

Medicare Updates - Last Updated July 10th

Key documents for Medicare telehealth coverage:

- The Center for Connected Health Policy provides [an overview chart here](#), which includes special considerations for FQHCs / RHCs
- There were two major announcements from CMS describing their changes, [March 30th](#) and [April 30th](#).
- [CMS Guidance on Telehealth for FQHCs & RHCs](#)
- [List of telehealth codes approved by Medicare](#) - note, Medicare uses “telehealth” to mean what we would call “telemedicine”, services that directly replace an office visit but are not the full universe of remotely delivered health care.
- Telecommunications / Virtual Visits / Portal Visits - the other category of remote services [are described here](#) as relates to COVID-19, note the telehealth services category on this page is no longer accurate. For more information on these options, many of which predate COVID-19 see also the [CCHP remote communications fact sheet](#).

Additionally, the Center for Connected Health Policy has [this video explaining the framework behind telehealth policy](#), if you want to know how it all fits together.

Overview of Medicare & Telehealth as COVID-19 Response

The following is a timeline following the evolution of Medicare policy. Note that some of the linked documents are continuously updated, so while they will be referenced in an earlier phase of policy development, the link goes to a more recent version.

Vocabulary:

- Medicare is not as meticulous as some other places in using “telemedicine” to refer to real time audio/visual consultations that replace a regular office visit. That’s “telehealth” in their world.
- While VT Medicaid and Commercial payers talk about brief telecommunications services or triage calls, Medicare’s equivalent is “Virtual Check-Ins” and “eVisits”. They previously offered a fourth category of brief telephone communications, to encompass newly reimbursable codes of 99441-99443 and 98966-98968, but

then shifted to add telephone communications to their telehealth services.

- Public Health Emergency - most of these flexibilities are tied to the [Public Health Emergency](#), which is declared by the Secretary of Human Services and can only be declared for 90 days at a time, at which point it must be renewed. So, if you see an expiration date for these rules that usually means the date by which the Secretary must extend the emergency.

Timeline of Major Updates: Note that most (if not all) of these updates were applied retrospectively.

1. Pre-COVID-19, Medicare telehealth had some significant restrictions. These included, but were not limited to, not allowing FQHCs and RHCs to bill as *providers* of telemedicine (aka the “distant site” rule), placing limits on facilities where providers and patients could be located, and placing geographical limitations based on urban / rural designations.
 - a. [MLN Telehealth Guide](#) (updated in mid-March)
2. In the first wave of new CMS guidance we saw a lot of changes including:
 - a. Removing location and geographical restrictions
 - b. Allowing telephone-based services if the telephone had audio / visual capacity
 - c. Waiving the “established patient” clause for telemedicine, but not (yet) for other types of telehealth

Also of note in this phase were allowing temporary use of HIPAA non-compliant platforms to deliver telemedicine ([OCR decision of non-enforcement](#)) and [1135 waivers](#), which included a blanket waiver that allowed licensed providers to bill telework across state lines. Both are discussed in our [implementation sheet](#).

Details on this first set of changes, dated March 17th:

- [Guidance from CMS on newly available remote services](#)
- [Facts sheet](#)
- [Super-abridged chart version](#)

At this time the Office of Inspector General announced that [physicians could waive all cost shares on telehealth services](#) during the Public Health Emergency.

3. The CARES legislation in Congress introduced more flexibilities, followed by new changes at CMS. Key changes include:
 - a. Allowing FQHCs & RHCs to bill as telemedicine providers (aka Distant Sites) - based on [Section 3704 of the CARES Act](#)
 - i. Note that this switches to a different payment schedule and imposes a co-pay, which can be waived (but not recouped) using a CS modifier.
 - b. Waiving the established patient clause for all telehealth
 - c. Expanding the [telehealth service codes](#) available
 - d. Offering some telephone-only codes, 99441-99443 and 98966 -98968
 - e. Making Remote Patient Monitoring easier for patients with COVID-19 symptoms or diagnosis
 - f. Removing frequency limitations on some telehealth codes
 - g. Adding some provider types to brief telecommunications codes (not the same as telehealth service codes) - including some options for PTs, OTs, SLTs. This list is evolving.
 - h. Allowing virtual supervision

Additional [guidance published on April 17](#) provided distant site billing guidance for FQHCs, the short story being that Medicare will reimburse \$92 per telehealth visit (remember still audio-visual, *not* telephone only), and that the *only* brief telecommunication / telephone code for FQHCs would be G0071.

- Note that for FQHCs, the two most-protested-against elements of this rule (keeping Distant Site billing temporary to the PHE and setting the reimbursement based on an average of the physician fee schedule) were set in Congressional statute, not under CMS rulemaking authority.
- The audio-only components are about to change in Phase 4 of revisions.

Key documents describing these changes:

- [CMS Regulatory Changes Background Sheet](#) (3/30)
- [FQHC & RHC Flexibilities](#) - Not Distant Site Billing (3/28)
- [FQHC & RHC Guidance](#) - Distant Site Billing (First published 4/17)
- [Physicians & Other Clinicians New Flexibilities](#) (3/30)
- [Telehealth Codes](#) (includes indicating which are temporary)
- [Interim Final Rule](#)

- [Dear Clinicians Letter](#) (4/7)
4. On April 30th, CMS issued a [Second Interim Final Rule \(IFR\)](#), this [article offers a good summary](#) of the full rule. Key changes for telehealth in this rule deal with audio-only options, approved telehealth services, and approved telehealth providers.
- a. CMS adds “audio-only” option automatically to certain [telehealth services](#), primarily in mental health and educational services, reflected in updated telehealth service codes.
 - b. CMS increases the rate for 99441-99443 (the audio-only codes that were previously their own weird category) and brings them over to telehealth services. Note for FQHCs/ RHCs these are now bundled into G2025.
 - c. Medicare removes the restrictions on what provider types are eligible to bill for telehealth services, and opens them to all providers who can bill Medicare and are working within their individual scope of practice.
 - d. CMS changes the process for adding services to the approved telehealth codes, allowing for a subregulatory addition of temporary codes.
 - e. Guidance for FQHCs / RHCs providing telehealth services follows these changes, with expanded lists of providers and services permitted to be billed under G2025. Cost reporting for these services will not affect PPS rate calculations.
 - f. Expansion of hospital services that can be provided to outpatients in a home setting via “incident-to” billing.

Key documents describing these changes:

- [CMS Announcement of Changes](#) (4/30)
 - [Second Interim Final Rule \(IFR\)](#) (4/30)
 - [Telehealth Codes](#) (includes indicating audio-only and temporary codes)
 - [FQHC & RHC Guidance](#) (ongoing updates)
 - [MLN Updated Video](#) (5/8)
5. July 1st = FQHCs can bill the bundled G2025 code for telehealth services.
6. CMS has started the process of transitioning some temporary changes to permanent ones. Note that many changes are not solely within CMS regulatory control, but require other entities or Congress to act first.
- [CY2021 Changes for Home Health Agencies](#) (6/25)

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