

Medicare Payment Rules Changed to Allow Broad Use of Remote Communications Technology

April 6, 2020 – Dorsey Health Law

by Ross C. D'Emanuele and Charis Zimmick



Related People

- Ross C. D'Emanuele

Related Capabilities

- Healthcare & Life Sciences
- Healthcare Transactions & Regulations
- Healthcare Litigation
- Medical Devices

On Monday, April 6th the Centers for Medicare and Medicaid Services (“CMS”) adopted an interim final rule to change a wide range of Medicare payment policies during the COVID-19 public health emergency so that Medicare providers and suppliers have flexibility to furnish services to beneficiaries using remote communications technology. As healthcare providers implement infection prevention and control procedures throughout their operations, CMS recognizes that immediately and temporarily increasing the availability of services using telecommunications technology is necessary and appropriate to maintain Medicare beneficiary access to medically necessary services without jeopardizing their health or the health of the healthcare workers furnishing those services.

The interim final rule with comment period is applicable to services provided beginning March 1, 2020, and will be effective for the period of the COVID-19 public health emergency. The rule addresses a variety of Medicare payment policies (including coverage, supervision, and “home bound” requirements) applicable to physicians and other clinicians, hospitals, home health agencies, hospice agencies, independent laboratories, ambulance service providers, rural health clinics, federally qualified health centers, inpatient rehabilitation facilities, and Medicare Part C and D health plans. The following summarizes the Medicare payment policy changes.

1. Place of Service Coding for Medicare Telehealth Services

Medicare pays for a discrete set of services under Social Security Act § 1834(m) that are reported using codes that describe “face-to-face” services but are furnished using audio/video, real-time communication technology, instead of in-person. Clinicians bill for these Medicare telehealth services using a unique place of service code “02,” which identifies them as Medicare telehealth services. CMS pays the physician or practitioner for Medicare telehealth services at the lower Medicare Physician Fee Schedule “facility rate” because facility expenses (e.g., staff, supplies, and equipment) associated with the services are generally incurred by the site where the patient is located, and not by the remotely-located practitioner.

On an interim basis CMS will pay for Medicare telehealth services at the rate that ordinarily would be paid under the Medicare physician fee schedule if the services were furnished in-person. Physicians and other practitioners billing for Medicare telehealth services should report the place of Service code that would have been reported had the service been furnished in person instead of place of service code “02.” Because

Medicare identifies claims for telehealth services through the place of service code “02,” CMS has finalized use on an interim basis of CPT telehealth modifier 95, which applies to claim lines that describe services furnished via telehealth.

2. Additions to Medicare Telehealth Services

As noted above, Medicare pays for a defined set of Medicare telehealth services. For telehealth services with dates of service beginning March 1, 2020 through the end of the declared COVID-19 public health emergency (including any renewals), CMS is adding the following services to the list of covered Medicare telehealth services. Together with CMS’ waivers the originating site requirements applicable to Medicare telehealth services and the OIG’s policy statement addressing waiver of beneficiary copayments for telehealth services, this expansion in covered telehealth services can facilitate the meaningful and quick expansion in deployment of telehealth services.

A. Emergency Department Visits

- 99281
- 99282
- 99283
- 99284
- 99285

B. Initial and Subsequent Observation, and Observation Discharge Day Management

- 99217
- 99218
- 99219
- 99220
- 99224
- 99225
- 99226
- 99234
- 99235
- 99236



C. Initial Hospital Care and Hospital Discharge Day Management

- 99221
- 99222
- 99223
- 99238
- 99239

D. Initial Nursing Facility Visits and Nursing Facility Discharge Day Management

- 99304

- 99305
- 99306
- 99315
- 99316

E. Critical Care Services

- 99291
- 99292

F. Domiciliary, Rest Home, or Custodial Care Services

- 99327
- 99328
- 99334
- 99335
- 99336
- 99337

G. Home Visits

- 99341
- 99342
- 99343
- 99344
- 99345
- 99347
- 99348
- 99349
- 99350

H. Inpatient Neonatal and Pediatric Critical Care

- 99468
- 99469
- 99471
- 99472
- 99473
- 99475
- 99476

I. Initial and Continuing Intensive Care Services

- 99477
- 99478
- 99479
- 99480

J. Care Planning for Patients With Cognitive Impairment

- 99483

K. Group Psychotherapy

- 90853 (Group psychotherapy (other than of a multiple-family group))

L. End-Stage Renal Disease (ESRD) Services

- 90952
- 90953
- 90959
- 90962

M. Psychological and Neuropsychological Testing

- 96130
- 96131
- 96132
- 96133
- 96136
- 96137
- 96138
- 96139

N. Therapy Services: For these services, CMS states that because Social Security Act § 1834(m) does not provide for payment for these services as Medicare telehealth services when furnished by physical therapists, occupational therapists, or speech language pathologists.

- 97161
- 97162
- 97163
- 97164
- 97165
- 97166
- 97167
- 97168
- 97110
- 97112
- 97116
- 97535
- 97750
- 97755
- 97760
- 97761
- 92521



- 92522
- 92523
- 92524
- 92507

O. Radiation Treatment Management Services

- 77427
- 77427

3. Frequency Limitations on Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations

CMS is removing the frequency restrictions for each of the following codes for subsequent inpatient visits and subsequent nursing facility visits furnished via Medicare telehealth for the duration of the PHE for the COVID–19 pandemic.

A. Subsequent Inpatient Visits

- 99231
- 99232
- 99233

B. Subsequent Nursing Facility Visits

- 99307
- 99308
- 99309
- 99310

C. Critical Care Consultation Services

- G0508
- G0509

4. Required “Hands-On” Visits for ESRD Monthly Capitation Payments

Current Medicare rules state that for End Stage Renal Disease (“ESRD”) related services that are on the Medicare telehealth list, a required clinical examination of the vascular access site must be furnished face-to-face “hands on” (without the use of an interactive telecommunications system) by a physician, clinical nurse specialist (CNS), nurse practitioner (NP), or physician assistant (PA). CMS is permitting on an interim basis the required clinical examination to be furnished as a Medicare telehealth service during the COVID–19 pandemic. In addition, Medicare rules typically require that a beneficiary receive a face-to-face visit, without the use of telehealth, at least monthly in the case of the initial 3 months of home dialysis and at least once every 3 consecutive months after the initial 3. CMS states that they will exercise enforcement discretion on an interim basis to relax enforcement in connection with the requirements under Social Security Act §

1881(b)(3)(B) that certain visits be furnished without the use of telehealth. Specifically, CMS will not conduct review to consider whether those visits were conducted face-to-face, without the use of telehealth. This applies to the following codes:

- 90951
- 90952
- 90953
- 90954
- 90955
- 90957
- 90958
- 90959
- 90960
- 90961
- 90962
- 90963
- 90964
- 90965
- 90966
- 90967
- 90968
- 90969
- 90970



5. Communication Technology-Based Services

Certain services are performed using remote communications technology and are paid for by the Medicare program, but are not considered Medicare telehealth services because these services are by their nature performed using communications technology and are not ordinarily performed in person. These services include certain remote patient monitoring services (e.g., CPT codes 99453, 99454, 99457, and 99458, virtual check-in services).

CMS payment rules for these services have limited their use to established patients only, and advance beneficiary consent has been required. The interim final rule states that all of these services can be furnished to both new and established patients. CMS also states that beneficiary consent to receive these services can be obtained annually, can be obtained at the time that a service is furnished, and may be documented by auxiliary staff under general supervision.

To mitigate exposure risks, CMS is also broadening the types of clinicians that can perform remote evaluation of patient images and virtual check-ins (HCPCS codes G2010 and G2012) to include licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists.

6. Direct Supervision

Many services paid under the Medicare physician fee schedules, such as services performed incident to a physician's professional service (see 42 C.F.R. § 410.26), must be provided under the direct supervision of the billing physician or nonphysician practitioner, meaning that the physician or nonphysician practitioner must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure.

CMS is temporarily modifying the definition of direct supervision at 42 C.F.R. § 410.32(b)(3)(ii) to state that direct supervision includes virtual presence through audio/video real-time communications technology.

Similarly, the definitions of direct supervision applicable to hospital outpatient services at 42 C.F.R. § 410.28(e)(1) and hospital rehabilitation and intensive cardiac rehabilitation services described at 42 C.F.R. §§ 410.47 and 410.49 are modified in the same manner to permit physician supervision of these hospital services via virtual presence through audio/video real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider.

Additionally, the minimum default level of physician supervision for the initiation of outpatient non-surgical extended duration therapeutic services will now be changed from direct supervision to general supervision.

7. Definition of Homebound for Purposes of Home Health Benefits

The interim final rule addresses whether beneficiaries instructed to remain in their homes or are under "self-quarantine" are considered "confined to the home" or "homebound" for purposes of the Medicare home health benefit. CMS states that the current definition of "confined to the home" (that is, "homebound") would apply to patients: (a) Where a physician has determined that it is medically contraindicated for a beneficiary to leave the home because he or she has a confirmed or suspected diagnosis of COVID-19; or (b) where a physician determines that it is medically contraindicated for a beneficiary to leave the home because the patient has a condition that may make the patient more susceptible to contracting COVID-19.

Beneficiaries must meet all other eligibility requirements to receive Medicare home health services. The beneficiary must be under the care of a physician; receiving services under a plan of care established and periodically reviewed by a physician; be in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology; or have a continuing need for occupational therapy.

8. Home Health Benefits and Remote Technology

CMS is also amending home health plan of care requirements at 42 C.F.R. § 409.43(a) to allow the integration of technology and remote communication into the home health plan of care, so long the use of technology is related to the skilled services being furnished by the nurse/therapist/therapy assistant to optimize the services furnished during the home visit, and that the use of technology is included on the home health plan

of care along with a description of how the use of such technology will help to achieve the goals outlined on the plan of care without substituting for an in person visit as ordered on the plan of care.

On an interim basis home health agencies can report the costs of telecommunications technology as allowable administrative and general costs on their cost reports.

9. Telecommunications and Hospice

For hospices, regulations at 42 C.F.R. § 418.204 are modified to state that when a patient is receiving routine home care, hospices may provide services via a telecommunications system if it is feasible and appropriate to do so to ensure that Medicare patients can continue receiving reasonable and necessary services for the palliation and management of a patients' terminal illness and related conditions without jeopardizing the patients' health or the health of those who are providing such services. The use of such technology must be included on the plan of care. The inclusion of technology on the plan of care must continue to meet the requirements at 42 C.F.R. § 418.56, and must be tied to the patient-specific needs as identified in the comprehensive assessment and the measurable outcomes that the hospice anticipates will occur as a result of implementing the plan of care.

Telecommunication technology can also be used by a hospice physicians or nurse practitioner for a face-to-face visit used solely for the purpose of recertifying a patient for hospice services. Telecommunications technology for this purposes means multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site hospice physician or nurse practitioner.

Hospices can also report hospices can report the costs of telecommunications technology used to furnish services under the routine home care level of care during the public health emergency as "other patient care services" on their cost report.

10. Inpatient Rehabilitation Facilities

In order to be considered medically necessary, inpatient rehabilitation facility services must be expected to require medical supervision involving a rehabilitation physician conducting face-to-face visits with the patient at least 3 days per week throughout the patient's stay. CMS is modifying these rules to permit such visits to be conducted using remote telecommunication technology. In addition, CMS is temporarily eliminating the requirement that at the time of admission a patient's medical record at the facility must contain a postadmission physician evaluation.

11. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

For RHCs and FQHCs, CMS is expanding the services that can be included in the

payment for HCPCS code G0071, and is updating the payment rate for this code to include the national non-facility payment rates for three new codes (CPT Codes 99421, 99422, and 99423) to reflect the addition of these services.

In addition, to address the impact of the COVID–19 pandemic on underserved rural and urban communities, CMS is implementing changes to the requirements for visiting nursing services furnished in the home by RHCs and FQHCs. For the duration of the public health emergency, any area typically served by the RHC, and any area that is included in the FQHCs service area plan, is determined to have a shortage of home health agencies, and there is no need for the RHC or FQHC to request a determination that there is a shortage of home health agencies in the area in order for visiting nurse services to be covered by Medicare.

12. Clinical Laboratory Fee Schedule and Merit-based Incentive Payment System Updates



In order to expand the testing available to Medicare beneficiaries who need it, payments will now be provided to independent laboratories for specimen collection for COVID-19 testing under certain circumstances. A travel allowance will also be provided for a lab technician to collect a specimen for testing from non-hospital inpatients

or homebound patients.

Clinician participation in a COVID-19 clinical trial utilizing a drug or biological product to treat a patient with a COVID-19 infection will now be credited as an improvement activity for the Merit-based Incentive Payment System (MIPS) 2020 performance period. Additionally, the MIPS automatic extreme and uncontrollable circumstances policy will be applied to MIPS eligible clinicians for the 2019 MPS performance period as data submission for 2019 will be impacted.

13. Opioid Treatment Programs

Audio-only telephone calls will be permitted for the therapy and counseling portions of the weekly bundle of services furnished by Opioid Treatment Programs if the beneficiaries do not have access to two-way audio/video communications technology.

14. Teaching Physicians, Residents and Moonlighting Regulations

The teaching physician regulations are amended to allow the teaching physician to provide supervision either with physical presence or be present through interactive telecommunications technology during the key portion of residents' service. Residents

may also provide services from quarantine, such as reading the results of tests and other imaging studies under the supervision of the teaching physician by interactive telecommunications technology. This change does not apply in the case of surgical, high risk, interventional, or other complex procedures, services performed through an endoscope, and anesthesia services.

CMS clarified that Medicare may make payment under the PFS for teaching physician services, including under the primary care exception, when a resident furnishes telehealth services to beneficiaries under direct supervision of the teaching physician which is provided by interactive telecommunications technology.

CMS is also permitting the hospital that is paying the resident's salary and fringe benefits for the time that the resident is at home or in the home of a patient that is already a patient of the physician or hospital, but performing patient care duties within the scope of the approved residency program, to claim that resident for indirect medical education and direct graduate medical education purposes.

During the emergency, "moonlighting," or services of residents that are not related to their approved GME programs and are performed in the inpatient setting of a hospital in which they have their training program, are separately billable physicians' services for which payment can be made.

15. Psychiatric Hospitals

CMS has deleted several references to 42 C.F.R. § 482.12(c) in 42 C.F.R. § 492.61(d) to clarify that the latter's provisions apply to all patients, not only Medicare beneficiaries.

16. Innovation Center Models

CMS is now permitting certain beneficiaries to obtain the set of Medicare Diabetes Prevention Program (MDPP) services more than once per lifetime, increase the number of virtual make-up sessions, and allow certain MDPP suppliers to deliver virtual MDPP sessions on a temporary basis. CMS is also implementing a 3-month extension to the Comprehensive Care for Joint Replacement model performance year 5 and amending the CJR extreme and uncontrollable circumstances policy to be applicable to episodes impacted by the COVID-19 pandemic.

17. Remote Physiologic Monitoring

Remote physiologic monitoring services can temporarily be furnished to new patients, as well as to established patients. Further, consent to receive RPM services can be obtained once annually, including at the time services are furnished, during the duration of the COVID-19 public health emergency. RPM codes can also be used for physiologic monitoring of patients with acute and/or chronic conditions.

18. Evaluation and Management (E/M) Services

CMS is finalizing, on an interim basis, separate payment for CPT codes 98966-98968 and CPT codes 00441-99443. For these codes, work RVUs as recommended by certain AMA Committees are finalized:

- 0.25 for CPT code 98966
- 0.50 for CPT code 98967
- 0.75 for CPT code 98968
- 0.25 for CPT code 99441
- 0.50 for CPT code 99442
- 0.75 for CPT code 99443.

Additionally, CMS is finalizing the recommended direct PE inputs which consist of 3 minutes of post-service RN/LPN/MTA clinical labor for each time code. CMS will also not conduct reviews to consider whether those services were furnished to established patients, and the services may be furnished to new patients as well. To facilitate billing of CPT codes 98966-98968, CMS is designating these codes as “sometimes therapy” services that would require the private practice occupational therapist, physical therapist, and speech-language pathologist to include the corresponding GO, GP, or GN therapy modifier on those claims.

CMS is also permitting the office/outpatient E/M level selection for office/outpatient services when furnished via telehealth to be based on MDM or time, with time defined as all of the time associated with the E/M on the day of the encounter. Any requirements regarding documentation of history and/or physical exam in the medical record are removed for office/outpatient services via telehealth, though E/M visits should continue to be documented as necessary to ensure quality and continuity of care.

19. National Coverage Determination and Local Coverage Determination Requirements

Certain National Coverage Determinations and Local Coverage Determinations of covered items or services will not apply during the COVID-19 Pandemic, including: face-to-face and in person requirements; clinical indications for certain respiratory, home anticoagulation management and infusion pump policies; and requirements for consultations or services furnished by or with the supervision of a particular medical practitioner or specialist.

20. Part C and Part D Quality Star Ratings

CMS is modifying the calculation of the 2021 and 2022 Medicare Part C and D Star Ratings in several ways to address the expected disruption to data collection. The interim final rule:

A. replaces the 2021 Star Ratings measures calculated based on HEDIS and Medicare CAHPS data collections with earlier values from the 2020 Star Ratings (which are not affected by the public health threats posed by COVID-19);

B. establishes how CMS will calculate or assign Star Ratings for 2021 in the event that CMS' functions become focused on only continued performance of essential agency functions and CMS and/or its contractors do not have the ability to calculate the 2021 Star Ratings;

C. modifies the current rules for the 2021 Star Ratings to replace any measure that has a data quality issue for all plans due to the COVID-19 outbreak with the measure-level Star Ratings and scores from the 2020 Star Ratings;

D. in the event that CMS is unable to complete HOS data collection in 2020 (for the 2022 Star Ratings), replaces the measures calculated based on HOS data collections with earlier values that are not affected by the public health threats posed by COVID-19 for the 2022 Star Ratings;

E. removes guardrails for the 2022 Star Ratings; and

F. expands the existing hold harmless provision for the Part C and D Improvement measures to include all contracts for the 2022 Star Ratings.

21. Ordering Medicaid Home Health Services

In addition to physicians, licensed practitioners such as NPs and PAs may order Medicaid home health services during the existence of the PHE for the COVID-19 pandemic. These services include part-time or intermittent nursing, home health aide services, medical supplies, equipment, and appliances, and may include therapeutic services. This change applies to who can order home health services covered under 42 C.F.R. § 440.70(b)(1)–(4). It does not expand the benefit categories where these items can be covered.

22. Origin and Destination Requirements Under the Ambulance Fee Schedule

The list of destinations for covered ambulance transportation is expanded to include all destinations, from any point of origin, that are equipped to treat the condition of the patient consistent with EMS protocols established by state and/or local laws where the services will be furnished.

23. Inpatient Hospital Services Furnished Under Arrangements Outside the Hospital

The “under arrangements” policy is changed to allow hospitals broader flexibilities to furnish inpatient services, including routine services, outside the hospital. For services provided for discharges for patients admitted to the hospital during the PHE for COVID-19 beginning March 1, 2020, if routine services are provided under arrangements outside the hospital to its inpatients, these services are considered as being provided by the hospital.

24. Advance Payments to Suppliers Furnishing Items and Services under Part B

Under Medicare Part B, the definition of advance payments to suppliers furnishing items and services will change from a payment made by the carrier to a payment made by the contractor, and payments under emergency exceptions will be permitted. CMS is also increasing the advance payment limit from 80 percent of the anticipated payment to 100 percent.