

C. Medicare Telehealth Services

1. Billing and Payment for Telehealth Services

Several conditions must be met for Medicare to make payments for telehealth services under the PFS. The service must be on the list of Medicare telehealth services and meet all of the following additional requirements:

- The service must be furnished via an interactive telecommunications system.
- The service must be furnished by a physician or other authorized practitioner.
- The service must be furnished to an eligible telehealth individual.
- The individual receiving the service must be located in a telehealth originating site.

When all of these conditions are met, Medicare pays a facility fee to the originating site and makes a separate payment to the distant site practitioner furnishing the service.

Section 1834(m)(4)(F)(i) of the Act defines Medicare telehealth services to include professional consultations, office visits, office psychiatry services, and any additional service specified by the Secretary, when furnished via a telecommunications system. We first implemented this statutory provision, which was effective October 1, 2001, in the CY 2002 PFS final rule with comment period (66 FR 55246). We established a process for annual updates to the list of Medicare telehealth services as required by section 1834(m)(4)(F)(ii) of the Act in the CY 2003 PFS final rule with comment period (67 FR 79988).

As specified at §410.78(b), we generally require that a telehealth service be furnished via an interactive telecommunications system. Under §410.78(a)(3), an interactive telecommunications system is defined as 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.

Telephones, facsimile machines, and stand-alone electronic mail systems do not meet the definition of an interactive telecommunications system. An interactive telecommunications system is generally required as a condition of payment; however, section 1834(m)(1) of the Act allows the use of asynchronous “store-and-forward” technology when the originating site is part of a federal telemedicine demonstration program in Alaska or Hawaii. As specified in §410.78(a)(1), asynchronous store-and-forward is the transmission of medical information from an originating site for review by the distant site physician or practitioner at a later time.

Medicare telehealth services may be furnished to an eligible telehealth individual notwithstanding the fact that the practitioner furnishing the telehealth service is not at the same location as the beneficiary. An eligible telehealth individual is an individual enrolled under Part B who receives a telehealth service furnished at a telehealth originating site.

Practitioners furnishing Medicare telehealth services are reminded that these services are subject to the same non-discrimination laws as other services, including the effective communication requirements for persons with disabilities of section 504 of the Rehabilitation Act of 1973 and section 1557 of the Affordable Care Act, as well as and language access for persons with limited English proficiency, as required under Title VI of the Civil Rights Act of 1964 and section 1557 of the Affordable Care Act. For more information, see http://www.hhs.gov/ocr/civilrights/resources/specialtopics/hospitalcommunication_

Practitioners furnishing Medicare telehealth services submit claims for telehealth services to the Medicare Administrative Contractors (MACs) that process claims for the service area where their distant site is located. Section 1834(m)(2)(A) of the Act requires that a practitioner who furnishes a telehealth service to an eligible telehealth individual be paid an amount equal to

the amount that the practitioner would have been paid if the service had been furnished without the use of a telecommunications system.

Originating sites, which can be one of several types of sites specified in the statute where an eligible telehealth individual is located at the time the service is being furnished via a telecommunications system, are paid a facility fee under the PFS for each Medicare telehealth service. The statute specifies both the types of entities that can serve as originating sites and the geographic qualifications for originating sites. For geographic qualifications, our regulation at §410.78(b)(4) limits originating sites to those located in rural health professional shortage areas (HPSAs) or in a county that is not included in a metropolitan statistical area (MSA).

Historically, we have defined rural HPSAs to be those located outside of MSAs. Effective January 1, 2014, we modified the regulations regarding originating sites to define rural HPSAs as those located in rural census tracts as determined by the Federal Office of Rural Health Policy of the Health Resources and Services Administration (HRSA) (78 FR 74811). Defining “rural” to include geographic areas located in rural census tracts within MSAs allows for broader inclusion of sites within HPSAs as telehealth originating sites. Adopting the more precise definition of “rural” for this purpose expands access to health care services for Medicare beneficiaries located in rural areas. HRSA has developed a website tool to provide assistance to potential originating sites to determine their geographic status. To access this tool, see our website at <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html>.

An entity participating in a federal telemedicine demonstration project that has been approved by, or received funding from, the Secretary as of December 31, 2000 is eligible to be an originating site regardless of its geographic location.

Effective January 1, 2014, we also changed our policy so that geographic status for an originating site would be established and maintained on an annual basis, consistent with other telehealth payment policies (78 FR 74400). Geographic status for Medicare telehealth originating sites for each calendar year is now based upon the status of the area as of December 31 of the prior calendar year.

For a detailed history of telehealth payment policy, see 78 FR 74399.

2. Adding Services to the List of Medicare Telehealth Services

As noted previously, in the CY 2003 PFS final rule with comment period (67 FR 79988), we established a process for adding services to or deleting services from the list of Medicare telehealth services. This process provides the public with an ongoing opportunity to submit requests for adding services, which are then reviewed by us. Under this process, we assign any submitted request to make additions to the list of telehealth services to one of two categories. Revisions to the criteria that we use to review requests in the second category were finalized in the CY 2012 PFS final rule with comment period (76 FR 73102). The two categories are:

- Category 1: Services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services. In reviewing these requests, we look for similarities between the requested and existing telehealth services for the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter, a practitioner who is present with the beneficiary in the originating site. We also look for similarities in the telecommunications system used to deliver the service; for example, the use of interactive audio and video equipment.

- Category 2: Services that are not similar to the current list of telehealth services. Our review of these requests includes an assessment of whether the service is accurately described by

the corresponding code when furnished via telehealth and whether the use of a telecommunications system to furnish the service produces demonstrated clinical benefit to the patient. Submitted evidence should include both a description of relevant clinical studies that demonstrate the service furnished by telehealth to a Medicare beneficiary improves the diagnosis or treatment of an illness or injury or improves the functioning of a malformed body part, including dates and findings, and a list and copies of published peer reviewed articles relevant to the service when furnished via telehealth. Our evidentiary standard of clinical benefit does not include minor or incidental benefits.

Some examples of clinical benefit include the following:

- Ability to diagnose a medical condition in a patient population without access to clinically appropriate in-person diagnostic services.
- Treatment option for a patient population without access to clinically appropriate in-person treatment options.
- Reduced rate of complications.
- Decreased rate of subsequent diagnostic or therapeutic interventions (for example, due to reduced rate of recurrence of the disease process).
- Decreased number of future hospitalizations or physician visits.
- More rapid beneficial resolution of the disease process treatment.
- Decreased pain, bleeding, or other quantifiable symptom.
- Reduced recovery time.

The list of telehealth services, including the proposed additions described below, is included in the Downloads section to this final rule at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html>.

Requests to add services to the list of Medicare telehealth services must be submitted and received no later than December 31 of each calendar year to be considered for the next rulemaking cycle. To be considered during PFS rulemaking for CY 2019, qualifying requests must be submitted and received by December 31, 2017. Each request to add a service to the list of Medicare telehealth services must include any supporting documentation the requester wishes us to consider as we review the request. Because we use the annual PFS rulemaking process as a vehicle for making changes to the list of Medicare telehealth services, requesters should be advised that any information submitted is subject to public disclosure for this purpose. For more information on submitting a request for an addition to the list of Medicare telehealth services, including where to mail these requests, see our website at <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html>.

3. Submitted Requests to Add Services to the List of Telehealth Services for CY 2018

Under our existing policy, we add services to the telehealth list on a category 1 basis when we determine that they are similar to services on the existing telehealth list for the roles of, and interactions among, the beneficiary, physician (or other practitioner) at the distant site and, if necessary, the telepresenter. As we stated in the CY 2012 PFS final rule with comment period (76 FR 73098), we believe that the category 1 criteria not only streamline our review process for publicly requested services that fall into this category, but also expedite our ability to identify codes for the telehealth list that resemble those services already on this list.

We received several requests in CY 2016 to add various services as Medicare telehealth services effective for CY 2018. The following presents a discussion of these requests, and our proposals for additions to the CY 2018 telehealth list. Of the requests received, we found that three services were sufficiently similar to services currently on the telehealth list to qualify on a

category 1 basis. Therefore, we proposed to add the following services to the telehealth list on a category 1 basis for CY 2018:

- HCPCS code G0296 (Counseling visit to discuss need for lung cancer screening using low dose ct scan (ldct) (service is for eligibility determination and shared decision making))

We found that the service described by HCPCS code G0296 is sufficiently similar to office visits currently on the telehealth list. We believed that all the components of this service, which include assessment of the patient's risk for lung cancer, shared decision making, and counseling on the risks and benefits of LDCT, can be furnished via interactive telecommunications technology.

- CPT codes 90839 and 90840 (Psychotherapy for crisis; first 60 minutes) and (Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service))

We proposed to add CPT codes 90839 and 90840 on a Category 1 basis. We found that these services are sufficiently similar to the psychotherapy services currently on the telehealth list, even though these codes describe patients requiring more urgent care and psychotherapeutic interventions to minimize the potential for psychological trauma. However, we identified one specific element of the services as described in the CPT prefatory language that we concluded may or may not be able to be furnished via telehealth, depending on the circumstances of the particular service. The CPT prefatory language specifies that the treatment described by these codes requires, "mobilization of resources to defuse the crisis and restore safety." In many cases, we believed that a distant site practitioner would have access (via telecommunication technology, presumably) to the resources at the originating site that would allow for the kind of mobilization required to restore safety. However, we also believed that it would be possible that

a distant site practitioner would not have access to such resources. Therefore we proposed to add the codes to the telehealth list with the explicit condition of payment that the distant site practitioner be able to mobilize resources at the originating site to defuse the crisis and restore safety, when applicable, when the codes are furnished via telehealth. “Mobilization of resources” is a description used in the CPT prefatory language. We believed the critical element of “mobilizing resources” is the ability to communicate with and inform staff at the originating site to the extent necessary to restore safety. We solicited comment on whether our assumption that the remote practitioner is able to mobilize resources at the originating site to defuse the crisis and restore safety is valid.

Although we did not receive specific requests, we also proposed to add four additional services to the telehealth list based on our review of services. All four of these codes are add-on codes that describe additional elements of services currently on the telehealth list and would only be considered telehealth services when billed as an add-on to codes already on the telehealth list.

The four codes are:

- CPT code 90785 (Interactive complexity (List separately in addition to the code for primary procedure))
- CPT codes 96160 and 96161 (Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument) and (Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument))

- HCPCS code G0506 (Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service))

In the case of CPT codes 96160 and 96161, and HCPCS code G0506, we recognized that these services may not necessarily be ordinarily furnished in-person with a physician or billing practitioner. Ordinarily, services that are typically not considered to be face-to-face services do not need to be on the list of Medicare telehealth services; however, these services would only be considered Medicare telehealth services when billed with a base code that is also on the telehealth list and would not be considered Medicare telehealth services when billed with codes not on the Medicare telehealth list. We believed that by adding these services to the telehealth list it will be administratively easier for practitioners who report these services in association with a visit code that is furnished via telehealth as both the base code and the add-on code would be reported with the telehealth place of service.

We also received requests to add services to the telehealth list that do not meet our criteria for Medicare telehealth services. We did not propose adding the following procedures for physical, occupational, and speech therapy, initial hospital care, and online E/M by physician/qualified healthcare professional to the telehealth list, or changing the requirements for ESRD procedure codes furnished via telehealth, for the reasons noted in the paragraphs that follow.

a. Physical and Occupational Therapy and Speech-Language Pathology Services: CPT Codes—

- CPT code 97001: now deleted and reported with CPT codes 97161, 97162, or 97163, as follows: CPT code 97161 (Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of

care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome); CPT code 97162 (Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome); or CPT code 97163 (Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome.)

- CPT code 97002: now deleted and reported as CPT code 97164 (Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of

care using a standardized patient assessment instrument and/or measurable assessment of functional outcome.)

- CPT code 97003: now deleted and reported with CPT codes 97165, 97166, or 97167, as follows: CPT code 97165 (Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component); CPT code 97166 (Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component));

or CPT code 97167 (Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component.)

- CPT code 97004: now deleted and reported as CPT code 97168 (Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and a revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required.)

- CPT code 97110 (Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility)

- CPT code 97112 (Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities)

- CPT code 97116 (Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing))
- CPT code 97535 (Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes)
- CPT code 97750 (Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes)
- CPT code 97755 (Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes)
- CPT code 97760 (Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes)
- CPT code 97761 (Prosthetic training, upper and/or lower extremity(s), each 15 minutes)
- CPT code 97762 (Checkout for orthotic/prosthetic use, established patient, each 15 minutes)

Section 1834(m)(4)(E) of the Act specifies the types of practitioners who may furnish and bill for Medicare telehealth services as those practitioners under section 1842(b)(18)(C) of the Act. Physical therapists, occupational therapists and speech-language pathologists are not among the practitioners identified in section 1842(b)(18)(C) of the Act. We stated in the CY 2017 PFS final rule (81 FR 80198) that because these services are predominantly furnished by physical therapists, occupational therapists and speech-language pathologists, we did not believe

it would be appropriate to add them to the list of telehealth services at this time. In a subsequent submission for 2018, the original requester suggested that we might propose these services to be added to the list so that they can be furnished via telehealth when furnished by eligible distant site practitioners. We considered that possibility; however, since the majority of the codes are furnished by therapy professionals over 90 percent of the time, we believed that adding therapy services to the telehealth list that explicitly describe the services of the kinds of professionals not included on the statutory list of distant site practitioners could result in confusion about who is authorized to furnish and bill for these services when furnished via telehealth. We also noted that several of these services, such as CPT code 97761, require directly physically manipulating the beneficiary, which is not possible to do through telecommunications technology. Therefore, we did not propose adding these codes to the list of Medicare telehealth services.

b. Initial Hospital Care Services: CPT Codes—

- CPT code 99221 (Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or 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 problem(s) requiring admission are of low severity.)

- CPT code 99222 (Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate 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 problem(s) requiring admission are of moderate severity.)

- CPT code 99223 (Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high 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 problem(s) requiring admission are of high severity.)

We previously considered a request to add these codes to the telehealth list. As we stated in the CY 2011 PFS final rule with comment period (75 FR 73315), while initial inpatient consultation services are currently on the list of approved telehealth services, there are no services on the current list of telehealth services that resemble initial hospital care for an acutely ill patient by the admitting practitioner who has ongoing responsibility for the patient's treatment during the course of the hospital stay. Therefore, consistent with prior rulemaking, we did not propose that initial hospital care services be added to the Medicare telehealth services list on a category 1 basis.

The initial hospital care codes describe the first visit of the hospitalized patient by the admitting practitioner who may or may not have seen the patient in the decision-making phase regarding hospitalization. Based on the description of the services for these codes, we believed it is critical that the initial hospital visit by the admitting practitioner be conducted in person to ensure that the practitioner with ongoing treatment responsibility comprehensively assesses the patient's condition upon admission to the hospital through a thorough in-person examination. Additionally, the requester submitted no additional research or evidence that the use of a

telecommunications system to furnish the service produces demonstrated clinical benefit to the patient; therefore, we also did not propose adding initial hospital care services to the Medicare telehealth services list on a category 2 basis.

We note that Medicare beneficiaries who are being treated in the hospital setting can receive reasonable and necessary E/M services using other HCPCS codes that are currently on the Medicare telehealth list including those for subsequent hospital care, initial and follow-up telehealth inpatient and emergency department consultations, as well as initial and follow-up critical care telehealth consultations.

Therefore, we did not propose to add the initial hospital care services to the list of Medicare telehealth services for CY 2018.

c. Online E/M by physician/QHP: CPT Code—

- CPT code 99444 (Online evaluation and management service provided by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient or guardian, not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network)

As we indicated in the CY 2016 final rule with comment period (80 FR 71061), CPT code 99444 is assigned a status indicator of “N” (Non-covered service). Under section 1834(m)(2)(A) of the Act, Medicare pays the physician or practitioner furnishing a telehealth service an amount equal to the amount that would have been paid if the service was furnished without the use of a telecommunications system. Because CPT code 99444 is currently non-covered, there would be no Medicare payment if this service were furnished without the use of a telecommunications system. Because this code is a non-covered service for which no Medicare

payment may be made under the PFS, we did not propose adding online E/M services to the list of Medicare telehealth services for CY 2018.

d. Monthly Capitation Payment (MCP) for ESRD-related services for home dialysis, by age:

CPT Codes—

- CPT codes 90963 (End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents); 90964 (End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2–11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents); 90965 (End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12–19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents); and 90966 (End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older)

- 90967 (End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age); 90968 (End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 2-11 years of age); and 90969 (End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age); and 90970 (End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older).

In the CY 2004 PFS final rule with comment period (68 FR 63216), we established HCPCS G-codes for ESRD monthly capitation payments (MCPs), which were replaced by CPT

codes in CY 2009 (73 FR 69898). The services described by CPT codes 90963 through 90966 were added to the Medicare telehealth list in CY 2005 (69 FR 66276) and CPT codes 90967 through 90970 were added to the Medicare telehealth list in the CY 2017 PFS final rule (81 FR 80194); however, we specified that the required clinical examination of the vascular access site must be furnished face-to-face “hands on” (without the use of an interactive telecommunications system) by a physician, clinical nurse specialist (CNS), nurse practitioner (NP), or physician assistant (PA). The American Telemedicine Association (ATA) submitted a new request for CY 2018 requesting that we allow telehealth coverage of ESRD procedure codes without in-person exam of the catheter access site monthly. Our current policy reflects our understanding that evaluation of the integrity and functionality of the access site is a critical element of the services described by the codes and that this element cannot be performed via telecommunications technology. The requester did not submit evidence to support the assertion that effective examination of the access site can be executed via telecommunications technology. Therefore, for CY 2018, we did not propose any changes to the policy requiring that the MCP practitioner must furnish at least one face-to-face encounter with the home dialysis patient per month for clinical examination of the catheter access site. However, we are interested in more information about current clinically accepted care practices and to what extent telecommunications technology can be used to examine the access site. We are also interested in information about the clinical standards of care regarding the frequency of the evaluation of the access site.

In summary, we proposed adding the following codes to the list of Medicare telehealth services beginning in CY 2018 on a category 1 basis:

- HCPCS code G0296 (Counseling visit to discuss need for lung cancer screening using low dose CT scan (ldct) (service is for eligibility determination and shared decision making))

- HCPCS code G0506 (Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service))
- CPT code 90785 (Interactive complexity (List separately in addition to the code for primary procedure))
- CPT codes 90839 and 90840 (Psychotherapy for crisis; first 60 minutes) and (Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary procedure))
- CPT codes 96160 and 96161 (Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument) and (Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument)

The following is a summary of the comments we received regarding the proposed addition of services to the list of Medicare telehealth services:

Comment: Many commenters supported one or more of our proposals to add the counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT) (HCPCS code G0296) and psychotherapy for crisis (CPT codes 90839 and 90840) to the Medicare telehealth list for CY 2018. Commenters also supported one or more of our proposals to add comprehensive assessment of and care planning for patients requiring chronic care management services (HCPCS code G0506), interactive complexity (CPT code 90785) and administration of health risk assessment (CPT codes 96160 and 96161). Commenters noted that

by adding these services to the Medicare telehealth list, CMS was enhancing access and quality of care for Medicare beneficiaries.

Response: We thank commenters for their support of the proposed additions to the list of Medicare telehealth services. After consideration of the public comments received, we are finalizing our proposal to add these services to the list of Medicare telehealth services for CY 2018 on a Category 1 basis.

Comment: Several commenters were supportive of CMS's proposed requirement that the distant site practitioner be able to mobilize resources at the originating site to defuse the crisis and restore safety, when applicable, when furnishing psychotherapy for crisis. One commenter stated that CMS' requirements for mobilization of resources are very important and the distant site practitioner should be aware of available services where the beneficiary is located in the event of a crisis. Another commenter pointed out that social workers who provide telehealth services are required by the National Association of Social Workers to be familiar with the resources in the state in which the patient resides. Several commenters requested that CMS clarify what was meant by "mobilization of resources" and provide applicable examples.

Response: We appreciate commenters' responses to the explicit requirement regarding mobilization of resources for the psychotherapy for crisis codes (CPT codes 90839 and 90840). As noted above, "mobilization of resources" is a description used in the CPT prefatory language. We would reiterate that, according to CPT, the critical element of "mobilizing resources" is the ability to communicate with and inform staff at the originating site to the extent necessary to restore safety.

Comment: Several commenters disagreed with the proposal not to add CPT codes 99221-99223 (inpatient hospital care) to the Medicare telehealth list. One commenter stated that

they believe these services could be furnished via Medicare telehealth. They pointed to the fact that for CY 2017, CMS valued the critical care consultation G-codes (HCPCS codes G0508 and G0509) with RVUs similar to those for the inpatient hospital care codes as evidence that CMS believes they are essentially the same service.

Response: As we discussed in the 2018 PFS proposed rule, we do not believe that the full range of services described by CPT codes 99221-99223 can be furnished via telecommunications technology as we believe it is critical that the initial hospital visit by the admitting practitioner be conducted in person to ensure that the practitioner with ongoing treatment responsibility comprehensively assesses the patient's condition upon admission to the hospital through a thorough in-person examination..

We believe that the telehealth critical care consultation codes (HCPCS codes G0508 and G0509) more accurately describe the kind of services that can be furnished to patients via telehealth than the initial inpatient hospital visit E/M codes that describe services with elements that can only be furnished in-person. The valuation for HCPCS codes G0508 and G0509 was developed based on our assessment that the overall work (resources in time and intensity) involved in furnishing the services is similar to the in-person critical care service codes, not that all elements of the services are the same. Many services paid under the PFS share similar, if not exactly the same work RVUs, without necessarily describing the exact same elements of the service. For more on the critical care consultation codes in the context of telehealth, please see the CY 2017 PFS final rule (81 FR 80196 through 80197 and 81 FR 80352).

Comment: Several commenters disagreed with our decision not to add various physical and occupational therapy, and speech language pathology services to the Medicare telehealth list.

Response: As noted above, the majority of the codes requested are furnished by therapy professionals over 90 percent of the time, and we believe that adding therapy services to the telehealth list that are furnished by professionals not included on the statutory list of distant site practitioners could result in confusion about who is authorized to bill for these services when furnished via telehealth. Additionally, some of the codes involve physical manipulation of the patient, which cannot be accomplished via an interactive telecommunications system.

Comment: Several commenters responded to our decision not to remove the requirement for a monthly in-person visit to examine the catheter access site for ESRD services conducted via telehealth. Another commenter encouraged CMS to lessen the requirements by making the in-person visit a quarterly, as opposed to monthly, requirement. Other commenters stated that the examination of the catheter access site could be conducted remotely via telecommunications technology.

Response: We appreciate the feedback on our proposal and we will consider the comments on the frequency of the examination of the catheter access site and whether the examination could be conducted remotely for future rulemaking.

Comment: One commenter disagreed with the decision not to propose to add CPT code 99444 (online E/M) to the Medicare telehealth list, stating that this service would increase access to care, especially for follow-up visits and medication management.

Response: As we noted above, CPT code 99444 is currently non-covered, so there is no Medicare payment for this service. As such, there would be no payment for this service even if we were to add it to the telehealth list. Additionally, because this service does not describe a service typically furnished in-person, it would not be considered a telehealth service under the

applicable provisions of law. For both of these reasons, we continue to believe that it would not be appropriate to add CPT code 99444 to the Medicare telehealth list.

Comment: Many commenters provided recommendations for additional services that could be added to the Medicare telehealth list, such as an add-on code for patients requiring care planning for cognitive impairment, follow-up care for liver transplant patients, emergency department visits, oncology and podiatric-specific services, eConsult services, Medical Nutrition Therapy (MNT), and Diabetes Self Management Training (DSMT).

Response: We thank commenters for these suggestions and will consider these for future notice and comment rulemaking. We also wish to remind commenters that requests for specific services to be added to the Medicare telehealth list can be submitted until December 31st of each calendar year to be considered for the next rulemaking cycle. For more information on submitting a request for an addition to the list of Medicare telehealth services, including where to mail these requests, see our website at <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html>.

Since several commenters requested that we add MNT and DSMT to the telehealth list, we also wish to remind commenters that codes for both MNT and DSMT are currently on the Medicare telehealth list. The current list of Medicare telehealth services can be viewed on our website, <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.html>.

4. Elimination of the Required Use of the GT Modifier on Professional Claims

We have required distant site practitioners to report one of two longstanding HCPCS modifiers when reporting telehealth services. Current guidance instructs practitioners to submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional

service along with the telehealth modifier GT (via interactive audio and video telecommunications systems). For federal telemedicine demonstration programs in Alaska or Hawaii, practitioners are instructed to submit claims using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GQ if telehealth services are performed “via an asynchronous telecommunications system.” By coding and billing these modifiers with a service code, practitioners are certifying that both the broad and code-specific telehealth requirements have been met.

In the CY 2017 PFS final rule (81 FR 80201), we finalized payment policies regarding Medicare’s use of a new Place of Service (POS) Code describing services furnished via telehealth. The new POS code became effective January 1, 2017, and we believe its use is redundant with the requirements to apply the GT modifier for telehealth services. We did not propose to implement a change to the modifier requirements during CY 2017 rulemaking because at the time of the CY 2017 PFS proposed rule, we did not know whether the telehealth POS code would be made effective for January 1, 2017. However, we noted in the CY 2017 PFS final rule that, like the modifiers, use of the telehealth POS code certifies that the service meets the telehealth requirements.

Because a valid POS code is required on professional claims for all services, and the appropriate reporting of the telehealth POS code serves to indicate both the provision of the service via telehealth and certification that the requirements have been met, we believe that it is unnecessary to also require the distant site practitioner report the GT modifier on the claim. Therefore, we proposed to eliminate the required use of the GT modifier on professional claims. Because institutional claims do not use a POS code, we proposed for distant site practitioners billing under CAH Method II to continue to use the GT modifier on institutional claims. For

purposes of the federal telemedicine demonstration programs in Alaska or Hawaii, we proposed to retain the GQ modifier to maintain the distinction between synchronous and asynchronous telehealth services, as reflected in statute.

The following is a summary of the public comments received on our proposal to eliminate the required use of the GT modifier on professional claims:

Comment: The majority of the commenters were supportive of eliminating the required use of the GT modifier on professional claims and agreed that this would reduce administrative burden.

Response: We thank the commenters for their support of the proposal. After considering the public comments, we are finalizing the proposal to eliminate the required use of the GT modifier on professional claims.

Comment: One commenter supported the proposal to no longer require the GT modifier on professional claims, but requested that we not delete the GT modifier because other payers who receive Medicare crossover claims might still require its use.

Response: We appreciate the commenters' concerns and reiterate that the GT modifier will be retained for Medicare for use in CAH Method II billing. Our decision to no longer use the modifier for professional claims will not affect its use in other appropriate circumstances.

Comment: One commenter stated that there is significant effort involved in updating computer systems to use the new POS code rather than a modifier, and encouraged CMS to consider that in future rulemaking.

Response: We appreciate the comment. We note that the required use of the telehealth POS code was finalized for CY 2017; however, we have a continuing interest in reducing administrative burden and will consider this for future rulemaking.

Comment: One commenter urged CMS to adopt a uniform method for identification of telehealth services and suggested that we use the 95 modifier, the new CPT modifier for CY 2017.

Response: We appreciate the comment, especially with the possibility that this could reduce administrative burdens associated with multiple modifiers. We will consider use of the 95 modifier for this purpose for future rulemaking.

Comment: A few commenters noted that the policy on the telehealth place of service (POS) code that was finalized for CY 2017 and took effect on January 1, 2017 resulted in a decrease in payment for some distant site practitioners furnishing services via telehealth in the non-facility setting and one commenter requested that we reverse the policy to pay the facility rate for all services furnished via telehealth.

Response: We understand the concerns raised about the current policy of using the facility rate for payment to distant site telehealth practitioners for telehealth services and will also further consider this policy for future rulemaking.

5. Comment Solicitation on Medicare Telehealth Services

We have received numerous requests from stakeholders to expand access to telehealth services. As noted above, Medicare payment for telehealth services is restricted by statute, which establishes the services initially eligible for Medicare telehealth and limits the use of telehealth by defining both eligible originating sites (the location of the beneficiary) and the distant site practitioners who may furnish and bill for telehealth services. Originating sites are limited both by geography and provider setting. We have the authority to add to the list of telehealth services based on our annual process, but cannot change the limitations relating to geography, patient setting, or type of furnishing practitioner because these requirements are

specified in statute. For CY 2018, we sought information regarding ways that we might further expand access to telehealth services within the current statutory authority and pay appropriately for services that take full advantage of communication technologies.

Comment: We received many thoughtful comments in response to the comment solicitation. Commenters were very supportive of CMS expanding access to telehealth services. Many commenters noted that Medicare payment for telehealth services is restricted by statute, but encouraged CMS to continue to explore alternate means to recognize and support technological developments in healthcare. Commenters provided many suggestions for how CMS could expand access to telehealth services within the current statutory authority and pay appropriately for services that take full advantage of communication technologies, such as waiving portions of the statutory restrictions using demonstration authority.

Response: We thank the commenters for their input. We reiterate our commitment to expanding access to telehealth services consistent with statutory authority, and paying appropriately for services that maximize telecommunications technology. We will carefully review the comments and consider commenters' suggestions for future rulemaking and any appropriate sub-regulatory changes.

6. Comment Solicitation on Remote Patient Monitoring

In addition to the broad comment solicitation regarding Medicare telehealth services, we also specifically solicited comment on whether to make separate payment for CPT codes that describe remote patient monitoring. We note that remote patient monitoring services would generally not be considered Medicare telehealth services as defined under section 1834(m) of the Act. Rather, like the interpretation by a physician of an actual electrocardiogram or electroencephalogram tracing that has been transmitted electronically, these services involve the

interpretation of medical information without a direct interaction between the practitioner and beneficiary. As such, they are paid under the same conditions as in-person physicians' services with no additional requirements regarding permissible originating sites or use of the telehealth place of service code.

We noted we were particularly interested in comments regarding CPT code 99091 (Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time). This code is currently assigned a procedure status of B (bundled). As with many other bundled codes, we currently assign RVUs for this code based on existing RUC recommendations, even though we have considered the services described by the code to be bundled with other services. In addition to comments on the payment status and valuation for this code (the RUC-recommended value, specifically) we sought information about the circumstances under which this code might be reported for separate payment, including how to differentiate the time related to these services from other services, including care management services. For example, PFS payment for analysis of patient-generated health data is considered included in chronic care management (CCM) services (CPT codes 99487, 99489, and 99490) to the extent that this activity is medically necessary and performed as part of CCM (see the CY 2015 PFS final rule (79 FR 67727), CY 2016 PFS final rule (81 FR 80244), and the CMS FAQ available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment_for_CCM_Services_FAQ.pdf). We also sought comment from beneficiaries and beneficiary advocacy organizations on the value of such

services and what protections might be necessary to assure that beneficiaries are properly informed that they are receiving a remote monitoring service, since beneficiaries would be required to pay standard cost sharing for such services. Finally, regarding CPT code 99091, we sought available information regarding potential utilization assumptions we might make for the service for purposes of PFS ratesetting, were we to make it payable for CY 2018 or in the future; since making such assumptions would be necessary to implement separate payment. We noted that since the PFS is a budget neutral system, any increase in payment made for particular services would result in decreases in payment for other services, and the degree of that decrease would depend, in large part, on the utilization assumptions.

We also sought comment on other existing codes that describe extensive use of communications technology for consideration for future rulemaking, including CPT code 99090 (Analysis of clinical data stored in computers (eg, ECGs, blood pressures, hematologic data)). CPT code 99090 is also assigned a procedure status of B (bundled). CPT code 99090 also has a payment status of bundled; and we do not have RUC-recommended values for this service, and therefore, currently do not assign RVUs.

The following is a summary of the public comments received on our proposals and our responses:

Comment: Commenters were generally supportive of CMS recognizing the increasing importance of remote patient monitoring. Several commenters recommended that CMS make separate payment for CPT code 99091. Other commenters acknowledged that the current code, which has not been separately payable for some time, may not optimally describe the services furnished using current technology. Some of these commenters encouraged CMS to make the

services separately payable for CY 2018, but also noted that the CPT Editorial Panel is currently working on codes that more accurately describe remote monitoring.

A few commenters expressed opposition to making CPT codes 99090 and/or 99091 separately payable, noting that these are generic codes and are duplicative of other codes that are more specific, such as CPT codes 93297 ((Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, analysis, review(s) and report(s) by a physician or other qualified health care professional)) and CPT code 93228 (External mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; review and interpretation with report by a physician or other qualified health care professional)). Several commenters encouraged CMS to wait for the CPT Editorial Panel to complete its work of reviewing and revising the CPT codes and consider valuing the new codes in the future. Of the commenters who were supportive of unbundling and making separate payment for CPT code 99091, a few suggested that CPT code 99091 could be billed in association with chronic care management (CCM) services.

Response: We agree with commenters that monitoring services can be a significant part of ongoing medical care and that we should recognize these services for separate payment as soon as practicable. However, we also agree with commenters that the two codes in question may not optimally describe these services as currently furnished. In order to reconcile these concerns, especially considering the expectation that CPT coding revisions are expected in the immediate future, we believe that activating CPT code 99091 for separate payment under

Medicare for 2018 will serve to facilitate appropriate payment for these services in the short term. Unlike CPT code 99090, CPT code 99091 specifies that the information is interpreted by a physician or other qualified health care professional, and it specifies that this activity requires a minimum of 30 minutes of time. After consideration of these differences between the two CPT codes, and after consideration of the public comments recommending that we make separate payment for CPT code 99091, we were persuaded to change the status of CPT code 99091 from bundled to active for CY 2018. In addition, as noted in the CY 2018 PFS proposed rule, the RUC had already provided CMS with RVUs for CPT code 99091, whereas it did not provide CMS with RVUs for CPT code 99090. Also, we did not receive specific comments to suggest reasons for changing CPT code 99090 to “active” status, so we are retaining the “bundled” status for that code. We will consider whether to adopt and establish relative value units for CPT codes that may be developed by the CPT Editorial Panel under our standard process for future years through notice and comment rulemaking. However, the comments make it clear to us that separate payment for this code will not mitigate the need for coding revisions. In order to account for some of the concerns raised by commenters regarding the broad nature of the code that describes professional collection and interpretation of the stored patient data, we believe that we can apply some of the current requirements regarding chronic care management services (CCM) to identify circumstances appropriate for reporting the code. Specifically, given the non face-to-face nature of the services described by CPT code 99091, we are requiring that the practitioner obtain advance beneficiary consent for the service and document this in the patient’s medical record. Additionally, for new patients or patients not seen by the billing practitioner within 1 year prior to billing CPT code 99091, we are requiring initiation of the service during a face-to-face visit with the billing practitioner, such as an Annual Wellness Visit or Initial

Preventive Physical Exam, or other face-to-face visit with the billing practitioner. Levels 2 through 5 E/M visits (CPT codes 99212 through 99215) would qualify as the face-to-face visit. However, services that do not involve a face-to-face visit by the billing practitioner or are not separately payable under the PFS (such as CPT code 99211, anticoagulant management, online services, telephone and other E/M services) do not qualify as initiating visits. The face-to-face visit included in transitional care management (TCM) services (CPT codes 99495 and 99496) would also qualify. We are also adopting the prefatory language for CPT code 99091, including the requirement that it “should be reported no more than once in a 30-day period to include the physician or other qualified health care professional time involved with data accession, review and interpretation, modification of care plan as necessary (including communication to patient and/or caregiver), and associated documentation.”

Finally, because we believe the kind of analysis involved in furnishing this service is complementary to CCM and other care management services, for the purposes of Medicare billing, we are allowing that CPT code 99091 can be billed once per patient during the same service period as CCM (CPT codes 99487, 99489, and 99490), TCM (CPT codes 99495 and 99496), and behavioral health integration (BHI) (CPT codes 99492, 99493, 99494, and 99484). We note that under current billing rules, time counted toward the CCM codes generally refers to time spent by clinical staff furnishing care management services; while CPT code 99091 refers to practitioner time. We note that time spent furnishing these services could not be counted towards the required time for both codes for a single month.

We also note that the new separate payment for CPT code 99091 will be excluded from the calculation of the net reduction in expenditures due to changes in coding and valuation for purposes of the misvalued code target, consistent with policies finalized in the CY 2016 PFS

final rule with comment period (80 FR 70926). CPT code 99091 describes a service that is newly separately reportable, but for which no corresponding reduction is being made to existing codes and instead reductions under the PFS are being taken exclusively through a budget neutrality adjustment.

We look forward to forthcoming coding changes through the CPT process that we anticipate will better describe the role of remote patient monitoring in contemporary practice and potentially mitigate the need for the additional billing requirements associated with these services.

7. Telehealth Originating Site Facility Fee Payment Amount Update

Section 1834(m)(2)(B) of the Act established the Medicare telehealth originating site facility fee for telehealth services furnished from October 1, 2001 through December 31, 2002, at \$20.00. For telehealth services furnished on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the Medicare Economic Index (MEI) as defined in section 1842(i)(3) of the Act. The originating site facility fee for telehealth services furnished in CY 2017 is \$25.40. The MEI increase for 2018 is 1.4 percent and is based on the most recent historical update through 2017Q2 (1.8 percent), and the most recent historical MFP through calendar year 2016 (0.4 percent). Therefore, for CY 2018, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge or \$25.76. The Medicare telehealth originating site facility fee and the MEI increase by the applicable time period is shown in Table 8.

TABLE 8: The Medicare Telehealth Originating Site Facility Fee

| Time Period | MEI Increase | Facility Fee |
|-----------------------|---------------------|---------------------|
| 10/01/2001–12/31/2002 | N/A | \$20.00 |
| 01/01/2003–12/31/2003 | 3 | \$20.60 |
| 01/01/2004–12/31/2004 | 2.9 | \$21.20 |

| Time Period | MEI Increase | Facility Fee |
|-----------------------|---------------------|---------------------|
| 01/01/2005–12/31/2005 | 3.1 | \$21.86 |
| 01/01/2006–12/31/2006 | 2.8 | \$22.47 |
| 01/01/2007–12/31/2007 | 2.1 | \$22.94 |
| 01/01/2008–12/31/2008 | 1.8 | \$23.35 |
| 01/01/2009–12/31/2009 | 1.6 | \$23.72 |
| 01/01/2010–12/31/2010 | 1.2 | \$24.00 |
| 01/01/2011–12/31/2011 | 0.4 | \$24.10 |
| 01/01/2012–12/31/2012 | 0.6 | \$24.24 |
| 01/01/2013–12/31/2013 | 0.8 | \$24.43 |
| 01/01/2014–12/31/2014 | 0.8 | \$24.63 |
| 01/01/2015–12/31/2015 | 0.8 | \$24.83 |
| 01/01/2016–12/31/2016 | 1.1 | \$25.10 |
| 01/01/2017–12/31/2017 | 1.2 | \$25.40 |
| 01/01/2018–12/31/2018 | 1.4 | \$25.76 |