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ON THE SUBJECT

LOOKING AROUND THE CORNER: MEDICARE REIMBURSEMENT FOR TELEHEALTH SERVICES AFTER THE PUBLIC HEALTH EMERGENCY

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As regulators make public statements in support of permanently expanding telemedicine uses, telehealth stakeholders are asking a key question: "What would it take for the recent changes to Medicare telehealth reimbursement to become permanent beyond the public health emergency?"

In response to the Coronavirus (COVID-19) public health emergency (PHE), legislators and regulatory agencies changed the rules related to telehealth services, particularly in the case of telehealth services delivered to Medicare beneficiaries. During the PHE, telehealth providers are able to receive Medicare reimbursement for a greater variety of telehealth services, leverage more types of healthcare providers and treat Medicare patients in more locations than ever before. Telehealth providers are energized by these changes and are voicing resistance to the prospect of losing these new reimbursement opportunities post-PHE.

The pathways to making these and other changes permanent are neither simple nor clear, however. Medicare reimbursement of telehealth services is governed by both statutory and regulatory requirements, and therefore the PHE-driven changes have come via federal legislation and regulatory modifications by the Centers for Medicare and Medicaid Services (CMS). While CMS has the authority to make certain permanent modifications to telehealth reimbursement, other modifications require congressional action. CMS is considering whether and how to make some of these changes permanent, and this paper describes what steps would be necessary to do so.

STATUTORY BARRIERS TO MEDICARE REIMBURSEMENT OF TELEHEALTH SERVICES

Historically, the originating site and geographic requirements have been significant barriers to Medicare reimbursement of telehealth services. Medicare generally reimburses telehealth services provided to beneficiaries only when they are at a qualifying originating site (*e.g.*, practitioner office, hospital, rural health clinic) and are located in a rural area (originating site requirements). Practically, this means that beneficiaries are not permitted to receive telehealth services when they are located in their own home. The originating site requirements are set forth in statute under 42 USC §

1395m(m)(4)(C) and may be modified only through congressional action.[1]

Given the risks posed by in-person medical care during the PHE, the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, one of the first acts of legislation passed in response to the pandemic, permitted the waiver of the originating site requirements "in any emergency area . . . during any portion of any emergency period." 42 USC § 1320b-5(b)(8). Subsequently, the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) expanded the authority of the Secretary of Health and Human Services to waive the statutory requirements related to Medicare coverage of telehealth services furnished in any emergency area during any portion of the PHE. Accordingly, any waivers issued by the Secretary will be ineffective once the PHE declaration is lifted. As a result, congressional action is the only pathway to permanently revise the originating site requirements and certain other barriers to Medicare reimbursement of telehealth services.

REGULATORY FLEXIBILITY TO MODIFY MEDICARE REIMBURSEMENT OF TELEHEALTH SERVICES

While modifying the originating site requirements requires congressional action, CMS still has significant powers to otherwise modify rules related to Medicare telehealth. For example, 42 USC § 1395m(m)(4) defines the term "telehealth service" to include specified Current Procedural Terminology (CPT) codes (including professional consultations, office visits and office psychiatry services) and "any additional service specified by the Secretary." This existing statutory language gives the Secretary the authority to designate additional CPT codes as qualifying telehealth services. CMS has previously exercised this authority by proposing qualifying telehealth services in the annual Medicare Physician Fee Schedule (PFS) rulemaking process. However, based on its existing criteria for adding new telehealth services, CMS also used this authority to add several qualifying telehealth services for the duration of the PHE.

During the PHE, CMS has promulgated additional regulatory changes to Medicare telehealth rules. As with its expansion of CPT codes, however, CMS justified many of these changes in reference to the circumstances arising during the PHE. For example, a frequent CMS goal in modifying the rules has been to reduce the risk of patient and provider exposure to COVID-19. Although CMS has the power to make these modifications permanent—including the expansion of permissible telehealth services—under its existing authority through its usual rulemaking process, it will have to determine that these changes are appropriate for telehealth under normal, non-PHE circumstances.

The table below outlines the myriad statutory and regulatory changes to Medicare rules during the PHE, and analyzes how these changes could become permanent after the PHE has been lifted.

[1] Medicare does not apply the requirements for "telehealth services" to remote patient monitoring, e-visits or virtual check-ins, because these services may be provided when patients are at home.

TELEHEALTH CHANGES BROADLY APPLICABLE ACROSS PROVIDER TYPES

TELEHEALTH		
Pre-PHE Policy	**Policy During The PHE**	**Post-Phe Requirements To Make Changes Permanent**
Qualifying Providers Medicare limits the type of healthcare providers eligible to provide telehealth services from a distant site to the following: ▪ Physicians ▪ Nurse practitioners (NPs) ▪ Physician assistants (PAs) ▪ Nurse-midwives ▪ Clinical nurse specialists (CNSs) ▪ Certified registered nurse anesthetists ▪ Clinical psychologists (CPs) and clinical social workers (CSWs) [Note: CPs and CSWs cannot bill Medicare for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services. They cannot bill or get paid for CPT codes 90792, 90833, 90836 and 90838.] ▪ Registered dietitians or nutrition professionals	CMS expanded the types of healthcare professionals that can furnish distant site telehealth services to include all providers that are eligible to bill Medicare for their professional services. The expanded list of healthcare providers now includes (in addition to the providers listed in the left column): ▪ Physical therapists ▪ Occupational therapists ▪ Speech language pathologists Source: COVID-19 Emergency Declaration Blanket Waivers	**Congressional Action** 42 USC § 1395m(m)(1) permits the Secretary to pay for telehealth services that are furnished by a "physician" or a "practitioner," as those terms are defined in 42 USC § 1395x(r) and 42 USC § 1395u(b)(18)(C), respectively. These terms encompass only certain types of providers.[2] Congressional action would be necessary to permanently revise or otherwise expand the list of practitioners permitted to receive Medicare reimbursement for telehealth services.
Originating Site Fee Certain facilities (where the patient is located) qualify for a telehealth originating site fee. These qualifying sites include: ▪ Physician and practitioner offices ▪ Hospitals	CMS will pay a telehealth originating site fee for Medicare beneficiaries receiving telehealth services in their home or other temporary expansion site, if the beneficiary's home or temporary expansion site is a provider-based department of the hospital, and the beneficiary is registered as an outpatient of the hospital	**Congressional Action** Pursuant to 42 USC § 1395m(m)(2)(B)(ii), facility fees shall not be paid when the originating site is the patient's home. Other regulatory changes during the PHE permit many services to be provided in the patient's home and permit

[2] Specifically, physicians, PAs, NPs, CNSs, certified registered nurse anesthetists, certified nurse-midwives, CSWs, CPs, and registered dietitians or nutrition professionals.

TELEHEALTH		
Pre-PHE Policy	**Policy During The PHE**	**Post-Phe Requirements To Make Changes Permanent**
▪ Critical Access Hospitals (CAHs) ▪ Rural Health Clinics ▪ Federally Qualified Health Centers ▪ Hospital-based or CAH-based Renal Dialysis Centers (including satellites) ▪ Skilled Nursing Facilities (SNFs) ▪ Community Mental Health Centers ▪ Renal Dialysis Facilities ▪ Homes of beneficiaries with End-Stage Renal Disease (ESRD) receiving home dialysis ▪ Mobile Stroke Units	for purposes of receiving telehealth services billed by the physician or practitioner. Source: CMS Interim Final Rule (2)	providers to bill for those services as if they are provided in person. Many providers would typically furnish these services in hospital outpatient departments, which would receive a facility fee based on the encounter. CMS found a regulatory mechanism through which to pay facility fees when the patient is located in the home during the PHE, but after the PHE ends, the circumstances supporting this approach will no longer exist. Accordingly, congressional action would be necessary to permanently permit payment of facility fees when the originating site is the home.
Originating Site Location Medicare requires that a beneficiary receive telehealth services at a designated healthcare facility or rural site (originating site).	The originating site requirement is waived. Patients can be anywhere, including their home. Sources: Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (Sec. 102) CARES Act (Sec. 3703) FAQs	**Congressional Action** The originating site requirements are set forth in statute under 42 USC § 1395m(m)(4)(C). Congressional action is necessary to modify the originating site requirements outside of a PHE.
Covered Services Medicare provides a list of telehealth services payable under the Medicare PFS, which is updated annually.	CMS temporarily expanded the list of telehealth services eligible for reimbursement. The additional services include: ▪ Certain emergency department visits ▪ Initial and subsequent observation	**Regulatory Action** Pursuant to 42 USC § 1395m(m)(4)(F), "telehealth service" includes certain CPT codes (including professional consultations, office visits and office psychiatry services) and "any additional service specified by the Secretary." This existing statutory language gives the

TELEHEALTH		
Pre-PHE Policy	**Policy During The PHE**	**Post-Phe Requirements To Make Changes Permanent**
	▪ Initial hospital care and hospital discharge day management ▪ Initial nursing facility visits and nursing facility discharge day management ▪ Critical care ▪ Domiciliary, rest home or custodial care ▪ Home visits ▪ Inpatient neonatal and pediatric critical care ▪ Initial and continuing intensive care ▪ Care planning for patients with cognitive impairment ▪ Croup psychotherapy ▪ ESRD care ▪ Psychological and neuropsychological testing ▪ Radiation treatment management ▪ Therapy services (including licensed CSW services, CP services, physical therapy services, occupational therapist services and speech language pathology services) Sources: List of Telehealth Services Additional Telehealth Services	Secretary the authority to designate additional CPT codes as qualifying telehealth services. CMS has exercised this authority by proposing qualifying telehealth services in the PFS rulemaking process. In 67 Fed. Reg. 79966, 79988 (Dec. 31, 2002), CMS prescribed a method for evaluating new services to add to the list of telehealth services. This rule requires CMS to categorize the services according to whether they are similar to those currently on the list of telehealth services, and evaluate them in accordance with criteria that apply to such category. CMS may permit these services to be provided via telehealth after the COVID-19 PHE has been lifted. In order to do so, CMS must go through the same process that is typically used for the list of telehealth services—*i.e.*, propose their addition in the annual PFS proposed rule and demonstrate that they comply with the criteria typically used for this analysis.
Payment Rates For services that have different rates in non-facility and facility places of service, Medicare uses the facility (lower) payment rate when services are furnished via telehealth. Telehealth services must be billed using place of service code 02, which is designated as a	CMS will assign the payment rate that ordinarily would have been paid under the PFS if the services were furnished in person. This means that physicians who normally would have seen the patient in a physician office setting will receive the non-facility (higher) rate.	**Regulatory Action** According to the Social Security Act, distant site providers should be reimbursed “an amount equal to the amount that such [provider] would have been paid . . . had such service been furnished without the use of a telecommunications system.” The act also mandates that the originating site be reimbursed

TELEHEALTH		
Pre-PHE Policy	**Policy During The PHE**	**Post-Phe Requirements To Make Changes Permanent**
facility setting. Services that have different payment rates in non-facility and facility settings therefore are reimbursed at the facility (lower) rate when furnished via telehealth.	Source: CMS Interim Final Rule	based on the facility rate. *See* 42 USC § 1395m(m)(2). CMS has the power to modify prior interpretations of the statutory payment requirement for distant site providers.
Modality – Expanded Use of Telephones with Visual Capabilities Medicare requires that telehealth services be delivered through interactive audio and video telecommunications system that permit real-time communication between the patient at the originating site and the provider at the distant site. Telephones are excluded from the definition of audio and video telecommunications system.	Providers are allowed to use audio-visual functionality on mobile phones. The US Department of Health and Human Services Office for Civil Rights (OCR) will exercise enforcement discretion allowing the good faith use of popular video-chat applications, including FaceTime, Zoom and Skype. Note: CMS's argument for this modification does not rely on PHE-specific concerns, but the change is still limited to the duration of the PHE. Sources: Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (Sec. 102) OCR Guidance CMS Interim Final Rule	**Regulatory Action** Under 42 CFR § 410.78(a)(3), the definition of "interactive telecommunications system," through which telehealth services must be provided, specifically excludes telephones. In the first interim final rule, CMS added a new exception that removes this limiting language for the duration of the PHE, effectively permitting telehealth services to be provided by telephones if they incorporate two-way audio-visual functionality (*i.e.*, smartphones). OCR also announced that it would exercise enforcement discretion regarding HIPAA requirements that typically apply to remote communications technologies that transmit protected health information. In particular, OCR stated that covered healthcare providers can use any non-public-facing remote communication product that is available to communicate with patients, including applications such as Apple FaceTime, Facebook Messenger, Google Hangouts, Zoom and Skype. It excluded from the notice other applications such as Facebook Live, Twitch and TikTok. There is no statutory definition for "interactive telecommunications," so CMS has the authority to

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Pre-PHE Policy	**Policy During The PHE**	**Post-Phe Requirements To Make Changes Permanent**
		promulgate alternative definitions of this term through the rulemaking process, as it did in its first interim final rule.
Modality – Expanded Codes for Telephone Consults Medicare does not cover certain services provided via telephone (audio-only).	CMS will allow reimbursement for certain audio-only evaluation and management (E/M) telephone codes to new *and* established Medicare patients. Opioid treatment programs may also conduct therapy and counseling sessions through audio-only telephone calls. CMS will increase payments for certain telephone E/M services (99441-99443) to match payments for similar office/outpatient visits (99212-99214). This change will increase payments for these services from a range of about $14-$41 to about $46-$110. The increased payments are retroactive to March 1, 2020. CMS also added these telephone E/M codes to the list of Medicare telehealth services. Because services on the Medicare telehealth list are required to be furnished using both audio and video, CMS waived requirements that these telephone E/M codes be provided using video. Sources: CMS Interim Final Rule CMS Interim Final Rule (2)	**No Action / Regulatory Action** CMS changed the designation of telephone E/M services from non-covered services to covered services for the duration of the PHE. No action would be required for CMS to make this change permanent, other than announcing that the services are covered even after the PHE.
Licensure	CMS will waive Medicare and Medicaid's requirements that physicians and non-physician	**Congressional Action**

TELEHEALTH		
Pre-PHE Policy	**Policy During The PHE**	**Post-Phe Requirements To Make Changes Permanent**
Medicare requires that providers be licensed in the state in which the patient is located. Medicaid requirements vary by state.	practitioners be licensed in the state where they are providing services when the following four conditions are met: ▪ The provider is enrolled as such in the Medicare program. ▪ The provider possesses a valid license to practice in the state that relates to the provider's Medicare enrollment. ▪ The provider furnishes services—whether in person or via telehealth—in a state in which the PHE is occurring in order to contribute to relief efforts in a professional capacity. ▪ The provider is not affirmatively excluded from practice in the state or in any other state that is part of the 1135 emergency area. Note: Practitioners must continue to comply with state licensure requirements. Sources: 1135 Waiver CMS Interim Final Rule	42 USC 1395m(m)(1) permits the Secretary to pay for telehealth services that are furnished by a "physician" or a "practitioner," as those terms are defined in 42 USC § 1395x(r) and 42 USC § 1395u(b)(18)(C), respectively. In turn, those statutory provisions require the provider to be "legally authorized" to practice the profession under state law, which would require compliance with state licensure requirements. Because the underlying requirement is set forth in statute and the authority to waive the requirement is similarly statutorily limited to periods of emergency, CMS would not be permitted to waive these licensing requirements more broadly without statutory action.
Established Patient Requirement The code descriptions of certain telehealth services specify that the service must be provided to an "established patient." Under the relationship requirement, the patient must have seen the healthcare provider (or another	CMS will exercise enforcement discretion to relax the established patient requirement of the code descriptors. Source: CMS Interim Final Rule Note: The Coronavirus Preparedness and Response Supplemental Appropriations Act	**Regulatory Action** In order to permanently change the established patient requirement, CMS would have to issue a rule removing this language from the code descriptors.

TELEHEALTH		
Pre-PHE Policy	**Policy During The PHE**	**Post-Phe Requirements To Make Changes Permanent**
provider in the same practice) before the telehealth visit.	2020 also added a requirement that telehealth services only be provided to patients to whom the provider (or another provider in the same practice) has previously provided services (the prior relationship requirement). In subsequent guidance, CMS announced that it will not enforce this requirement, and the CARES Act removed the requirement altogether.	
Enrollment ▪ Provider enrollment is a formal process that includes a written application and screening requirements, such as criminal background checks, and certification of compliance with applicable state and federal laws and regulations. Telehealth practitioners who deliver care from their homes on regular basis, such that the practitioner's home is a "practice location," must enroll their homes in Medicare as a practice location. 42 CFR 424.516	▪ CMS will waive certain enrollment requirements, including the written application and enrollment of practitioner home addresses as a "practice location," when services are provided by telehealth from the practitioner's home on a regular basis. CMS will set up toll-free hotlines at each Medicare Administrative Contractor (MAC) to initiate temporary Medicare billing privileges on an expedited basis for practitioners not already enrolled in Medicare. Source: FAQ	**Regulatory Action** ▪ Modification to 42 CFR 424.516 would be necessary to continue to exempt telehealth practitioners from the requirements for Medicare program participation and enrollment, but a modified process for enrollment of telehealth practitioners could be established by CMS and MAC guidance. In addition, regulatory changes to 42 CFR 424.516 or revisions to CMS and MAC guidance regarding the definition of "practice location" would be necessary to exempt telehealth practitioners from enrolling their homes as a practice location.
Frequency of Services The frequency of telehealth services is limited for certain Medicare services. Examples include services rendered in inpatient facilities and SNFs.	Certain services no longer have limitations on the number of times they can be provided by Medicare telehealth: ▪ A subsequent inpatient visit can be furnished via Medicare telehealth, with no frequency limits.	**Regulatory Action** When CMS has added services to the Medicare telehealth list in the past, it has specified frequency limitations for certain services due to concerns regarding patient acuity and complexity.

TELEHEALTH		
Pre-PHE Policy	**Policy During The PHE**	**Post-Phe Requirements To Make Changes Permanent**
	▪ A subsequent SNF visit can be furnished via Medicare telehealth, with no frequency limits. ▪ Critical care consult codes may be furnished to a Medicare beneficiary by telehealth beyond the once-per-day limitation. Source: CMS Interim Final Rule	Under 42 USC § 1395(m)(4)(F)(i), CMS has the authority to specify additional Medicare telehealth services other than those set forth in statute and, accordingly, may also impose restrictions and requirements that govern those services. As a result, CMS may permanently remove these frequency limitations.
Medicare Advantage Medicare Advantage plans and coverage vary.	CMS issued a memo to Medicare Advantage plans that clarified the types of flexibilities available during a PHE and state-level declarations of emergency. Source: March 10, 2020, HPMS Memo	**Congressional Action** 42 CFR 422.100(m) provides special requirements during a disaster or emergency related to Part A/B and supplemental Part C benefit access. CMS would not be permitted to implement plan flexibilities more broadly without statutory action.

OTHER TELEMEDICINE GUIDANCE: REGULATORY CHANGES PROVIDING INCREASED FLEXIBILITY TO USE TELEMEDICINE IN PLACE OF IN-PERSON REQUIREMENTS

OTHER TELEMEDICINE GUIDANCE		
Pre-PHE Policy	**Policy During The PHE**	**Post-PHE Requirements To Make Changes Permanent**
Direct Supervision Direct supervision requires that a physician be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. The physician does not have to be present in the room when the procedure is performed.	CMS modified the definition of direct supervision to include virtual physician presence through audio/video real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary or healthcare provider. This interim change has broad application across a variety of settings. Note: CMS is seeking information from commentators on whether CMS should develop guardrails. Source: CMS Interim Final Rule	**Regulatory Action** Under 42 CFR § 410.32(b)(3)(ii), direct supervision requires that a physician be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. The physician does not have to be present in the room when the procedure is performed. In the first interim final rule, CMS permits direct supervision to include "virtual presence through audio/video real-time communications technology" when using such technology would "reduce exposure risks" for either the beneficiary or the provider. CMS could make this change more broadly applicable through additional regulatory action.
Teaching Physician With some exceptions, if a resident participates in a service furnished in a teaching setting, PFS payment is made only if the teaching physician is present during the key portion of the service or procedure for which payment is sought.	The requirement for the presence of a teaching physician can be met, at a minimum, through direct supervision by interactive telecommunications technology. This includes both in-person and telehealth visits. Source: CMS Interim Final Rule	**Regulatory Action** Under 42 CFR § 415.172, if a resident participates in a service furnished in a teaching setting, physician fee schedule payment is made only if the teaching physician is present during the key portion of any service or procedure for which payment is sought.

OTHER TELEMEDICINE GUIDANCE		
Pre-PHE Policy	**Policy During The PHE**	**Post-PHE Requirements To Make Changes Permanent**
		CMS could make this policy more broadly applicable through additional regulatory action.
Diagnostic Testing Review and Interpretation Review and interpretation of diagnostic testing is limited to established patients and specific providers.	CMS will relax enforcement of the "established patient" aspect of the code descriptors. CMS will not conduct review to consider whether services were furnished to established patients. CMS also expanded the list of providers that may use these specific codes to include licensed CSWs, CPs, physical therapists, occupational therapists and speech-language pathologists. Source: CMS Interim Final Rule	**Regulatory Action** Certain communication-technology-based services, including remote interpretations of diagnostic tests, typically specify an "established patient" requirement in the code descriptor. CMS could make this change more broadly applicable through additional regulatory action.
Remote Patient Monitoring Remote patient monitoring (RPM) is limited to established patients who have more than one disease.	RPM can be provided to new *and* established patients, patients with both acute and chronic conditions, and patients with only one disease. Source: CMS Interim Final Rule	**No Action** Generally speaking, RPM services may only be provided to established patients. The interim final rule provides that they may be provided to new patients for the duration of the public health emergency. Unlike the other RPM provisions, this clarification does not appear to be time-limited by the PHE. Therefore, although the ability to use these codes for new patients is only effective for the duration of the PHE, it appears that the RPM codes may be used for acute and/or chronic conditions even after the PHE is over without further action. CMS could expand the codes for use with new

OTHER TELEMEDICINE GUIDANCE		
Pre-PHE Policy	**Policy During The PHE**	**Post-PHE Requirements To Make Changes Permanent**
		patients through additional regulatory action.
Local and National Coverage Determinations CMS relies on local coverage determinations (LCDs) and national coverage determinations (NCDs) to set requirements for face-to-face visits around evaluation and assessments.	To the extent that an NCD or LCD would otherwise require a face-to-face visit for evaluations and assessments, clinicians do not have to meet those requirements during the PHE. Source: CMS Interim Final Rule	**Regulatory Action** CMS relies on LCDs and NCDs to set requirements for face-to-face visits around evaluation and assessments. CMS has the ability to make this change more broadly applicable.

GUIDANCE BY PROVIDER TYPE: SPECIFIC POLICY CHANGES FOR CERTAIN MEDICARE PROVIDERS

GUIDANCE BY PROVIDER TYPE		
Pre-PHE Policy	**Policy During The PHE**	**Post-PHE Requirements To Make Changes Permanent**
Rural Health Centers (RHCs) and Federally Qualified Health Centers (FQHCs) RHCs and FQHCs are prohibited from serving as distant site telehealth providers and therefore cannot qualify for the distant site payment. Reimbursable codes are limited in scope.	RHCs and FQHCs can be distant sites and can be reimbursed at an amount comparable to the PFS amount. CMS also expanded telehealth codes that RHCs and FQHCs may use for reimbursement, and will allow these to be applied to new *and* established patients. Sources: CARES Act (Sec. 3704) CMS Interim Final Rule	**Congressional Action** Under 42 USC § 1395m(m), only certain specified types of providers may serve as distant site practitioners, and they are individual provider types (*e.g.*, physicians, nurse practitioners). Statutory change would be necessary to permit RHCs and FQHCs to serve as distant sites after the PHE. **Regulatory Action** The interim final rule also expanded telehealth codes that RHCs and FQHCs may use for reimbursement, and will allow these to be applied to new *and* established patients. CMS could make it more broadly applicable through additional regulatory action.
Inpatient, Nursing and Critical Care CMS requires a variety of in-person visits and limits the frequency of telehealth services for Medicare patients with certain conditions that need specific follow-up visits.	CMS removed the frequency restrictions for certain codes related subsequent inpatient visits, subsequent nursing facility visits and critical care consultation services. Source: CMS Interim Final Rule	**Regulatory Action** CMS has placed certain limits around the frequency of telehealth services for Medicare patients with certain conditions that need specific follow-up visits. CMS could make this change more broadly applicable through additional regulatory action.
Home Dialysis	The CARES Act waives the face-to-face requirement.	**Congressional / Regulatory Action**

GUIDANCE BY PROVIDER TYPE		
Pre-PHE Policy	**Policy During The PHE**	**Post-PHE Requirements To Make Changes Permanent**
Home dialysis requires face-to-face evaluation of the patient. Clinical examination of the vascular access site must be furnished through a face-to-face "hands on" encounter.	CMS will allow a telehealth service to substitute for the face-to-face requirement for the clinical examination of the vascular access site for ESRD. Source: CARES Act (Sec. 3705)	The CARES Act provides the Secretary with the authority to waive the statutory requirement for a nephrologist to conduct a face-to-face evaluation of a home dialysis patient during the PHE (codified at 42 USC § 1395rr(b)(3)(B)(iii)). Because face-to-face visits are a statutory requirement and the CARES Act only provides the Secretary with the authority to waive them during the PHE, Congress would have to pass additional legislation in order to make this change permanent. With regard to vascular access site examination, CMS typically requires that this ESRD service be furnished through a face-to-face "hands on" encounter. Unlike the home dialysis evaluation requirements discussed above, this requirement was promulgated via regulation and can similarly be removed via regulation. Additional regulatory action would be required to make it permanent.
Hospice Hospice physicians and NPs cannot conduct recertification encounters using telehealth. Hospice services are generally required to be in person for the purposes of reimbursement.	The CARES Act allows qualified providers to use telehealth technologies to fulfill the hospice face-to-face recertification requirement. CMS further clarified this in its first interim final rule. When a patient receives routine home care, hospices may provide services via a telecommunications system, if it is feasible and appropriate to do so, to ensure that Medicare patients continue receiving reasonable and necessary services for the palliation and management of	**Regulatory Action** Under 42 CFR § 418.22, Medicare hospice conditions of participation require a hospice patient's primary care physician to perform a face-to-face evaluation of a patient every 60 days to recertify that the patient continues to be eligible to receive the Medicare hospice benefit. The statute is silent as to whether a face-to-face encounter solely for the purpose of Medicare hospice recertification could be conducted

GUIDANCE BY PROVIDER TYPE		
Pre-PHE Policy	**Policy During The PHE**	**Post-PHE Requirements To Make Changes Permanent**
	terminal illness and related conditions without jeopardizing the patients' health or the health of providers. Sources: CARES Act (Sec. 3706) CMS Interim Final Rule	via telecommunications technology by the hospice physician or NP, so this may be changed administratively. CMS could make this change more broadly applicable through additional regulatory action.
Nursing Homes Physician and non-physician practitioners are required to perform in-person visits for nursing home residents.	CMS will waive this in-person requirement and allow visits to be conducted, as appropriate, via telehealth options. CMS removed some frequency restrictions for services for subsequent inpatient visits and subsequent nursing facility visits furnished via Medicare telehealth as well as critical care consultation codes for the duration of the PHE. Source: CMS Interim Final Rule	**Regulatory Action** CMS has waived the requirement in 42 CFR 483.30 for physicians and non-physician practitioners to perform in-person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options. CMS could make this change more broadly applicable through additional regulatory action.
Rehabilitation Medicare requires rehabilitation physicians to conduct face-to-face visits with the patient at least three days per week throughout the patient's stay in the inpatient rehabilitation facility.	CMS will allow the face-to-face visits to be conducted via telehealth. Source: CMS Interim Final Rule	**Regulatory Action** Under 42 CFR 412.622(a)(3)(iv), rehabilitation physicians to conduct face-to-face visits with the patient at least three days per week throughout the patient's stay in the inpatient rehabilitations facility to ensure that the patient's medical and functional statuses are being continuously monitored as the patient's overall plan of care is being carried out. CMS could make this change more broadly applicable through additional regulatory action.

GUIDANCE BY PROVIDER TYPE		
Pre-PHE Policy	**Policy During The PHE**	**Post-PHE Requirements To Make Changes Permanent**
Home Health Provision of home health services via telehealth is limited, depending on the beneficiary's care plan.	The CARES Act requires the Secretary to issue guidance encouraging the use of telecommunications systems, including RPM consistent with the plan of care. CMS provided detailed information on how to adjust a plan of care to include RPM or other telemedicine services. The CARES Act also encourages the use of telecommunications systems for home health services furnished during emergency period. Source: CARES Act (Sec. 3707) CMS Interim Final Rule	**Regulatory Action** 42 CFR § 409.43 originally limited the use of telecommunications for home health services, but CMS has temporarily revised this statute to provide home health agencies flexibility to use telecommunication systems in addition to RPM, and explained how to adjust a plan of care during the public health emergency. CMS is statutorily prohibited by 42 CFR § 409.43 from paying for home health services furnished via a telecommunications system if such services substitute for in-person home health services ordered as part of a plan of care, and from paying directly for such services under the home health benefit. CMS could make these changes more broadly applicable through additional regulatory action.

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