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CMS Proposes New Medicare Changes in Telehealth for 2021

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On August 3, 2020, the Centers for Medicare and Medicaid Services (CMS) issued the advance copy of its proposed 2021 Physician Fee Schedule rule, which contains new telehealth services covered under Medicare. Compared to last year, where CMS made only minor additions to telehealth services, the changes proposed for 2021 are bold and designed to more deliberately expand the use of telehealth technologies among Medicare beneficiaries.

The most notable change is to allow physicians to fulfill direct supervision requirements while remote, provided the physician is immediately available to engage via audio-video technology if needed. This change can greatly increase physician leverage and virtual oversight, including more incident-to billing options. Another notable change is CMS' proposal to remove frequency limitations for facility inpatient-type telehealth services.

This article discusses the new changes and proposed telehealth codes and explains how to submit public comments on the proposed rule. The public comment period is open through the end of September 2020. For additional background, you can learn about the basics of Medicare telehealth services and CMS' annual review process at this article.

1. Direct Supervision via Telehealth and Incident-To Billing

CMS proposed changing the definition of direct supervision to allow the supervising physician to be remote and use real-time, interactive audio-video technology. This is a big change because the current definition of direct supervision requires the physician to be physically present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. (It does not require the physician to be physically present in the actual room when the service or procedure is performed.) If finalized, the change would be in effect through December 31, 2021 or the end of the Public Health Emergency (PHE), whichever is later.

Under this new definition, direct supervision requirements could be met if the supervising physician was immediately available to engage via audio-video

technology. It does not require the physician's real-time presence or observation of the service via interactive audio-video technology throughout the performance of the procedure. Audio-only technology is not sufficient to fulfill direct supervision requirements.

The new definition opens opportunities for telehealth and incident-to billing. CMS acknowledged there are no Medicare regulations that explicitly prohibit eligible distant site practitioners from billing for telehealth services provided incident-to their services. But because the current definition of direct supervision requires on-site presence of the billing clinician when the service is provided, it is difficult for a billing clinician to fulfill direct supervision of services provided via telehealth incident-to their professional services by auxiliary personnel. Under the new definition, CMS believes services provided incident to the professional services of an eligible distant site physician or practitioner could be reported when they meet direct supervision requirements at both the originating and distant site through the virtual presence of the billing physician or practitioner.

The duration of this change is time-limited because CMS has concerns that widespread direct supervision through virtual presence may not be safe for some clinical situations. For instance, virtual direct supervision might not be appropriate in complex, high-risk, surgical, interventional, or endoscopic procedures, or for patients with dementia, or patients where an in-person physical examination is necessary and important. CMS is seeking comments as to whether there should be any additional "guardrails" or limitations to ensure patient safety/clinical appropriateness, beyond typical clinical standards, as well as restrictions to prevent fraud or inappropriate use if this new definition were to become permanent beyond December 31, 2021. CMS also seeks information on what risks this policy might introduce to beneficiaries as they receive care from practitioners that would supervise care virtually in this way. Commenters are invited to provide data and information about their implementation experience with direct supervision using virtual presence during the PHE, including comments on the degree of aging and disability competency training that is required for effective use of audio/video real-time communications technology.

2. Remove Frequency Limitations for Nursing Facility and Hospital Inpatient Services

CMS proposed changing the frequency limitation to cover subsequent nursing facility care services furnished via telehealth to once every 3 days (the current rule covers it only once every 30 days). The original 30 day restriction was due to concerns on the acuity and complexity of nursing facility residents, and to ensure nursing facility residents have frequent encounters with their admitting practitioner. However, CMS has been persuaded that the use of telehealth is crucial to maintaining a continuum of care in nursing facilities, and to honor the independent medical judgment of treating

clinicians to decide whether telehealth vs in-person care should be used depending on the needs of each specific resident.

CMS did not propose changing the frequency limitations for subsequent inpatient hospital telehealth services (once every 3 days). But CMS is seeking comments if it would enhance patient access to care if frequency limitations were removed altogether (and, if so, how best to ensure that patients receive in-person care when necessary).

3. Additional Guidance on Communications Technology Based Services (CTBS)

- CTBS by Therapists. CMS proposed to allow HCPCS codes G2061 through G2063 to be billed by, for example, licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists who bill Medicare directly for their services when the service furnished falls within the scope of these practitioner's benefit categories. CMS allows this currently under PHE waivers, but the proposed rule would make it permanent. CMS also proposed to expand billing of other CTBS by nonphysician practitioners through the creation of two additional HCPCS G codes that can be billed by practitioners who cannot independently bill for E/M services:

    - G20X0 *(Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the CMS-1734-P 114 patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment.)*
    - G20X2 *(Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion)*

  To facilitate billing of CTBS by therapists, CMS proposed to designate HCPCS codes G20X0, G20X2, G2061, G2062, and G2063 as "sometimes therapy" services. When billed by a private practice PT, OT, or SLP, the codes would need to include the corresponding GO, GP, or GN therapy modifier to signify that the CTB are furnished as therapy services furnished under an OT, PT, or SLP plan of care.

- Consent. Providers must continue to obtain patient consent for these services (the consent is to be billed the applicable co-pay). CMS believes the timing or manner in which beneficiary consent is acquired should not interfere with the provision of the service itself. The consent can be verbal or written, and can be

documented by the billing practitioner or by auxiliary staff under general supervision.

- Compliance Tip. When the brief communication technology-based service originates from a related E/M service (including one furnished as a telehealth service) provided within the previous 7 days by the same physician or other qualified health care professional, this service is considered bundled into that previous E/M service and is not separately billable to Medicare or to the beneficiary (i.e., it is a provider-liable service).

4. New Telehealth Services For 2021

CMS received several requests to add new telehealth services. After review of the submissions, CMS proposed adding nine new codes to the list, set forth in the table below.

Service Type	HCPCS Code	Service Descriptor
Visit Complexity Associated with Certain Office/Outpatient E/Ms	GPC1X	Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services (Add-on code, list separately in addition to an evaluation and management visit)
Prolonged Services	99XXX	Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)

Group Psychotherapy	90853	Group psychotherapy (other than of a multiple-family group)
Neurobehavioral Status Exam	96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)
Care Planning for Patients with Cognitive Impairment	99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity; Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]); Medication reconciliation and review for high-risk medications; Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); Evaluation of safety (eg, home), including motor vehicle operation; Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.

Domiciliary, Rest Home, or Custodial Care services	99334	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent with the patient and/or family or caregiver.
	99335	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent with the patient and/or family or caregiver.
Home Visits	99347	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.
	99348	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key

		components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

These nine services are sufficiently similar to services already on the list of Medicare telehealth services, so CMS classified them as Category 1 under a streamlined review process. Subject to public comment, these services are expected to be added to the list of Medicare telehealth services when the final rule is published, and would go into effect January 1, 2021. Note: for HCPCS 99437-99438, CMS the patient's home can serve as a qualifying originating site when the patient is being treated for a substance use disorder or a co-occurring mental health disorder (in accordance with the SUPPORT Act).

CMS rejected a request to add CPT 96040 (genetic counseling services) to the list. Genetic counselors are not allowed to bill Medicare directly for their professional services. Nor are genetic counselors eligible distant site practitioners for telehealth under the Social Security Act.

For 2021, CMS proposed creating a temporary Category 3 for those services added to the Medicare telehealth list during the public health emergency (PHE) for the COVID-19 pandemic that will remain on the list through the calendar year in which the PHE ends. CMS proposed adding thirteen codes to the list of Medicare telehealth services. We will discuss those Category 3 services, as well as the approximately 50 other codes CMS has temporarily added as telehealth services during the pendency of the PHE, in a companion article.

5. How to Submit Comments on the Proposed Rule

Providers, technology companies, and entrepreneurs interested in telehealth should consider submitting comments to the proposed rule anonymously or otherwise – via electronic submission at this link. Alternatively, commenters may submit comments by mail to:

- *Regular Mail*: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1734-P, P.O. Box 8016, Baltimore, MD 21244-8016.
- *Express Overnight Mail*: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1734-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

If submitting via mail, please be sure to allow time for comments to be received before the closing date. CMS is soliciting comments on the proposed rule until 5:00 p.m. through the end of September.

6. Conclusion

Continued expansions in Medicare reimbursement mean providers should make enhancements to telehealth programs now, both for the immediate cost savings and growing opportunities for revenue generation, to say nothing of clinical quality and patient satisfaction. Though providers should be mindful of any sunset provisions on these expansions and be prepared to adjust operations in accordance with those timelines. We will continue to monitor CMS for any rule changes or guidance that affect or improve telehealth opportunities.