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2024 Medicare Physician Fee Schedule Final Rule Extends COVID-19 Telehealth Policies and Includes Bonus Extension

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The CY 2024 Medicare Physician Fee Schedule Final Rule (Final Rule) implemented several statutory extensions to COVID-19 telehealth waivers and flexibilities, finalized proposed policies, and extended an important telehealth flexibility that was not addressed in the proposed rule.

Key takeaways from the Final Rule are explained in further detail below.

Enrollment of Home Addresses of Remote Practitioners

The CY 2024 Proposed Rule did not address issues related to enrollment and claims submission for remote practitioners even though providers and practitioners have increasingly been expressing concerns in this area. In response to this feedback, the Final Rule extends through the end of CY 2024 a COVID-19 Public Health Emergency (PHE) flexibility allowing remote practitioners to provide telehealth services from their homes while continuing to bill from their currently enrolled location without reporting their home address.

Privacy issues associated with reporting home addresses, as well as the administrative burden of changing billing practices, adding home addresses to the Medicare enrollment file, and coordinating with the appropriate Medicare Administrative Contractors (MACs) were among the concerns raised to the Centers for Medicare & Medicaid Services (CMS). Pursuant to longstanding inter-jurisdictional reassignment guidance, practices would have to enroll with the MACs of remote practitioners who furnish services from a different MAC jurisdiction because they moved or who were hired remotely to provide services in short supply. CMS indicated that the agency plans to consider how to handle the challenges associated with enrollment and claims submission for services provided by remote practitioners in the future once the flexibility ends.

Changes to Payment for Telehealth Services

As proposed, the COVID-19 PHE flexibility allowing physicians and practitioners who billed for Medicare telehealth services to report the place of service (POS) code that they would have reported if the service had been furnished in person is set to terminate at the end of CY 2023. Starting at the beginning of CY 2024:

- Telehealth services provided to patients who are not in the home (including patients in physician's offices) should be reported with POS 02 and will be paid at the facility rate starting at the beginning of CY 2024. When the clinician is in the hospital and the patient is in the home, the billing practitioner should use a hospital POS code along with modifier 95.

- All telehealth services provided to patients in their homes should be reported with POS 10 and will be paid at the higher non-facility rate.

Without further legislative changes, when the Consolidated Appropriations Act (CAA) 2023 extension of the flexibilities related to originating sites ends, the patient's home will not be a Medicare-eligible originating site for services other than mental health and other very limited exceptions. Therefore, most telehealth claims other than mental health telehealth would be paid at the facility rate absent further changes. CMS thinks this is

appropriate based on the belief that the facility costs (clinical staff, supplies, and equipment) associated with furnishing the service would generally be incurred by the originating site where the patient is located rather than by the distant site practitioner.

Billing for Telehealth Outpatient Therapy, Diabetes Self-Management Training (DSMT), and Medical Nutrition Therapy (MNT)

Hospitals will be permitted to bill for remote outpatient physical therapy (PT), occupational therapy (OT), speech-language pathology (SLP), DSMT, and MNT services furnished by therapists and institutional staff to patients in their homes through the end of 2024. In this context, beneficiary homes do not need to be registered as provider-based departments of the hospital, but institutional providers should apply modifier 95 on the claim line when billing for these services.

Permitting the Virtual Presence of Teaching Physicians

CMS finalized its proposal to continue to allow virtual presence in all teaching settings in clinical instances when the service is furnished virtually through telehealth (e.g., a three-way telehealth visit with parties in different locations). This virtual presence policy continues to require real-time observation (not mere availability) by the teaching physician and excludes audio-only technology.

CMS has been exercising enforcement discretion to allow teaching physicians in all residency sites to be present through audio/video real-time communications technology for purposes of billing under the MPFS for services they furnish to residents through the end of the CY 2024 rulemaking process.

Removing Certain Telehealth Frequency Limitations for Subsequent Inpatient Visits, Subsequent Nursing Facility Visits, and Critical Care Consultation Services

CMS finalized its proposal for CY 2024 to continue to remove the frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations. CMS' policy applies to the following codes:

- Subsequent inpatient visit CPT codes 99231, 99232, 99233
- Subsequent nursing facility visit CPT codes 99307, 99308, 99309, 99310
- Critical Care Consultation Services - HCPCs Codes: G0508, G0509

CMS explained that the continued suspension of the frequency limits on a temporary basis for CY 2024 will allow it more time to evaluate patient safety while preserving access to care in a way that is not disruptive to practice patterns established during the PHE. CMS will continue to evaluate the data and responses it received to the proposed rule as it determines the most appropriate way to support patient safety while promoting access to care.

RPM and RTM Payment Policies

CMS finalized the proposals for remote patient monitoring (RPM) and remote therapeutic monitoring (RTM) by adopting the following policies:

- Practitioners may separately furnish and be paid for RPM or RTM services furnished to a beneficiary who received a procedure or surgery that is covered under a payment for a global period.

- RPM, RTM, Community Health Integration (CHI), and Principal Illness Navigation (PIN) services will be included in the general care management HCPCS code G0511 when these services are provided by RHCs and FQHCs.

Billing for RPM and RTM Services

By way of background, in the CY 2020 MPFS final rule, CMS confirmed that the RPM code family (CPT codes 99453,99454, 99457, and 99458) describes chronic care RPM services that involve the collection, analysis, and interpretation of digitally collected physiologic data, followed by a treatment plan and management of the patient under the treatment plan. In the CY 2024 MPFS Final Rule, CMS reminded interested parties that the code family for RTM services includes CPT codes 98975, 98976, 98977, 98978, 98980, and 98981 which involve the monitoring of program or therapy adherence through a scheduled recording, or program alert, or an interactive communication with the patient or caregiver. In previous rulemaking, CMS confirmed that remote monitoring codes are designated as care management services and the rules for general supervision apply. In the CY 2024 Final Rule, CMS discussed its prior policy as set forth in the CY 2023 PFS final rule, where the code sets 98975, 98976, 98977, and 98978 require the collection of no fewer than 16 days of data in a 30-day period.

RPM Services May be Furnished Only to Established Patients:

The Final Rule confirms that RPM services may be furnished only to established patients, meaning that an initiating visit is required for patients not seen by the practitioner within the last year. As a reminder and as discussed in the proposed rule, CMS confirmed that patients who received initial RPM services during the PHE are established patients.

Data Collection Requirements/Applicable Code Sets:

In the Final Rule, CMS clarified that the following codes require the collection of a minimum of 16 days of data in a 30-day period, collected on at least one medical device as defined in section 201(h) of the FFDCA: 98976, 98977, and 98978. CMS further clarified that the 16-day data collection requirement does not apply to CPT codes 99457, 99458, 98980, and 98981. CMS inadvertently included the foregoing codes in the discussion of the proposed rule. The data collection requirements do not apply to codes 99457, 99458, 98980, and 98981 because they are treatment management codes that account for time spent in a calendar month.

As originally addressed in the CY 2021 PFS Final Rule, CMS reiterated that even when multiple medical devices are provided to a patient, the services associated with all the medical devices can only be billed once per patient per 30-day period and only when at least 16 days of data are collected.

Payment for RPM or RTM in Conjunction with Other Services:

In the CY 2024 MPFS Final Rule, CMS clarified its policy that when RPM and RTM are furnished in conjunction with other services practitioners may bill for RPM or RTM services, but not both. Either RPM or RTM services may be billed concurrently with certain care management services for the same patient as long as time or effort are not counted twice. Care management services include Chronic Care Management (CCM)/Transitional Care Management (TCM)/Behavioral Health Integration (BHI), Principal Care Management (PCM), and Continuous Passive Motion (CPM). CMS confirmed that according to the 2023 Current Procedural Terminology (CPT) Codebook:

- CPT code 98980 (RTM treatment management) cannot be reported in conjunction with CPT codes 99457/99458 (RPM treatment management).

CMS remains focused on allowing practitioners to select the appropriate care management services while reducing significant issues of possible fraud, waste, and abuse associated with overbilling for these services.

Appropriate Billing of RPM or RTM Services:

In the Final Rule, CMS confirmed that practitioners may separately furnish and be paid for RPM or RTM services to a beneficiary who received a procedure or surgery that is covered under a payment for a global period. Payment for RTM or RPM services would be separate from the global payment. In other words, the prohibition on the provision of RPM or RTM services during a global period only applies to billing practitioners who have received the global service payment.

Specifically, CMS finalized that providing RTM or RPM services during the global period is permitted if the practitioner is not receiving global service payment because they did not furnish the global procedure.

RPM and RTM Services Provided by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs):

Finally, CMS finalized its policy to include RPM, RTM, Community Health Integration (CHI), and Principal Illness Navigation (PIN) services in the general care management HCPCS code G0511 when these services are provided by RHCs and FQHCs.

Conclusion

The CY 2024 Final Rule finalizes a number of important extensions to telehealth flexibilities established during the PHE and clarifies payment policies related to telehealth and other remote services. The Final Rule reinforces CMS's continued emphasis on promoting access to patient care while continuing to evaluate practice patterns and utilization following the PHE to identify whether more permanent changes to these policies are appropriate.

If you have any questions regarding the CY 2024 PFS Final Rule or other regulatory requirements affecting telehealth and remote monitoring services, please contact Allison M. Cohen, Alissa D. Fleming, Katherine Denney, or any other member of Baker Donelson's Telehealth Team.