate standard for Medicare telehealth services.

*Periodic In-Person Visit Requirements for At-Home Mental Health Telehealth Services***.** Under the Final Rule, CMS will delay the periodic in-person visit requirements associated with mental health telehealth coverage until 152 days after the COVID-19 PHE. Until this date, telehealth services furnished to diagnose and treat mental

health disorders may be furnished to Medicare beneficiaries in their homes without prior or intermittent in-person visits under COVID-19 related flexibilities temporarily lifting originating site requirements. Starting the 152nd day after the PHE ends, Medicare will not pay for telehealth services furnished to beneficiaries in their homes for purposes of diagnosis, evaluation, or treatment of mental health disorders unless the physician or practitioner providing the telehealth service furnishes an item or service in-person within 6 months prior to the first time the physician/practitioner furnishes the telehealth service, and at least once every 12 months thereafter.

Telehealth Service Modifiers. CMS directed practitioners during the COVID-19 PHE to add the modifier "95" to claims to indicate a telehealth service along with the place of service (POS) code that would have been reported if the service had been furnished in-person instead of using POS 02 for all telehealth claims. This temporary policy allowed claims for telehealth services to be paid based on the POS where the service generally would be furnished during the PHE. CMS has finalized the use of modifier "95" for services that would have been furnished in-person through the later of the end of the year in which the PHE ends or December 31, 2023.

After the temporary policy ends, CMS will no longer require the modifier "95". Practitioners will instead be required to use the following POS indicators for telehealth services: POS 02 (telehealth provided other than in a patient's home) or POS 10 (telehealth provided in a patient's home). Most telehealth services will be billed with POS 02, which will once again be paid at the MPFS facility rate irrespective of the POS that the service would be furnished if the practitioner were in-person. For services furnished in a facility as an originating site, POS 02 may be used, and the corresponding facility fee can be billed, per pre-PHE policy, beginning the 152nd day after the end of the PHE. Claims for Medicare telehealth mental health services, clinical assessments for patients with End-Stage Renal Disease that are receiving home dialysis, and Medicare telehealth mental health services that are co-occurring with substance use treatment that are furnished with the patient in their home will be billed with POS 10.

Under the Final Rule, beginning January 1, 2023, physicians or qualified practitioners, RHCs, FQHCs, and OTPs will be required to append either the "FQ" modifier and/or "93" modifier, which are identical in meaning to claims for services furnished using audio-only communications technology.

Virtual Direct Supervision. CMS declined to extend the temporary policy to allow practitioners to meet the immediate availability requirement for direct supervision through virtual presence via real-time, audio/visual technology beyond the end of the calendar year in which the PHE ends. In its 2023 CY PFS Proposed Rule, CMS solicited comments on whether to allow virtual direct supervision in the future and/or whether this policy should be continued for only a subset of services. In the Final Rule, CMS explains that it will consider the comments it received for potential future PFS rulemaking. In the meantime, it plans to continue to evaluate whether it would be appropriate to allow virtual direct supervision outside of the COVID-19 PHE. While the temporary policy remains in effect, supervising practitioners continue to be required to append the "FR" modifier to any applicable telehealth claim when they provide direct supervision for a service using virtual presence.

Changes to Remote Therapeutic Monitoring Policies

In CY 2022, CMS finalized five Remote Therapeutic Monitoring/Treatment Management (RTM) codes (CPT codes 98975-98977, 98980-98981) effective 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.

In the CY 2023 PFS Proposed Rule, CMS attempted to address two challenges to the provision of RTM services: 1) RTM services cannot be billed incident to the services of certain non-physician practitioners (NPPs), and 2) RTM had to be furnished the direct supervision of the billing practitioner. While CMS effectively addressed one of these in the Final Rule by allowing these services to be furnished under general supervision, CMS has not yet finalized a policy that would allow these services to be furnished by clinical staff incident to the services of CSWs, CRNAs, PTs, OTs, and SLPs. Below is further detail on the key RTM proposals and how they differ from what was ultimately finalized.

Billing Incident to Certain Non-Physician Health Care Professionals' Services

Even though CMS intended for NPPs to be able to provide RTM services, CMS has expressed concerns about billing RTM services incident to some types of NPPs (including CSWs, CRNAs, PTs, OTs, and SLPs). This is because Medicare Part B does not include a benefit for services furnished incident to the professional services of these practitioners. For these practitioners, CMS has previously stated that RTM services had to be furnished *directly* by the billing practitioner, or in the case of a PT or OT, by a therapy assistant billing under the PT's or OT's supervision.

In an effort to address this, CMS proposed to create two new codes (GRTM 3 and GRTM 4) to expressly facilitate RTM services furnished by qualified nonphysician healthcare professionals who cannot bill under Medicare Part B for services furnished incident to their professional services. These codes would not include incident to activities in the PE. These codes would be designated as "sometimes therapy" codes, meaning the services could be billed outside of a therapy plan of care by physicians and certain NPPs, but would have to be furnished under a therapy plan of care when furnished by PTs, OTs, and SLPs.

The Direct Supervision Requirement

CMS has received feedback regarding the operational challenges associated with the direct supervision required to bill existing RTM codes for services furnished by auxiliary personnel incident to a physician or other qualified medical professional.

To address this, CMS also proposed to create two new HCPCS G codes (GRTM1 and GRTM2) that include clinical labor activities (i.e., incident to services such as communicating with a patient, resolving technology concerns, reviewing data, updating and modifying care plans, and addressing lack of patient improvement) that could be furnished by auxiliary personnel under general (instead of direct) supervision.

Finalized Policies

In the CY 2023 Final Rule, CMS decided not to finalize the proposals to create the four new G-codes (GRTM-1-4). Instead, for CY 2023, CMS decided to maintain current policies for the RTM treatment management CPT codes 98980 and 98981, with two exceptions (which are listed below).

- Beginning January 1, 2023, any RTM service may be furnished under our general supervision requirements.
- CMS finalized that the reimbursement rates for the PE-only device code for cognitive behavioral therapy services would be determined by local Medicare Administrative Contractors (MACs) for CY 2023.

Takeaways

The Final Rule makes several important changes related to Medicare's coverage of telehealth services. It adds services to the Medicare Telehealth Services List, extends Medicare's coverage of certain temporary telehealth services by 151 days, and changes how practitioners report telehealth services for processing of claims after the COVID-19 PHE. It also delays intermittent in-person visits required for expanded Medicare coverage of mental health telehealth services and provides that virtual direct supervision will be discontinued absent future rulemaking or legislation. Additionally, CMS has finalized that RTM services may be furnished under general supervision but has not finalized a policy that would facilitate RTM services furnished by NPPs who cannot bill for services furnished incident to their professional services.

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