What Telehealth May Look Like in 2021

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The Medicare Physician Fee Schedule (PFS) proposed rule was released on Aug. 4, 2020. The Centers for Medicare & Medicaid Services (CMS) waived the 60-day publication requirement for the final rule and replaced it with a 30-day notification so that comments on the proposed rule were due on Oct. 5. The final rule will become effective Jan. 1, 2021, although it may not be published until Dec. 1, 2020. CMS also released on Aug. 4 an executive order proposing increased flexibility for telehealth and rural healthcare in light of the COVID-19 pandemic. The 2021 PFS proposed these changes specific to telehealth.

Telehealth Services After the End of the Public Health Emergency

In response to COVID-19 and as part of the public health emergency (PHE), CMS expanded telehealth services to be more broadly accepted and applicable than these services were prior to the pandemic. As part of the waivers and expansion, CMS has allowed for telehealth services to be provided in various settings, including office settings and the patient's home. As part of the Interim Final Rule released in both March and April 2020, CMS indicated when the PHE ends, the waivers and expansions would also end and services would revert back to pre-PHE days. Health and Human Services Secretary Alex Azar extended the PHE for another 90 days effective July 25, 2020. This extended waivers and expansions through Oct. 23, 2020. On October 2, 2020, the Secretary of HHS again extended the PHE effective October 23, 2020. The extension will be in effect for another 90 days, ending approximately January 21, 2021.

CMS recognizes that even when the PHE is declared over, the effects of COVID-19, coupled with patient reluctance to return to hospitals and clinics for care, may linger, and the agency is proposing a phased-in end to the waivers and expansions for some items rather than a hard-and-fast stop. Specifically, CMS is proposing several changes to telehealth services moving forward, which include the following:

- Creating a Category 3 level of telehealth. This would allow for the services that meet the Category 1 and 2 telehealth services criteria to be added temporarily on an interim final basis as necessary and in response to this or another PHE.
- Proposing any service added to Category 3 would remain on the Medicare telehealth services list through the calendar year in which the PHE ends.
- Proposing most of the services added during the PHE to be removed as CMS, in review of the codes, did not find they met the Category 2 criteria already established for telehealth services. In the proposed rule, CMS asked for stakeholders to comment on whether these services should be added to the Category 3 designation. For example, the agency specifically asked whether HCPCS code **77427** (Radiation treatment management, 5 treatments) should be added as a Category 3 code.
- Proposing to amend language that when a code is deleted and replaced with a new CPT/HCPCS code that describes the same clinical services of a code currently on the Medicare telehealth services list, the new code would be considered a successor to the old code and updated accordingly.

Table 1, page 8, summarizes CMS proposals to the Medicare telehealth services list.

Telehealth Services Technology Requirements

During the PHE, CMS removed language and allowed for telehealth expanded services to be provided by "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 physician or practitioner." This allowed for providers and patients to use smartphones when communicating with audio and video capability. CMS is proposing to update the last sentence of the Medicare telehealth services regulation, which states: "prohibits the use of telephones, facsimile machines, and electronic mail systems for purposes of furnishing Medicare telehealth services." The regulation that prohibits the use of telephones could be confusing when a smartphone and the capabilities for the audio and video are used for the visit. Removing this verbiage would delete outdated references to technology and potentially alleviate confusion for providers looking to bill for these telehealth services.

Communication Technology-Based Services

As part of the CY 2019 PFS Final Rule, CMS created several G-codes for services furnished via telecommunications technology. These services are not considered telehealth services but use telecommunications technology between the provider and patient. Two of the codes created include:

- **G2010**: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related evaluation and management (E/M) service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.
- **G2012:** Brief communication technology-based service (e.g., virtual check-in) by a physician or other qualified healthcare professional who can report E/M services, provided to an established patient, not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

Both codes may be billed by nonphysician practitioners. CMS is also proposing to add two new codes effective Jan. 1, 2021. These new codes would also be billable by nonphysician practitioners, consistent with their scope of practice, for those who cannot bill independently for E/M services. The value of these codes would match G2010 and G2012, respectively.

- **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 patient within 24 business hours, not originating from a related service provided within the previous seven 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 healthcare professional who cannot report E/M services, provided to an established patient, not originating from a related E/M service provided within the previous seven days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

Audio-Only Visits

Prior to the PHE, CMS did not provide coverage for telephone services codes, 99441-99443. In large part, this is due to the fact these services can be provided to the patient, parent, or guardian. CMS does not typically cover services (or codes) that are not directly provided to the patient. However, as part of the PHE and stakeholder feedback that most beneficiaries did not want to, know how to, or have the capabilities to use video technology for visits, CMS approved their coverage.

Telecommunication codes available prior to the PHE were only the short duration G-codes referenced above and CMS noted that, for some patients, a longer telephone visit is needed. CMS is not proposing to recognize the telephone codes under PFS after the PHE has ended. This is due to the requirement of audio/video capabilities for telehealth services once the PHE has ended. However, the agency sought comments on whether a service similar to the check-in visit should be created that covers a longer period of time for the visit. CMS also sought comments on whether the audio-only visits should remain under provisional coverage until the end of year the PHE ends or whether they should be part of the permanent PFS payment policy.

Table 1. Summary of CY 2021 Proposals for Addition of Services to the Medicare Telehealth Services List

TYPE OF SERVICE	SPECIFIC SERVICES AND CPT CODES
C9016	Group Psychotherapy (CPT code **90853**)
C9024	Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT codes **99334-99335**)
C9028	Home Visits, Established Patient (CPT codes **99347-99348**)
C9030	Cognitive Assessment and Care Planning Services (CPT code **99483**)
C9033	Visit Complexity Inherent to Certain Office/Outpatient E/Ms (HCPCS code **GPC1X**)
C9463	Prolonged Services (CPT code **99417**)
C9464	Psychological and Neuropsychological Testing (CPT code **96121**)

Physician Supervision for Telehealth Services

For the duration of the PHE, CMS has redefined direct supervision under PFS to be provided through interactive real-time audio-video telecommunication technology. This allows the physician to provide real-time assistance and direction throughout a procedure or service by allowing them to see and interact with the staff member and patient without adding any unnecessary exposure. It is important to note that the supervision adjustments are meant as a *minimum* requirement. There may be circumstances in which the physical presence of the physician with the patient in the same location is necessary and more appropriate; for example, administration of certain drugs or therapies. CMS stressed that in these types of scenarios the physician and facility must make the best decision given the situation, even if this means potential exposure due to the nature of the scenario.

CMS is proposing to extend direct supervision expansion under PFS to end later in the calendar year in which the PHE ends or Dec. 31, 2021. In addition to the other waivers and extensions, this will allow an easement to the change in supervision for physicians and practices to prepare for the change back to the in-person requirement. CMS did note, if the PHE was not extended to overlap the expected date of the final rule release, supervision requirements would revert to the guidelines in place prior to March 1, 2020. Because the PHE has been extended into 2021, the changes to physician supervision will continue as established during the PHE. It is expected that the 2021 PFS final rule will provide details for how the expansion will be eased back when the PHE ends.

CMS did clarify that the use of real-time audio and video technology to provide direct supervision under the PFS does not mean the physician must be actively observing and using the technology throughout the entire procedure. Instead the supervising physician is immediately available to engage via the real-time audio and video technology (excluding audio-only) throughout the procedure.

CMS has also received requests for clarification for when a physician and patient are at the same physical location but the visit is provided using telecommunications technology and whether this can be billed as a telehealth visit. CMS did provide clarification for this in the Second Interim Final Rule released April 30, 2020. CMS states, "... If audio/video technology is used in furnishing a service when the beneficiary and the practitioner are in the same institutional or office setting, then the practitioner should bill for the service furnished as if it was furnished in person, and the service would not be subject to any of the telehealth requirements." OI

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