CY22 Physician Fee Schedule (PFS): ATA Summary of Telehealth Policy Changes

(Major changes proposed ➔ final **in bold**)

Category	Background	Policy	Proposed Rule	ATA Comment	Final Rule
Telemental Health Expansion	Congress passed section 123 of Consolidated Appropriations Act December 2020, permanently removing geographic and originating site barriers for telemental health services but imposing a new 6-month-prior in person requirement.	In-person requirement	Requires an in-person visit not only within the 6-month period prior to the first telehealth visit, but also within 6 months prior to subsequent telehealth visits.	This effectively creates a new, arbitrary, and not clinically supported in person requirement for telemental health services. Remove the continual 6-month in-person visit requirement.	Requires an in-person visit within 6 months prior to the first telehealth visit and an in-person visit must be furnished **every 12 months** unless the practitioner and patient agree the risk and burdens outweigh the benefits of in person.
		Additional providers	Seeks comments on how to address scenarios when a different practitioner in the same practice may need to offer services to the eligible telehealth individual.	At a minimum, allow a provider in the same practice to offer services to the patient should the provider be unavailable or if the patient would like to change providers in the practice.	Allows a clinician's colleague in the same subspecialty in the same group to furnish the in-person service to the beneficiary if the original practitioner is unavailable.
		Audio-only	Revises regulatory definition of "interactive telecommunications system" to permit use of audio-only for telemental health services in the home under certain conditions.	Support allowing for the use of audio-only technologies and consider other services outside of mental health. Avoid creating new paperwork burdens on providers. Make audio only available regardless of whether the patient is "established" or not.	Mental health services are different than other types of services. Creating a service-level modifier for telemental health services furnished in the home using audio-only communications technology if audio/visual is not available.
		FQHCs and RHCs	Requests feedback on whether to further align federally qualified health center (FQHC) and rural health clinic (RHC) telemental health services with the PFS, including by replicating the in-person requirement.	Commend alignment but urge not to impose in person requirement. Encourage additional alignment, such as for remote patient monitoring (RPM) codes.	Will pay for telemental health including for audio only, imposing same 6 month then 12 month in person requirements as PFS.

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Category 3 Services	Category 3 created to cover telehealth services temporarily during the PHE and while evaluating the case for permanence.	Temporary Extension	Extends Category 3 coverage through the end of 2023. Seeks comments on whether interim codes not on category 3 list should be added.	Continue to support newly created Category 3 codes for temporary telehealth services and support extension of category 3 coverage.	Maintains extension through CY23; longer extension outside scope of this rule.
		Permanent coverage	No codes moved to category 1 or 2.	The ATA continues to recommend specific codes be added to Category 1.	No codes added.
Remote Therapeutic Monitoring (RTM)	RTM is a family of five CPT codes (989X1, 989X2, 989X3, 989X4, and 989X5) created in October 2020 and valued by the RUC in January 2021.	Billing Practices	The services and code structure of RTM are similar to RPM and will be covered similarly. However, primary billers of RTM codes are projected to be nurses and physical therapists (PTs). In modeling after RPM codes, incident-to billing issues apply, which would disallow PTs from billing and disallow general supervision instead of direct supervision.	Using exclusively general medicine codes for RTM negates the possibility for RTM to be billed by a broader array of providers. CMS should remedy this, possibly by creating a temporary set of G-codes.	Despite concerns about construction of the codes, **permitting therapists and other qualified practitioners to bill RTM**, but direct supervision requirements still apply. Will consider further discussion of G-code and other suggestions.
		Coverage of Use Cases	RPM requires that data be physiologic and be digitally uploaded. RTM codes indicate that data could also be self-reported. Seeking comment on typical type of device(s) and associated costs of the device(s) that might be used to collect the various kinds of data included in the code descriptors.	Consider broader use cases for RTM, including but not limited to behavioral and mental health therapies and services addressing vascular, endocrine, neurological, and digestive systems. Cover and reimburse a condition-agnostic supply code.	Not addressed further.

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Remote Therapeutic Monitoring (RTM), *continued*		RPM Alignment	See above.	Align RTM and RPM coverage and payment: expand the universe of RTM codes beyond the currently proposed use cases, align the RTM codes with RPM that would allow for RTM services to be furnished incident-to under general supervision, extend to RTM the regulatory flexibilities that were recently allowed for RPM, including during the PHE. But do not apply misguided past RPM policies to RTM: don't apply minimum-days-of-monitoringrequirement, allow new and established patients, recognize that the same patient in the same month may need both RTM and RPM.	Not addressed further.
Remote Physiologic Monitoring (RPM)	Several policy issues need to beaddressed to ensure access to appropriate RPM (see CY21 comments).		N/A	The absence of RPM in the CY 2022 PFS proposed rule represents a missed opportunity for CMS to continue to address historical policy barriers and expand access to needed RPM care.	Not addressed.
Artificial Intelligence	More services have begun to include innovative technology such as software algorithms andAI, but these innovative applications are not well accounted for in payment methodology.		Poses set of questions about AI.	Concepts that must be addressed by the medical community, including how AI can influence health outcomes for racial minorities and people who are economically disadvantaged. Consider an alternate platform to raise these questions to ensure appropriate attention is given.	Will review the many public comments on this topic and consider how best to continue to engage with all stakeholders.

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Direct Supervision via Telemedicine	The 3/31/20 COVID-19 IFC changed the definition of “direct supervision” during the PHE to allow virtual supervision. The CY2021 PFS final rule continued that through 2021 or the end of the PHE, whichever is later.		Seeks comments on whether to permanently allow direct supervision via telehealth.	Amend definition of direct supervision to permanently allow direct supervision virtually/via telehealth.	Will continue to consider comments about permanently allowing direct supervision via telehealth.
Medicare Diabetes Prevention Program	Medicare covers CDC-recognizedDiabetes Prevention Program (DPP), but not if they’re virtual- only.		N/A	Urges Medicare payment for CDC-recognized virtual Diabetes Prevention Program providers.	Not addressed.

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