

KEY:

Blue – Requires Congressional Action

Green – Agency Has Authority to Act

Medicare Part B Services – Physician Fee Schedule (PFS)

Issue	Before COVID-19	During COVID-19*	After COVID-19: ATA's Recommended Action
Allowable Medicare Telehealth services	CMS keeps <u>list</u> of allowable Medicare telehealth services	CMS added 135 temporarily allowable codes	CMS should continue to evaluate and add codes, which has been initiated in the CY2021 PFS proposed rule
Distant site provider**	Limited to physicians, physician assistants (PAs), certified registered nurse anesthetists (cRNAs), certified nurse-midwives, clinical social works (CSWs), clinical psychologists, and registered dietitians	Congress allowed CMS to waive under 1135 authority; <u>CMS allowed</u> all providers that are eligible to bill Medicare to provide telehealth, including physical therapists, occupational therapists, speech language pathologists, and hospital outpatient departments (HOPDs)	Congress should allow CMS to determine practitioners appropriate to practice telehealth
Originating site – geographic**	Patient location limited to rural health professional shortage areas	Congress allowed CMS to waive under 1135 authority; CMS <u>waived</u> the geographic restrictions for telehealth claims starting March 6	Congress should strike the arbitrary geographic originating site restriction
Originating site – home**	Patient location limited to physician offices, critical access hospitals, rural health clinics, federally qualified health centers, hospitals, hospital-based renal dialysis centers, skilled nursing facilities, community mental health centers, and renal dialysis facilities and the home only for ESRD services	Congress allowed CMS to waive under 1135 authority; CMS <u>waived</u> the originating site restrictions for telehealth claims starting March 6, allowing patients to be in any healthcare facility or home	Congress should allow patients to receive services in the home and other sites of care

Medicare Part B Services - PFS (cont.)

Issue	Before COVID-19	During COVID-19*	After COVID-19: ATA's Recommended Action
Payment rates – site of service differential	Distant site providers shall be paid the amount equal to what they would have been paid in person. CMS required that telehealth services be billed with POS code 02 to indicate telehealth and paid the provider the facility rate (paying the facility fee to the originating site)	CMS temporarily requires providers to use the place of service code based on where they would have been in person (facility vs doctor office) and will pay accordingly. Instead of POS code 02, modifier 95 should be used to indicate telehealth	CMS should ensure that telehealth services are reimbursed fairly
Modality – audio only	Services must be delivered using a “telecommunications system” defined in regulations as synchronous audio-video ¹	CMS waived the regulatory definition requiring video and updated the list to include 89 codes allowed audio/phone-only	CMS should reimburse for audio-only services as clinically appropriate
Provider enrollment	Provider enrollment is a formal process that includes a written application and screening requirements, such as criminal background checks. Telehealth practitioners who deliver care from their homes on regular basis, such that the practitioner’s home is a “practice location,” must enroll their homes in Medicare as a practice location. CMS also charges application fees for provider enrollment for temporary Medicare billing privileges ²	CMS waived fees and other enrollment requirements and established a provider enrollment hotline	CMS should ensure that the provider enrollment process is not overly burdensome and that practitioners do not have to enroll their home address as their practice location
Teaching physician Supervision	With some exceptions, if a resident participates in a service furnished in a teaching setting, payment is made only if the teaching physician is present during the key portion of the service or procedure ³	CMS allowed the requirement for the presence of a teaching physician to be met through direct supervision by interactive telecommunications technology for both in-person and telehealth visits	CMS should allow teaching physician supervision remotely when clinically appropriate

Medicare Part B Services - PFS (cont.)

Issue	Before COVID-19	During COVID-19*	After COVID-19: ATA's Recommended Action
Direct supervision	In many settings, non-physician clinicians have direct supervision requirements requiring the presence of a physician when the service is provided ⁴	CMS <u>modified the definition</u> of direct supervision to include virtual physician presence through audio/video real-time communications technology when indicated to reduce exposure risks. This interim change has broad application across a variety of settings	CMS should review supervision requirements and only maintain those that are clinically appropriate. The ATA supports the removal of unnecessary supervision requirements in order to fully utilize care teams
Remote patient monitoring (RPM)	In recent years, CMS has allowed payment for remote physiological monitoring (RPM) of a patient, including the time it takes to train a patient on the use of a device and to analyze monthly data and maintain treatment plans	CMS has allowed RPM services to be delivered to new patients as well as established patients	CMS should allow RPM services to be delivered to patients with an established relationship, whether established in-person or virtually
		CMS has shortened the number of days of data required to be collected in a month from 16 to 3	CMS should consider clinical scenarios for which less than 16 days of data is appropriate
		CMS has allowed beneficiary consent to be obtained by auxiliary staff	CMS should finalize its proposal to make this flexibility permanent
Communication technology-based services	Medicare pays for services furnished routinely via telecommunications technology that are not considered Medicare telehealth services under 1834(m). Patient-initiated e-visits and virtual check-ins are allowed for established patients without geographic or originating site restrictions	CMS <u>finalized rules to allow</u> virtual check-ins to be done temporarily for new patients as well as established patients if they do not result in an in-person visit. Similarly, CMS is practicing enforcement discretion on the "established patient" requirement for e-visits	No action needed

Other Medicare

Issue	Before COVID-19	During COVID-19	After COVID-19: ATA's Recommended Action
Licensure	Medicare requires that providers be licensed in the state in which the patient is located	CMS waived Medicare requirements that out-of-state practitioners be licensed in the state where they are providing services. This does not waive state or local licensing requirements	Defer to the states on licensing requirements
Beneficiary cost sharing	Routine reductions or waivers of costs owed by federal health program beneficiaries potentially implicated federal anti-kickback statute	HHS OIG notified physicians and other practitioners that they will temporarily not be subject to administrative sanctions for waiving cost sharing	CMS should have the ability to reduce cost sharing for telehealth services
Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)**	FQHCs and RHCs were not eligible to provide telehealth services as distant site providers	Congress directed CMS to create a temporary payment for FQHCs and RHCs to be distant site providers	Congress should permanently make FQHCs and RHCs eligible with a permanent payment system
Medicare Diabetes Program	CMS did not allow the Medicare Diabetes Prevention Program expanded model (MDPP) clinical intervention to be delivered fully virtually	CMS temporarily allowed the delivery of MDPP sessions virtually	CMS should allow CDC-approved MDPP to be delivered virtually

Medicare Advantage

Issue	Before COVID-19	During COVID-19*	After COVID-19: ATA's Recommended Action
Risk adjustment	Diagnoses obtained during telehealth encounters did not count toward Medicare risk adjustment programs	CMS temporarily allowed diagnoses made over telehealth to count toward risk adjustment programs	CMS should permanently allow diagnoses made during telehealth encounters to count toward risk adjustment programs
Cost sharing	Medicare Advantage plans must submit planned enrollee cost-sharing to CMS in their annual benefit packages	CMS will exercise enforcement discretion of submitted planned cost sharing, thus allowing plans to temporarily waive cost sharing for things like telehealth	CMS should give MA plans the ability to reduce cost sharing for telehealth services
Telehealth outside the annual bid	Medicare Advantage plans must submit planned telehealth services to CMS in their annual benefit packages	CMS will exercise enforcement discretion of submitted planned telehealth services, thus allowing plans to temporarily add telehealth benefits	No action needed

Non-Medicare

Agency: Law	Issue	Before COVID-19	During COVID-19*	After COVID-19: ATA’s Recommended Action
Drug Enforcement Administration (DEA): Ryan Haight	Remote Prescribing of Controlled Substances	The DEA only allows telemedicine for prescribing of controlled substances if the patient is in a DEA-registered hospital or clinic	DEA used existing emergency authority under Ryan Haight to waive the restrictions and <u>allow telehealth regardless of where the patient is</u> so long as the prescription is issued for a legitimate purpose, synchronous audio/video is used, and the prescriber is DEA-registered and practicing in accordance with state and federal law	DEA should make this flexibility permanent through existing authority – via Special Registration or another existing exception under Ryan Haight
Office for Civil Rights (OCR): HIPAA	Modality – HIPAA compliance	HIPAA rules require technology platforms to meet requirements intended to protect patient privacy	OCR announced it will practice temporary enforcement discretion of HIPAA privacy rules for remote communications technology, allowing providers to use popular applications such as FaceTime, Zoom, or Skype (as long as they are private connections)	No action needed

**When "temporary" policy changes are noted in the "During COVID-19" column, it can be assumed that the temporary policy applies only during duration of the COVID-19 public health emergency (PHE). Congress gave HHS 1135 waiver authority in the CARES Act.*

***Limited by Section 1834(m) of the Social Security Act*

1 42 CFR § 410.78

2 42 CFR § 424.514 and 516

3 42 CFR § 415.172 and § 415.174

4 Multiple sections including 42 CFR § 482.12 and § 410.26 and § 410.32