| KEY: | Blue – Requires Congressional Action | Green – Agency Has Authority to Act |
|---|---|---|

## Medicare Part B Services – Physician Fee Schedule (PFS)

| Issue | Before COVID-19 | During COVID-19* | After COVID-19: ATA's Recommended Action |
|---|---|---|---|
| Allowable Medicare Telehealth services | CMS keeps list of allowable Medicare telehealth services | CMS added 135 temporarily allowable codes | **CMS should continue to evaluate and add codes, which has been initiated in the CY2021 PFS proposed rule** |
| Distant site provider** | Limited to physicians, physician assistants (PAs), certified registered nurse anesthetists (cRNAs), certified nurse-midwives, clinical social works (CSWs), clinical psychologists, and registered dietitians | Congress allowed CMS to waive under 1135 authority; 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 allow CMS to determine practitioners appropriate to practice telehealth** |
| Originating site – geographic** | Patient location limited to rural health professional shortage areas | Congress allowed CMS to waive under 1135 authority; CMS waived the geographic restrictions for telehealth claims starting March 6 | **Congress should strike the arbitrary geographic originating site restriction** |
| Originating site – home** | Patient location limited to physician offices, critical access hospitals, rural health clinics, federally qualified health centers, hospitals, hospital-based renal dialysis centers, skilled nursing facilities, community mental health centers, and renal dialysis facilities and the home only for ESRD services | Congress allowed CMS to waive under 1135 authority; 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 in the home and other sites of care** |

**Medicare Part B Services - PFS (cont.)**

| Issue | Before COVID-19 | During COVID-19* | After COVID-19: ATA's Recommended Action |
|---|---|---|---|
| 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 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 place of service 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 | **CMS should ensure that telehealth services are reimbursed fairly** |
| Modality – audio only | Services must be delivered using a "telecommunications system" defined in regulations as synchronous audio-video[1] | CMS waived the regulatory definition requiring video and updated the list to include 89 codes allowed audio/phone-only | **CMS should reimburse for audio-only services as clinically appropriate** |
| Provider enrollment | Provider enrollment is a formal process that includes a written application and screening requirements, such as criminal background checks. Telehealth practitioners who deliver care from their homes on regular basis, such that the practitioner's home is a "practice location," must enroll their homes in Medicare as a practice location. CMS also charges application fees for provider enrollment for temporary Medicare billing privileges[2] | CMS waived fees and other enrollment requirements and established a provider enrollment hotline | **CMS should ensure that the provider enrollment process is not overly burdensome and that practitioners do not have to enroll their home address as their practice location** |
| 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[3] | 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** |

**Medicare Part B Services - PFS (cont.)**

| Issue | Before COVID-19 | During COVID-19* | After COVID-19: ATA's Recommended Action |
|---|---|---|---|
| Direct supervision | In many settings, non-physician clinicians have direct supervision requirements requiring the presence of a physician when the service is provided[4] | 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 | **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** |
| 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** |
| | | 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 |

## Other Medicare

| Issue | Before COVID-19 | During COVID-19 | After COVID-19: ATA's Recommended Action |
|---|---|---|---|
| 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 | Defer to the states on licensing requirements |
| 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** |
| Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)** | FQHCs and RHCs were not eligible to provide telehealth services as distant site providers | 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** |
| 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** |

## Medicare Advantage

| Issue | Before COVID-19 | During COVID-19* | After COVID-19: ATA's Recommended Action |
|---|---|---|---|
| Risk adjustment | Diagnoses obtained during telehealth encounters did not count toward Medicare risk adjustment programs | CMS temporarily allowed diagnoses made over telehealth to count toward risk adjustment programs | **CMS should permanently allow diagnoses made during telehealth encounters to count toward risk adjustment programs** |
| 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 subit 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 |

**Non-Medicare**

| Agency: Law | Issue | Before COVID-19 | During COVID-19* | After COVID-19: ATA's Recommended Action |
|---|---|---|---|---|
| Drug Enforcement Administration (DEA): Ryan Haight | Remote Prescribing of Controlled Substances | The DEA only allows telemedicine for prescribing of controlled substances if the patient is in a DEA-registered hospital or clinic | DEA used existing emergency authority under Ryan Haight to waive the restrictions and allow telehealth regardless of where the patient is so long as the prescription is issued for a legitimate purpose, synchronous audio/video is used, and the prescriber is DEA-registered and practicing in accordance with state and federal law | **DEA should make this flexibility permanent through existing authority – via Special Registration or another existing exception under Ryan Haight** |
| Office for Civil Rights (OCR): HIPAA | Modality – HIPAA compliance | HIPAA rules require technology platforms to meet requirements intended to protection patient privacy | OCR announced it will practice temporary enforcement discretion of HIPAA privacy rules for remote communications technology, allowing providers to use popular applications such as FaceTime, Zoom, or Skype (as long as they are private connections) | No action needed |

**When "temporary" policy changes are noted in the "During COVID-19" column, it can be assumed that the temporary policy applies only during duration of the COVID-19 public health emergency (PHE). Congress gave HHS 1135 waiver authority in the CARES Act.*

***Limited by Section 1834(m) of the Social Security Act*

1 *42 CFR § 410.78*
2 *42 CFR § 424.514 and 516*
3 *42 CFR § 415.172 and § 415.174*
4 *Multiple sections including 42 CFR § 482.12 and § 410.26 and § 410.32*