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Telehealth updates: 2022 Physician Fee Schedule proposed rule and ongoing enforcement

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The COVID-19 pandemic has brought considerable transformation within the healthcare industry as well as uncertainty. Overnight, the pandemic elevated telehealth from a highly specialized and seemingly futuristic mode of care into a major component of today's healthcare delivery system. Nearing two years since the onset of the COVID-19 public health emergency (PHE), however, the permanence of Medicare coverage for various categories of telehealth services is still in question. On July 23, 2021, Centers for Medicare & Medicaid Services (CMS) published the Calendar Year 2022 Medicare Physician Fee Schedule (MPFS) proposed rule,[1] which included a number of notable prospective updates regarding the future of telehealth coverage. Meanwhile, the Office of Inspector General (OIG) and Department of Justice continue to prioritize telehealth fraud enforcement. This article will summarize the notable provisions in the proposed rule that pertain to telehealth and identify some of the most recent enforcement trends.

In order to understand the potential impact of the proposed rule, it is helpful to review how Medicare coverage for telehealth services has evolved. Prior to the PHE, CMS would only reimburse for telehealth services provided to patients residing in rural areas.[2] Furthermore, in order to provide payment, CMS previously required that the patient be physically located in specific originating sites, like a clinician's office or hospital. In response to the COVID-19 PHE, however, CMS has dramatically expanded the list of eligible telehealth services and allowed Medicare patients to receive telehealth services from their own home. Moreover, in an effort to encourage access, the OIG has even permitted providers to reduce or waive patient cost-sharing obligations for telehealth services.

Consequently, telehealth services have increased dramatically, having stabilized at an overall monthly volume 38 times greater than the pre-pandemic volumes.[3] As a result, stakeholders continue to question just how long the telehealth waivers will exist and how long the expanded list of telehealth-eligible services will be reimbursable.

CMS appeared to answer the question when it published the 2021 MPFS final rule on December 28, 2020.[4] The rule stated that the waivers and interim policies resulting from the Coronavirus Aid, Relief, and Economic Security Act will expire upon the conclusion of the PHE; however, CMS elected to use its authority to expand coverage for certain services. Historically, CMS classified reimbursable telehealth services in two separate categories: Category 1, consisting of services similar to office visits, professional consultations, and office psychiatry services currently on the list of telehealth services, and Category 2, consisting of services not similar to the current list of telehealth services but which are demonstrated to provide a clinical benefit to the patient. In response to the unique circumstances of the PHE and the lack of data regarding the benefits of the temporarily expanded services, CMS created a third category, Category 3, for purposes of evaluating the expanded services and potentially adding them permanently to either Category 1 or Category 2. Furthermore, CMS stated that the Category 3 services would remain reimbursable through the end of the year when the PHE ends.[5]

2022 MPFS proposed rule

On July 23, 2021, CMS published additional proposed changes to the MPFS, many of which affect telehealth.[6] First, rather than expire at the end of the calendar year when the PHE ends, CMS proposed to allow those temporary Category 3 telehealth services to remain on the Medicare list of telehealth services through the end of calendar year 2023.[7] CMS's decision to expand the timeline reflects acknowledgement that the original timeline would not allow stakeholders the necessary time to build support for any efforts to advocate for the permanent adoption of these services. As such, CMS envisions that stakeholders will be submitting their requests for consideration in the 2023 and 2024 Physician Fee Schedule rulemaking process. Nonetheless, CMS also reiterated its policy that any services added to the Medicare list of telehealth services on an interim basis but not included in Category 3 will be removed from the Medicare list as soon as the PHE expires. Still, CMS is soliciting comment on whether any other interim telehealth services not added to Category 3 should be added for purposes of data collection and review.

Another notable provision in the proposed rule relates to mental health services. Whereas the Social Security Act already included relaxed geographical and originating site restrictions for patients seeking telehealth treatment for a substance use disorder or a co-occurring mental health disorder, the Consolidated Appropriations Act, 2021 further waived the geographic and originating site restrictions for all other mental health services. However, in order for providers to bill for mental health services furnished via telehealth, the Consolidated Appropriations Act, 2021 included a requirement for the providers to have performed one in-person mental health service for the beneficiary within six months prior to the telehealth visit. Also, the secretary of the U.S. Department of Health & Human Services was tasked with developing additional in-person requirements.[8] Accordingly, in the proposed rule, CMS seeks comment on whether to require from the billing provider as a condition of payment to have performed an in-person visit within six months of any subsequent telehealth visits.[9] CMS also seeks comment on whether the in-person visit requirement can still be met when the in-person provider is another physician or practitioner within the same specialty and within the same group as the billing telehealth provider.

In addition to the requirements related to mental health, the proposed rule also contains a proposal to amend the CMS telehealth regulation at 42 C.F.R. § 410.78 to include rural emergency hospitals as eligible originating sites.[10] The change would make the regulation consistent with a recent statutory change to Section 1834(m)(4)(C)(ii) of the Social Security Act resulting from the Consolidated Appropriations Act, 2021.

The proposed rule also contains proposals related to what constitutes permitted telehealth technology. Whereas the CMS telehealth regulation requires telehealth services to include both audio and video capabilities, CMS has waived the requirement for specific behavioral health and counseling services, as well as evaluation and management visits, and reimburses those services when furnished with audio-only technology. However, as soon as the PHE ends, services performed via audio-only technology are set to no longer qualify as telehealth services. As such, citing the preponderance of audio-only mental health services performed throughout the pandemic and the shortage of available mental health providers, CMS proposes to amend the regulatory definition of "interactive communications system" to include audio-only communications technology furnished to established patients for the diagnoses, evaluation, or treatment of mental health disorders when the originating site is the patient's home.[11] However, consistent with the general proposal for mental health services furnished via telehealth, CMS proposes that the audio-only telehealth services must occur within six months of an in-person mental health visit. In addition, CMS proposes to limit reimbursement for audio-only visits to physicians or practitioners with capacity to furnish two-way audio/visual telehealth services. Accordingly, to qualify for reimbursement, the audio-only services must only be provided when the patient is unable or refuses to use two-way audio/visual technology.[12] CMS also proposes that the audio-only services

include a specific modifier that would serve as attestation that the patient meets the requisite requirements for the service and seeks comment on what additional documentation might be necessary for an audio-only visit and whether certain services such as Level 4 and Level 5 evaluation and management visit codes should be excluded from eligibility for reimbursement.

In addition to the proposals regarding audio-only services, CMS continues to seek comments regarding whether to permanently revise the definition of "direct supervision" under 42 C.F.R. § 410.32(b)(3)(ii) to include immediate availability through virtual presence of the supervising provider using real-time interactive audio/video communications technology. Medicare requires various diagnostic tests and services incident to physician services to be performed with a physician or practitioner immediately available and accessible. In response to the PHE, CMS allowed the direct supervision requirement to be met via telehealth; however, the 2021 final rule stated that the flexibility will last through the end of the calendar year in which the PHE ends.[13] As such, CMS is exploring whether to make the flexibility permanent.

Enforcement

Whereas the proposed rule includes interesting developments regarding the future of telehealth reimbursement, there have been a number of notable updates related to enforcement as well. In recent years, the Department of Justice has announced multiple large-scale prosecutions of telehealth fraud schemes that allegedly resulted in billions of dollars in losses to the Medicare program.[14] On September 17, 2021, the Department of Justice announced yet another series of large-scale prosecutions related to telehealth fraud that resulted in $1.1 billion in government losses.[15] Moreover, the OIG has expressed concern regarding the impact of the telehealth flexibilities during the PHE and vows to continue performing oversight work.[16] Accordingly, as of this writing, there are multiple telehealth-related items on the OIG Work Plan. Considering the substantial and continuing focus by the government on telehealth enforcement, providers must be vigilant to ensure that they are billing for these services appropriately.

Conclusion

The Medicare rules relating to telehealth services continue to evolve as uncertainty regarding the duration of the PHE continues. At the same time, the federal government is collecting data to analyze the impact of telehealth on cost, quality, and access while also signaling that telehealth will be a government enforcement priority for the foreseeable future. As such, providers should review the 2022 MPFS proposed rule and the subsequent final rule that will be published later in the year in order to stay compliant. Similarly, providers must prepare themselves for the end of the PHE and understand which services to continue furnishing via telehealth and which services to stop.

Takeaways

- On July 23, 2021, Centers for Medicare & Medicaid Services (CMS) published the Medicare Physician Fee Schedule proposed rule containing several notable proposals and solicitations of comments regarding telehealth.
- CMS proposes to extend the eligibility of Category 3 telehealth services through the end of calendar year 2023.
- Telehealth services temporarily added to the Medicare list that are not included in Category 3 will expire at the end of the public health emergency.

- The federal government continues to actively enforce and audit for telehealth fraud and noncompliance.
- Telehealth providers should familiarize themselves with the 2022 Medicare Physician Fee Schedule proposed rule and forthcoming final rule to stay compliant.

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7 Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, 86 Fed. Reg. 39,137.
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12 Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, 86 Fed. Reg. 39,149.
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