**Medicare Telehealth Coverage Before, During, and After the COVID-19 Public Health Emergency**

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**This issue brief from the Indian Health Service (IHS) Tribal Self-Governance Advisory Committee (TSGAC) provides Tribes and Tribal organizations information about reimbursement for Medicare telehealth and communications based technology services during the COVID-19 Public Health Emergency, and advocacy necessary for permanent telehealth services after the public health emergency.** [1]

## I. Executive Summary and Recommendations

Section 1834(m) of the Social Security Act governs Medicare "telehealth" services, which are a relatively narrow set of services subject to certain restrictions. Medicare also reimburses for other services provided remotely through communications based technology that are distinct from the Medicare telehealth benefit.

Medicare telehealth services include a limited list of services that are ordinarily furnished in person, but which may be furnished instead using real-time interaction through both audio and visual technology. Medicare telehealth services may only be provided in rural areas, and the patient must usually be at the facility at the time of service. Communications based technology services that are not considered Medicare telehealth services, but which may be reimbursed under Medicare include remote patient monitoring, virtual check-ins, and e-visits through an online patient portal.

During the COVID-19 public health emergency, the Centers for Medicare & Medicaid Services (CMS) used its authority to waive certain Medicare rules during public health emergencies and its authority to change its own regulations via rulemaking in order to expand access to Medicare telehealth and communications based technology services.[2] This expansion had an enormous impact on Indian Country, greatly expanding access to care.

Looking ahead to the end of the pandemic, CMS has permanently added certain Medicare telehealth services and permanently adopted certain flexibilities. However, there remains a need to

[1] This brief is for informational purposes only and is not intended as legal advice. For questions on this brief, please contact Sarah Sullivan, TSGAC Health Policy Consultant, at SSullivan16@outlook.com

[2] See, e.g., Centers for Medicare & Medicaid Services (CMS), Medicare Coverage and Payment of Virtual Services Fact Sheet, March 17, 2020, https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet; CMS, COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers, updated May 24, 2021, https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf; CMS, Interim Final Rule with Comment, 85 Fed.Reg. 19230 (Apr. 6, 2020); CMS, Interim Final Rule with Comment, 85 Fed.Reg. 27550 (May 8, 2020); CMS, Interim Final Rule with Comment, 85 Fed.Reg. 54820 (Sep. 2, 2020); CMS Final Rule, 85 Fed.Reg. 84472 (Dec. 28, 2020).

advocate for the following measures to ensure Indian health programs are able to leverage technology to provide patients the care they need:

- Congress removing geographic and site of service restrictions on Medicare telehealth services;
- Congress expanding the types of providers that may bill for Medicare telehealth services;
- Congress allowing facilities to collect a fee when they are coordinating telehealth visits for patients in their homes;
- CMS permitting audio-only telecommunications systems to be used to deliver Medicare telehealth services, including audio-only telephones and two-way radios;
- CMS ensuring that Medicare reimburses Indian health care providers for telehealth services at the OMB rate; and
- CMS permanently expanding, in consultation with Tribes, the types of services eligible for Medicare telehealth reimbursement;
- CMS permanently expanding, in consultation with Tribes, the availability and sustainability of virtual check-ins and e-visits, including allowing them for new patients; and
- CMS permanently authorizing direct supervision requirements for services incident to a physician's services to be fulfilled using real-time interactive audio and video technology.

## II. COVID-19 Public Health Emergency Flexibilities

### A. Pre-pandemic Medicare Telehealth Restrictions

The Social Security Act establishes the Medicare telehealth benefit at Section 1834(m). The provisions allow specified health providers to render certain services to Medicare beneficiaries when the provider is elsewhere (at a "distant site"). The statute provides that these services are rendered "via a telecommunications system" and that the provider is to be reimbursed at the same rate as the provider would be if the service were furnished in person.[3] A facility fee is also provided to the "originating site," the facility where the patient comes to receive the services.[4] The Social Security Act gives the Secretary of Health and Human Services (HHS) discretion to add services to the Medicare telehealth benefit. However, it places restrictions on the types of providers that may provide Medicare telehealth services,[5] limits Medicare telehealth services to rural areas,[6] and requires that the patient be in the facility (the "originating site") to receive services with the limited exception of certain end stage renal disease and

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[3] Social Security Act § 1824(m)(1), (2)(A).
[4] *Id.* § 1834(m)(2)(B).
[5] *Id.* § 1834(m)(1).
[6] *Id.* § 1834(m)(4)(C)(i).

substance use disorder services.[7] The statute does not generally allow Medicare reimbursement for services provided in a patient's home.

In addition to these statutory restrictions, CMS implemented additional restrictions on Medicare telehealth services in its regulations at 42 C.F.R. § 410.78. For example, CMS regulations required an "interactive" telecommunications system, which it defined to require two-way, audio-visual, real-time equipment and to exclude the use of telephones.[8]

### B. Expansion of Telehealth and Remote Flexibilities During the Pandemic

In response to the COVID-19 pandemic, CMS used its Section 1135 waiver authority to vastly expand the availability of Medicare telehealth services. Section 1135 of the Social Security Act allows CMS to waive certain Medicare or Medicaid requirements during a public health emergency. During the pandemic, Congress expanded CMS's authority under Section 1135 to include authority to waive Medicare telehealth restrictions.[9] CMS also implemented changes to its regulations, on a temporary basis, to expand access to Medicare telehealth services.

CMS added over 140 services to the Medicare telehealth benefit. It also lifted geographic restrictions to allow the benefit to be available outside of rural areas, and it lifted site-of-service restrictions so that patients could receive telehealth services in their homes or another remote location without having to come in to a facility. CMS also expanded the providers that could deliver Medicare telehealth services. CMS allowed certain services to be delivered using audio-only equipment, and it allowed telephones with both audio and visual capabilities to be used for delivery of any Medicare telehealth services.

CMS also increased access to Medicare reimbursable communications based technology services, expanding remote evaluation and virtual check-in flexibilities, allowing remote services to be used for new patients, and authorizing certain audio-only evaluation and management services. Additionally, CMS authorized certain provider direct supervision requirements for services provided incident to physician services to be met through a supervising practitioner using interactive audio/video real-time communications technology, expanding the ability of providers requiring direct supervision to furnish services.

## III. Making Medicare Telehealth and Remote Services Changes Permanent

Certain key Medicare telehealth flexibilities would require Congressional action to be extended beyond the end of the public health emergency. This includes expanding the list of providers that can

[7] *Id.* § 1834(m)(4)(C)(ii)(X).

[8] See 85 Fed.Reg. at 84531 (describing changes to 42 C.F.R. § 410.78(a)(3)).

[9] Coronavirus Preparedness and Response Supplemental Appropriations Act, Pub. L. 116-123, § 102 (March 6, 2020) (allowing waiver of certain Medicare telehealth restrictions); Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. 116-136, § 3703 (March 27, 2020) (allowing wavier of any Medicare telehealth restrictions).

furnish Medicare telehealth services and lifting the geographic and site-of-service ("originating site") restrictions that allow access to Medicare telehealth services outside of rural areas and when patients are in their homes. This means that without these flexibilities there will be a drastic restriction in the availability of Medicare telehealth services after the COVID-19 public health emergency unless Congress acts.

CMS has, however, used its authority to make permanent certain changes regarding the Medicare telehealth benefit and services provided through communications based technology. CMS has made permanent: allowing telephones with audio-visual technology to be used for telehealth visits; increasing the frequency limitation on telehealth visits for nursing home patients; and permanently allowing reimbursement for remote assessment of recorded video and/or images and virtual check-ins for established patients.

CMS has also permanently expanded the services that may be provided through the Medicare telehealth benefit. Section 1834(m) of the Social Security Act requires there be a process that provides, on an annual basis, for adding services to the Medicare telehealth benefit.[10] In the past, CMS has added services on two bases. Services were added on a "Category 1" basis if they were similar to services currently covered by the Medicare telehealth benefit. Services were added on a "Category 2" basis if they were not similar to currently covered services but there was sufficient evidence that providing the service via telehealth produced a demonstrated clinical benefit to the patient.[11]

Of the many Medicare telehealth services CMS temporarily allowed in response to COVID-19, CMS decided to adopt some of these on a Category 1 basis (*TABLE A*). Many others, however, did not qualify for Category 1 inclusion and did not have sufficient data to be adopted on a Category 2 basis. CMS, therefore, created a temporary third basis—"Category 3"—for adding services to the Medicare telehealth services list through the end of the public health emergency (*TABLE B*). CMS temporarily added services on a Category 3 basis if there was likely to be a clinical benefit to furnishing the services via telehealth, but sufficient data has not yet been collected or presented. There still remains services that CMS did not adopt on a temporary or permanent basis, such as home services for new patients (*TABLE C*).

To summarize, CMS has permanently adopted certain Medicare telehealth services that were allowed during the pandemic (*TABLE B*), it has allowed additional time to demonstrate that some services should be adopted permanently, and has ended inclusion of other services.

[10] Social Security Act § 1834(m)(4)(F).

[11] See 85 Fed.Reg. at 84502 (describing the Category 1 and Category 2 bases for adding services to the Medicare telehealth list, including examples of clinical benefits).

**_TABLE A:_ Category 1 Permanent Medicare Telehealth Additions**

| SERVICE | CPT or HCPCS CODE |
|---|---|
| Group Psychotherapy | CPT 90853 |
| Psychological and Neuropsychological Testing | CPT 96121 |
| Domiciliary, Rest Home, or Custodial Care services, Established patients | CPT 99334-99335 |
| Home Visits, Established patient | CPT 99347-99348 |
| Cognitive Assessment and Care Planning Services | CPT 99483 |
| Visit Complexity Inherent to Certain Office/Outpatient Evaluation and Management (E/M) | HCPCS G2211 |
| Prolonged Services | HCPCS G2212 |

**_TABLE B_: Category 3 Temporary Medicare Telehealth Services during COVID-19 PHE**

| SERVICE | CPT CODE |
|---|---|
| Domiciliary, Rest Home, or Custodial Care services, Establish patients | CPT 99336-99337 |
| Home Visits, Established Patients | CPT 99349-99350 |
| Emergency Department Visits, Level 1-5 | CPT 99281-99285 |
| Nursing facilities discharge day management | CPT 99315-99316 |
| Psychological and Neuropsychological Testing | CPT 96130-96133; CPT 96136-96139 |
| Therapy Services, Physical and Occupational Therapy, All levels | CPT 97161-97168;<br>CPT 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507 |
| Hospital discharge day management | CPT 99238-99239 |
| Inpatient Neonatal and Pediatric Critical Care, Subsequent | CPT 99469, 99472, 99476 |
| Continuing Neonatal Intensive Care Services | CPT 99478-99480 |
| Critical Care Services | CPT 99291-99292 |
| End-Stage Renal Disease Monthly Capitation Payment codes | CPT 90952, 90953, 90956, 90959, and 90962 |
| Subsequent Observation and Observation Discharge Day Management | CPT 99217; CPT 99224-99226 |

***TABLE C:*** **Services Not Added to the Medicare Telehealth List**

| SERVICE | CPT CODE |
|---|---|
| Initial Nursing Facility visits, all levels (Low, Moderate, and High Complexity) | CPT 99304-99306 |
| Radiation Treatment Management Services | CPT 77427 |
| Domiciliary, Rest Home, or Custodial services, New | CPT 99324-99328 |
| Home Visits, New Patient, all levels | CPT 99341-99345 |
| Inpatient Neonatal and Pediatric Critical Care, Initial | CPT 99468, 99471, 99475, 99477 |
| Initial Neonatal Intensive Care Services | CPT 99477 |
| Initial Observation and Observation Discharge Day Management | CPT 99218-99220; CPT 99234-99236 |
| Medical Nutrition Therapy | CPT G0271 |

## IV. Conclusion

During the COVID-19 public health emergency, Indian health care providers have experienced a dramatic expansion of their ability to render health care services remotely to patients using technology. However, many of the additional services and flexibilities that were allowed will expire at the end of the public health emergency. Action is needed from both Congress and CMS to re-envision the Medicare telehealth benefit to allow Indian health providers throughout the country to leverage technology to best serve the needs of their patients.

The TSGAC will continue to track Medicare telehealth coverage for during and after the COVID-19 pandemic. For questions or comments to the TSGAC ACA/IHCIA team, please contact Cyndi Ferguson, TSGAC ACA/IHCIA Project Lead at cyndif@senseinc.com.