

Centers for Medicare and Medicaid Services
Questions and Answers
Physicians, Nurses, and Allied Health Professionals Open Door Forum
Thursday, November 7, 2024

1. Question: My understanding is that as of January 1, telehealth as we've been doing it through the COVID years will no longer be paid for. We will not be able to do telehealth through on our regular Medicare patients.
 - a. Answer: That is somewhat correct in that the statutory waivers that have been in place on the geographic and site of service and practitioner type restrictions that are in the statute, those will, unless there is late breaking legislation this year, those will go back into effect on January 1, 2025. In terms of some of those are primarily, I imagine what you're asking about. I will say that to the extent to which CMS has regulatory authority to address other aspects of the telehealth flexibilities, we have extended a lot of things for an additional year or made a few things that we could permanent. So, but you're right, absent congressional action, the geographic inside of service restrictions will go back into effect.
 - i. Question: We've come to use telehealth in multiple ways. I believe it's probably an underused service since the pandemic is over, but we use it to help with our Medicare wellness exams to help with our depression screenings to help reach out to people who have difficulties in transportation getting to the physician's office. What can I do as a practitioner? Do I need to lobby congressman? Is there a way that Congress can change what's changing? How can we make sure we hold on to telehealth? I think it's a useful tool and we are expected to go through a lot of quality measures and get them things done for the patients and we use telehealth to help attain those quality measures in discussing things with patients that they need to do and have performed. So, what can I do? What can we do as physicians to hold onto this telehealth benefit for our patients, which I believe is beneficial?
 1. Answer: I do want to clarify that although the, I mean telehealth is available without any kind of waiver for beneficiaries that are in rural areas. Now your specific practice, I know that the definition of rural that I don't have off the top of my head is very specific and so I recognize that it does not always capture other rural patients outside of the very specific definition that is in the statute. So, I do just want to flag that the beneficiaries who meet the definitions of rural for purposes of the telehealth statute can continue to receive some telehealth services. Although unless it's a behavioral health

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service, they would need to be in a medical facility to receive that service, and they're not in their home. In terms of what you can do, I don't think that CMS is in the position of being able to tell you what you can and cannot do vis-a-vis Congress. But I would note that these types of changes to the statute would need to come from congressional action. There's nothing that CMS, we can do necessarily to advocate it beyond just noting that that is what it would require. I'm sorry, I know that that is kind of a technocratic answer, but that is sort of as far as we can go as an agency in terms of telling you sort of what you need to do. In order to find out if you are in a health professional shortage area, if you're not sure about that, there is a tool on HRSA's (Health Resources and Services Administration) website that you can look up and check to see if you would qualify for continued use of telehealth following the ending of the waivers.

a. Comment to CMS: Because we put the AQ modifier on and we, our county hospital, a small county hospital, had all that evaluation done. And so, we get that AQ modifier added. But what happens with CMS and what happens with red, white, and blue Medicare typically now happens with the Medicare Advantage programs. And so, I see telehealth going away nationwide, and I just think it's a mistake. I think it's a useful service and it's a mistake to take that away.

2. Question: My question concerns caregiver training services in the MPFS (Medicare Physician Fee Schedule) final rule. The answer came with regard to the CPT (Current Procedural Terminology) codes for caregiver training services that the services could be billable by physicians and practitioners, incident-to. So, in a non-facility setting, a practitioner's able to bill when auxiliary personnel incident to their professional services perform caregiver training services. And my question is, does that extend to the new HCPC (Healthcare Common Procedure Coding) level two codes that CMS finalized for caregiver training services in this rule? And then I have a follow up after that.

a. Answer: Yes, the auxiliary personnel designation does apply to all the caregiver training service codes, not just the CDT or HCPC systems, but all of them.

i. Question: My follow-up question is given that and thank you so much and I think that's great news for physician practices and necessary caregiver training services. I'm confused then, and I know this is a Physician Fee Schedule call, but I'm very confused about the policy for those same codes over in the outpatient Prospective Payment System rule where the status

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indicator is A, and CMS says they're only billable by hospitals when performed by therapist. So, it means that a physician cannot order auxiliary hospital personnel at a hospital to do caregiver training services for the patients that they're treating. And that seems inconsistent to me.

1. Answer: This is currently being worked on.

3. Question: The presenter who presented on telehealth services spoke about adding some service billable services for training, can she repeat that portion of her presentation please?

a. Answer: I don't have the specific HCPS (Healthcare Common Procedure Coding System) codes, but it's caregiver training services. These are the services that are available on the Medicare telehealth list.

4. Question: My question relates to CMS finalizing the permanent expansion of audio-only telehealth services. I believe I heard the word "all" in the presentation, and so thus the use of the word "all" implies that any code on the telehealth service list would be eligible for audio only, given the documentation requirements and modifier are met. So, can you please clarify, what charges would a provider drop for a telephone visit starting January 1, 2025?

a. Answer: The policy is that any service on the Medicare telehealth list that can also be provided to a beneficiary in their home, which recognizes the fact that absent any legislative extensions, the home is only an eligible originating site for behavioral health services among a couple of other very specific service sets like for diagnosis and treatment of an acute stroke. But largely the big bucket is behavioral health services. Those are only available to be provided to benes in their home unless Congress acts beginning January 1, 2025. So, within that, and so right now, that is the policy. However, the way that it is sort of, we did the audio-only extension is that, were Congress to either extend the originating site waivers or if they were to, similar to how they kind of carved out behavioral health and said that it could be in the home, that we would then, those services, whatever they might be, would also be available via audio only as well without CMS needing to undertake additional rulemaking. So that's sort of the policy. And I guess I'm not quite following the question about charges.

i. Question: Charges meaning codes. What billing codes, then, would a provider drop for a telephone visit starting January 1, 2025, given that the audio-only documentation requirements and the 93 modifier are met?

1. Answer: Yes, so it would be any code that is currently on the telehealth list that best describes the service furnished. We're not more specific than that in terms of providing a list of codes that can be provided via audio only. It just is dependent upon both what the requirements are around the originating site, whether the

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beneficiary's home is or is not extended as an originating site for all telehealth. But then also just you need to meet the requirements for the given code. That is kind of as specific as we've gotten.

a. Question: Ok. Is the 93 modifier then still need to be added?

i. Answer: we actually are asking for place of service, 11.

5. Question: My first one is in the last fiscal year, final rule for '24, the waiver was still in place to allow to defer the face-to-face visit requirement prior to initiating behavioral health services through telehealth. But I noticed that it was omitted in this fiscal year '25, meaning it wasn't even in the final rule. So, does that mean at this point, beginning fiscal year '25, or calendar year '25, apologies, that the face-to-face within six months prior is required to initiate behavioral health telehealth services?

a. Answer: Yes, that is correct. See, that requirement is actually, was part of the Consolidated Appropriations Act (CAA) of 2021 that made behavioral health services available via telehealth permanently in a wider range of circumstances. So, absent, again, what has happened year over year with these legislative extensions of the waivers, they have went ahead and waived that requirement as well. And so, what that means is if absent any congressional legislation—it sounds like a broken record—then yes, that would be the requirement for patients who are newly being treated for their behavioral health conditions via telehealth. I believe when we implemented the CAA in 2021 and through 2022 rulemaking, I believe we said in that rule that if the patient was already being seen via telehealth, they would not need to have, they count sort of as being grandfathered in.

i. Question: My follow-up question is very similar. There was the definition of a telehealth provider included speech therapists, occupational therapists, and physical therapists. Once again, I saw that absent in this fiscal final rule, calendar year, final rule, is that the same thing, that they will no longer be able to provide telehealth services come January 1, 2025?

1. Correct.

6. Question: I know you need to go back and look at place of service and modifier for those codes. My question was going to be just a little bit more specific, even though it's any code, does that apply to any code that's already approved as being approved for audio only, or would that include 99202 through 99215, which are the outpatient evaluation and management codes?

a. Answer: So that's right. So, we have not gone through and made a code-by-code determination in terms of what is available via audio only because for example, specifically with that code set that you highlighted, it is not condition specific.

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And so even if we're just talking about a behavioral health service provided via telehealth to a beneficiary in their home via communication modality, audio, video, audio only, that could be reported potentially depending on the specific circumstances with an outpatient, with an office outpatient E&M visit. And so, we did not to get into any more detail about how we would go about sort of identifying that. And so, no. I'd say yes, there are circumstances certainly where an office outpatient E&M could be provided.

- i. Comment to CMS: Great. Because sometimes psychiatrists do an E&M plus the behavioral health. So that's absolutely awesome.

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