KEY:	Blue – Requires Congressional Action	Green – Agency Has Authority to Act	Agency Has Authority to Act/Congress Could Act to Ensure Permanence

Medicare Fee-for-Service (Statutory)

These issues are limited by Section 1834(m) of the Social Security Act, and thus require congressional action in order to be updated. In March 2020[1], Congress gave HHS Section 1135 authority to waive restrictions for the duration of the COVID-19 Public Health Emergency (PHE). In the FY23 "omnibus"[2] passed in December 2022, Congress temporarily extended the flexibilities around these policies through the end of 2024.

Issue	Before COVID PHE	Through the end of 2024	2025+: ATA's Recommended Action
Geographic originating site	Patient location limited to rural health professional shortage areas	CMS waived the geographic restrictions for telehealth claims	**Congress should strike the arbitrary geographic restriction**
Originating site	Patient location limited to physician offices, critical access hospitals, rural health clinics, Federally Qualified Health Centers, hospitals, renal dialysis centers, skilled nursing facilities, and community mental health centers (and the home for ESRD)	CMS waived 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 regardless of the patient's location**
Distant site clinicians	Limited to physicians, physician assistants, certified registered nurse anesthetists, certified nurse-midwives, clinical social workers, clinical psychologists, and registered dietitians	CMS allowed 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 remove statutory restrictions and allow CMS to determine practitioners appropriate to practice telehealth**
FQHCs and RHCs	Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) were not eligible to provide telehealth services as distant sites	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**
Telemental	Telemental services were subject to the same restrictions as other services	Restrictions are permanently removed, but only if patient has seen the telehealth provider in-person in the prior 6 months	**Congress should repeal the in-person requirement**

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Medicare Fee-for-Service (Regulatory)

For the remainder of the FFS issues, the Centers for Medicare and Medicaid Services (CMS) has existing authority to make policy changes. See https://telehealth.hhs.gov/providers/billing-and-reimbursement/billing-and-coding-medicare-fee-for-service-claims/ for more guidance.

Issue	Before COVID PHE	During PHE (expire May 11, 2023 unless otherwise noted)	After PHE: ATA's Recommended Action
Allowable Medicare telehealth services	CMS keeps the list of allowable Medicare telehealth services	CMS added new codes temporarily allowable during the COVID PHE and a new Category 3 for temporary codes As of the CY23 Physician Fee Schedule (PFS)[3]: • Temporary PHE allowable codes expire 151 days after the expiration of the PHE, which would be Oct 9, 2023 • Category 3 codes expire at the end of CY23 However, CMS may update to extend through 2024 consistent with the FY23 omnibus	**CMS should extend all temporary codes through 2024 or until which time they can be evaluated for permanent coverage.** **See ATA comments to the CY23 PFS for further code recommendations**
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 place of service (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 POS 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 After CY23, CMS indicates POS code 10 should be used for home and 02 for a facility, and CMS includes nontraditional definitions of home, including homeless shelters and travel locations	**CMS should continue to pay the higher rate for telehealth through CY23 and subsequently ensure that telehealth services are reimbursed fairly** **Congress should allow patients to receive services regardless of the patient's location**

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Modality – audio only	Services must be delivered using a "telecommunications system" defined in regulations as synchronous audio-video[4]	CMS waived the regulatory definition requiring video and updated the list to include codes allowed audio/phone-only. Effective permanently beginning in 2021, CMS added a code for an audio only visit to determine the necessity of an in person visit. Additionally, effective January 2022, CMS allows for the use of audio-only when furnishing mental health services in certain circumstances. HHS Office for Civil Rights issued guidance explaining that HIPAA permits the use of audio-only technology.	**CMS should reimburse for audio-only services as clinically appropriate**
Provider enrollment	In order to bill Medicare for services, providers must get an NPI, complete a Medicare enrollment application and pay a fee, and get the application processed by their local Medicare Administrative Contractor (MAC)	CMS waived fees and other enrollment requirements and established a provider enrollment hotline	**CMS should update guidance to allow providers to report the practice location they are associated with rather than their home address**
Provider billing address	Claims for telehealth services were submitted to the contractors that process claims for the performing practitioner's service area.[5] "Service area" was not defined, but CMS provided subregulatory clarification that providers should enter on line 32 of the 1500 claim form the address "where they typically practice" and that should be the home if that is the location of typical practice	March 2022 COVID FAQs indicated there are no payment restrictions on distant site practitioners furnishing Medicare telehealth services from their home during COVID and practitioners are not required to update their Medicare enrollment to list their home location when practicing telehealth from home October 2022 CMS guidance indicated that when the PHE ends, practitioners will be required to resume reporting their home address on the Medicare enrollment	**CMS should update guidance to allow providers to report the practice location they are associated with rather than their home address**

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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[6]	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**
Direct supervision	In many settings, non-physician clinicians have direct supervision requirements requiring the presence of a physician when the service is provided[7]	CMS modified the definition 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. This currently expires at the end of CY23	**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**
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**
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**

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		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 finalized rules to allow 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
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	**CMS should recognize state licenses, privileges to practice through interstate compacts, and other models that authorize providers to practice in a jurisdiction other than that of their primary licensure (such as telehealth registries)**
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**

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Medicare Advantage

Issue	Before COVID PHE	During PHE (expire May 11, 2023 unless otherwise noted)	After COVID-19: ATA's Recommended Action
Risk adjustment	Diagnoses obtained during telehealth encounters did not necessarily count toward Medicare risk adjustment programs	CMS allowed diagnoses made over telehealth to count toward risk adjustment programs. This was announced in a memo during the PHE, but does not expire with the PHE.	**CMS should make clear that this is the ongoing policy.**
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

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Non-Medicare

Agency: Law	Issue	Before COVID PHE	During PHE (expire May 11, 2023 unless otherwise noted)	After PHE: ATA's Recommended Action
Drug Enforcement Administration (DEA): Ryan Haight	Remote Prescribing of Controlled Substances	Providers may only use telehealth to prescribe controlled substances with a prior in-person visit	DEA used PHE authority under Ryan Haight to waive the in-person requirement	***Update* Rule has been published and is in comment phase* DEA should issue Special Registration rules to allow telehealth providers to register and waive the in-person requirement. Congress should ensure there are no gaps in care until that is in place**
Treasury: CARES Act	HDHP safe harbor for telehealth	Employees in high deductible health plans with health savings accounts have to reach their deductible before their plan will cover services without cost-sharing	Congress created a safe harbor such that HDHPs can offer telehealth pre-deductible. This currently expires at the end of 2024	**Congress should permanently allow HDHPs to offer telehealth pre-deductible**
Labor, HHS and Treasury Departments: CARES Act FAQ	Telehealth as an excepted benefit under ERISA	When telehealth or remote care services are provided by an employer, the benefit is considered a "group health plan" under ERISA	Agencies take a non-enforcement position for employers wishing to provide telehealth or other remote care services to employees ineligible for any other employer-sponsored group health plan	**Congress should codify this flexibility and allow employers to offer telehealth as an excepted benefit**
Office for Civil Rights (OCR): HIPAA	Modality – HIPAA compliance	HIPAA rules require technology platforms to meet	OCR announced it will practice enforcement discretion of HIPAA privacy rules for remote	No action needed

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		requirements intended to protection patient privacy	communications technology, allowing providers to use popular private video chat applications	

1 *Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law 116-136*
2 *Consolidated Appropriations Act, 2023, Public Law 117-328*
3 *87 FR 69404*
4 *42 CFR § 410.78*
5 *Medicare Claims Processing Manual, Chapter 12, section 190.6.1 Submission of Telehealth Claims for Distant Site Practitioners*
6 *42 CFR § 415.172 and § 415.174*
7 *Multiple sections including 42 CFR § 482.12 and § 410.26 and § 410.32*

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