

June 1, 2020

The Honorable Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
P.O. Box 8016  
Baltimore, MD 21244-8016

Re: CMS-1744-IFC; Medicare and Medicaid Programs; Policy and Regulatory Revisions in  
Response to the COVID-19 Public Health Emergency

Dear Administrator Verma:

On behalf of the physician and medical student members of the American Medical Association (AMA), thank you for the regulatory flexibilities and policy updates in response to the 2019 novel coronavirus disease (COVID-19). The AMA appreciates the strong and swift actions undertaken by the Centers for Medicare & Medicaid Services (CMS) to address the needs of Medicare and Medicaid patients during the COVID-19 public health emergency (PHE) and help enable our physicians to focus on providing frontline care during this unprecedented pandemic. We provide feedback on the critical policy and regulatory revisions in the Interim Final Rule with Comments (IFC) and, where incorporated, policies from the enactment of the Coronavirus Preparedness and Response Supplemental Appropriations Act 2020,<sup>1</sup> the First Coronavirus Response Act,<sup>2</sup> and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act).<sup>3</sup>

The AMA strongly supports the goals in the IFC to increase access to services delivered through telecommunications technology, increase access to testing and services in a patient's home, and improve infection control and limit potential exposure to health care workers. The AMA also urges CMS to maintain several of these policies beyond the COVID-19 public health emergency. In the second part of this response, we provide detailed comments and examples of telehealth procedures that should continue under Medicare after the COVID-19 public health emergency.

As detailed below, the AMA strongly supports the following changes to expand patients' access to remote care and to reduce regulatory burdens on physicians during the COVID-19 pandemic:

- Expand the coverage of telehealth services to increase access and use of important medical services during the COVID-19 public health emergency;
- Pay telehealth visits at the same rates as in-office visits;

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<sup>1</sup> Public Law 116-123, enacted on March 6, 2020.

<sup>2</sup> Public Law 116-127, enacted on March 18, 2020.

<sup>3</sup> Public Law 116-136, enacted on March 27, 2020.

- Permit telehealth services to be used for new and established patients;
- Provide coverage of audio-only visits for patients who need contact with providers but lack the two-way telecommunications technologies;
- Allow telehealth services to originate in a Medicare beneficiary's home;
- Allow flexibilities for direct supervision for several procedures using audio-visual, two-way, synchronous technologies for teaching physicians and residents;
- Relax restrictions on the frequency of Medicare telehealth services for subsequent care services at inpatient and nursing facility settings;
- Permit physicians to waive cost sharing requirements for telehealth services during the COVID-19 public health emergency; and
- Support remote patient monitoring and contemporaneous Medicare beneficiary consent for these services.

### **Expansion of Telehealth Services under Medicare During the COVID-19 Public Health Emergency**

Medicare ordinarily pays for a limited set of services provided in-person with real-time, interactive telecommunications technology. Medicare requires the beneficiary to be at a facility when receiving telehealth services based in a rural or underserved area and pays the “originating site of service” a fee at the time the telehealth services are provided. CMS requires physicians to use the place of service code 02 to note the delivery of telehealth services. Given the circumstances of COVID-19, CMS has proposed numerous positive changes using telehealth to allow physicians to care for their patients. **The AMA strongly supports the coverage and payment of telehealth to ensure increased access and use of these services during COVID-19.**

The AMA supports the CMS policy to allow telehealth services to originate from the beneficiary's home. With COVID-19 being highly contagious and particularly devastating for those with comorbidities such as a hypertension, diabetes, cardiovascular disease, and respiratory conditions, seniors should make every attempt to adhere to the shelter at home recommendations of the CDC. It is crucial, however, that seniors receive medical care that many of them so desperately need. **The AMA strongly supports the allowance of telehealth services to originate in a Medicare beneficiary's home. The AMA strongly supports the use of telehealth beyond rural and underserved areas and applauds the extension of the telehealth benefit to all Medicare beneficiaries.** The AMA agrees that, during the COVID-19 public health emergency, physicians should report the place of service had telehealth not been used and include the Current Procedural Terminology® (CPT®) modifier 95 to denote that the services rendered were provided with telehealth.

**The AMA strongly supports CMS' decision to pay physicians practicing in office settings who see patients via telehealth instead of in-person at the non-facility (or office) rate for these services retroactive to March 1, 2020 and throughout the duration of the public health emergency.** Given the importance of using telehealth services as means of minimizing exposure risks for patients, physicians, and the community at large, we agree this change will maintain overall relativity under the physician fee schedule (PFS) for similar services and eliminate potential financial deterrents to the clinically appropriate use of telehealth.

In the IFC and for the duration of the COVID-19 public health emergency, CMS has added more than 135 services to the 2020 Medicare Telehealth CPT Codes list for Category 2 services. This expansion adds services that are not similar to those currently listed for telehealth services, but would demonstrate clinical

benefit to the beneficiary. The expanded list of telehealth services includes emergency department visits, initial and subsequent observation care, initial hospital care, initial observation discharge day management, hospital discharge day management, initial nursing facility visits, nursing facility discharge day management, critical care services, domiciliary rest home or custodial care, home visits, neonatal and pediatric critical care, intensive care services, care planning for patients with cognitive impairment, group psychotherapy, end-stage renal disease monthly services, psychological and neuropsychologist testing, therapy services, and radiation treatment management. **The AMA has consistently advocated for an expanded list of telehealth services covered under Medicare, and we support this decision to dramatically open these more than 135 CPT codes and services to beneficiaries via telehealth.** In particular, the AMA appreciates the inclusion of the emergency medicine codes and the weekly radiation oncology treatment codes which we have recommended. Given that CMS is allowing these telehealth services to be provided in most instances to both new and established patients this gives rise to important new services for patients.

In response to whether there are other services where the use of technology could mitigate the risk of exposure to COVID-19 where there is clinical benefit to using technology to provide such services, the AMA believes that CMS should continue to consider input from national medical specialty societies and practicing physicians. We appreciate that CMS will continue to improve access and update the list at: <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>.

The AMA agrees with the CMS expectation that the additions to the list of Medicare telehealth services, the change in the originating site of service, and the other flexibilities will not result in a significant change to the aggregate Medicare payments for these physician services.

### **Frequency Limitations on Subsequent Care Services in Inpatient and Nursing Facility Settings**

CMS typically limits on how frequently a service can be provided via Medicare telehealth to once every three days for hospital care services, and once every 30 days for subsequent nursing facility care services. Critical care consultations via Medicare telehealth are limited to only once per day, depending on patient acuity. Considering the limited in-person services at inpatient and nursing facilities due to COVID-19, CMS removed the frequency restrictions for nine CPT codes during the public health emergency.

**The AMA strongly supports relaxing the frequency limitations on Medicare telehealth services during this public health emergency.** For example, clinicians practicing in skilled nursing facilities are caring for patients who are most vulnerable during the COVID-19 pandemic, and the AMA had urged CMS to lift the restrictions on providing telehealth in these locations more than once per month. Many of these clinicians see patients in multiple facilities that can be far apart geographically. It is important for clinicians to reduce unnecessary exposures and limit the number of times that health care professionals come into contact with any COVID-19 cases and the buildings in which these cases are occurring.

Whereas end-stage renal disease home dialysis requires at least monthly face-to-face visits in the initial three months, and at least once every three consecutive months after, CMS has relaxed the enforcement of this statutory requirement during COVID-19 public health emergency. Instead, CMS will allow 19 CPT codes associated with end-stage renal disease (ESRD) monthly capitation to be paid when delivered via Medicare telehealth. **The AMA recognizes the need for these ESRD visits and the flexibility that telehealth provides in ESRD home dialysis, and we agree with this change during the COVID-19 public health emergency.** It is important for providers to treat ESRD home dialysis patients if there are

complications, but for routine, monthly check-in visits, ESRD patients are well served with telehealth monthly visits.

### **Telehealth Modalities and Cost-Sharing**

CMS will allow audio and video equipment for two-way, real-time interactive communication to be used for interactive communication between a Medicare patient and a distant site physician or practitioner during the COVID-19 public health emergency. Many Medicare beneficiaries use otherwise restricted devices, such as smartphones equipped with audio and visual technology, which will facilitate the necessary interactions with physicians. **The discretion allowing multi-media communication equipment is a welcomed change by the AMA during COVID-19.** The AMA encourages CMS to provide practical examples of the technologies and devices that Medicare beneficiaries are permitted to use so that the public can have a better understanding of what is allowed.

The U.S. Department of Health and Human Services Office for Civil Rights (HHS OCR) will exercise enforcement discretion and waive penalties for HIPAA violations to permit certain common technologies to be used during the COVID-19 public health emergency. As many people adapt to new communication technologies during the COVID-19 public health emergency, it is important for CMS and HHS OCR to differentiate between which technologies are permitted, and which should be avoided and why. The distinctions between the technologies that are not permitted are important to protect patient data and patient-provider communication and should not be ignored. **The AMA encourages HHS OCR to continue to actively monitor for fraud and abuse during the COVID-19 public health emergency and encourages more education around the permitted and unacceptable communication technologies.** The AMA stands ready to work with OCR to educate our physicians on the HIPAA rules and considerations in place during the COVID-19 public health emergency.

The CMS flexibility to allow physicians to waive any cost-sharing obligations for telehealth services delivered has been a tremendous relief to both physicians and patients during this COVID-19 public health emergency. Many physicians are scheduling calls and conducting telehealth visits outside of their office, so the secure systems to collect payment may not be available. Furthermore, physicians recognize the tremendous economic strain many of their patients are dealing with currently, and how cost-sharing for important services may create a barrier to care. **The AMA strongly supports the flexibility afforded to physicians to waive cost-sharing obligations given the numerous stressors to the health care system at this time.**

### **Communication Technology-Based Services**

CMS acknowledges other physician services that are not considered telehealth by definition but do represent communication technology-based services. Example of these services include remote monitoring, online digital evaluation, and management services and virtual check-ins. In order to support the provision of high-quality care during the COVID-19 public health emergency, CMS modified the consent process to require consent for these services once per calendar year. The AMA supports the establishment of an annual patient consent process where a physician would explain to the patient all non-face-to-face services to be utilized in the provision of their care and obtain consent for these services.

CMS also allowed for these communication technology-based services to be performed for new patients, in addition to established patients, during this COVID-19 public health emergency. The AMA supports this expansion. In the long-term, CMS and the CPT Editorial Panel may consider if the established patient

requirement is necessary on a service by service basis. Comprehensive claims data for January 1-June 30, 2020 should be immediately released in August 2020 so stakeholders may understand how these services have been utilized during the COVID-19 public health emergency to date and determine how best to design and modify code descriptions and coding policy moving forward.

### **Direct Supervision by Interactive Telecommunications Technology**

Our AMA endorses the use of innovative models of clinical and educational work hour requirements and direct resident physician supervision via real-time interactive audio and video technology to optimize patient safety and competency-based learning opportunities during the COVID-19 pandemic. The expansion of direct supervision being delivered using real-time interactive audio and video technology will help to decrease the risk of unnecessary exposure for both the patient and the physician. Moreover, it will help facilitate essential learning between the teaching physician, resident, and patient during this COVID-19 public health emergency.

However, guardrails should be included in order to ensure direct supervision is delivered efficaciously and to mitigate risk. As such, the AMA recommends:

- Encouraging the residency programs, Residency Review Committees, and the Accreditation Council for Graduate Medical Education (ACGME) to increase monitoring of clinical and educational work hour standards, in the context of the larger issue of patient safety, and acknowledging the impact of the changes to the direct supervision requirements on the residents and their optimal learning environment to ensure that appropriate education and supervision are maintained;
- The medical education community is acutely aware of, and working hard to determine how to best meet the need for reporting of information related to, among other things, workload and growing service demands, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice as they relate to the expansion of direct supervision and the use of real-time interactive audio and video technology; as such, the medical community would appreciate CMS sharing any additional information that it may have as it relates to the above mentioned items;
- Issue guidance that reiterates that home health episodes of care should not be bundled or delivered incident to a physician service, and list scenarios when direct supervision via telecommunications technology should escalate to direct supervision in-person; and
- Provide advice on when and how physicians must inform the patient that direct supervision by interactive telecommunication technology is being used.

The AMA further supports the limits on direct supervision by interactive telecommunications technology to exclude high-risk, surgical, interventional, and other complex procedures including endoscopies and anesthesia and does not have any additional procedures to add under the flexibilities that CMS has granted at this time.<sup>4</sup>

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<sup>4</sup> CMS extended flexibilities under the following four regulations during the COVID-19 public health emergency: a teaching physician must be present during the key portion of any service or procedure if reimbursement is sought under Medicare physician fee schedule (§ 415.172), all levels of an office or outpatient E/M service in a primary care center (§ 415.174), interpretation of diagnostic radiology and other diagnostic tests (§ 415.80), and use of a one-way mirror, video equipment, or similar device for delivering psychiatric services (§ 415.84).

Moreover, the AMA supports the expansion of the primary care exception to include all levels of office and outpatient evaluation and management (E/M) codes. Under this IFC, direct physician supervision with interactive telecommunications technology will support patients receiving services that include telephone E/M services, transitional care management services, online digital E/M services, and office or other outpatient E/M visits for both new and established patients. This is a welcome expansion since during this time, every physician should be utilized to their fullest extent to ensure proper patient care. Additionally, the AMA is supportive of the new, more flexible moonlighting provisions.

Overall, the AMA believes direct supervision by interactive telecommunications technology, and the expansion of the primary care exception, are appropriate in the context of the COVID-19 public health emergency and applaud CMS for allowing these options to be used during this time.

### **Medicare Home Health Benefit**

CMS has clarified that a physician may certify home health or skilled nursing care services for a Medicare beneficiary in need of physical therapy, occupational therapy, or speech therapy, and who is confined to the home or homebound during the COVID-19 public health emergency. CMS has further clarified that a person must either have a confirmed or suspected COVID-19 diagnosis, or a condition leading to increased risk for catching COVID-19. Other requirements for home health must be satisfied in addition to these special criteria in light of the COVID-19 public health emergency. The AMA recognizes the nature of the COVID-19 public health emergency is such that it is best for Medicare patients with comorbid conditions or suspected infection to limit their outside exposure and continue to receive services. Other instances where a similar approach would be advisable include similar infectious disease outbreaks (SARS, MERS), a resurgence of COVID-19 or instances of physical natural disaster.

For Medicare beneficiaries receiving home hospice services, it is understandable that many requirements are not practical during the COVID-19 public health emergency. The AMA appreciates that CMS has waived many regulatory burdens during the COVID-19 pandemic. **We urge the agency to further reduce burden by enabling the use of telemedicine and remote patient monitoring services to satisfy the face-to-face requirement in certifying eligibility for Medicare home health services during the public health emergency.** CMS should take appropriate steps to ensure the certification process is streamlined and minimizes paperwork burden for practicing physicians.

### **Modifications for Inpatient Rehabilitation Facility (IRF) Requirements**

An in-person physician evaluation is required within 24 hours of a Medicare patient admission to an inpatient rehabilitation facility. During COVID-19 public health emergency, CMS noted this post-admission evaluation is not required, although it may still occur. **The AMA supports this flexibility for facilities and physicians to determine what is most practical given limited resources and possible exposure to COVID-19, and to make the post-admission optional.** The AMA also supports the use of two-way telecommunications to facilitate a post-admission evaluation, where possible.

CMS also provides flexibility for IRFs that are unable to deliver therapy according to the “3-hour rule” (three hours of prescribed physical therapy, occupational therapy, speech-language pathology, prosthetics or orthotics therapy for at least five days a week). Documentation in the medical record may be done when practical if a post-admission evaluation within 24 hours is not possible and the 3-hour rule is not feasible due to COVID-19 staffing issues or the need to maintain distance for infection control.

### **Special Requirements for Psychiatric Hospitals**

The AMA recognizes the unprecedented nature of the COVID-19 public health emergency warrants utilization of new, temporary, and limited ways to treat patients and to stem the spread of the virus. It is with this perspective that the AMA supports the policy that grants non-physician providers (NPPs) and advance practice providers (APPs) permission to document progress notes in psychiatric facilities when practicing as a part of a physician-led team. Licensed practitioners acting consistently and in accordance with their state law and within the scope of their practice should be able to temporarily document progress notes of patients in psychiatric hospitals in concert with physician-led teams.

### **Innovation Center Models**

#### 1. Medicare Diabetes Prevention Program

CMS has made numerous, significant adaptations for several of its innovation models due to the COVID-19 public health emergency. The AMA strongly supports the flexibilities CMS has made for the Medicare Diabetes Prevention Program (MDPP) to allow beneficiaries to receive services more than once per lifetime and to access sessions on a virtual basis during the COVID-19 public health emergency.

From the beginning of the MDPP, the AMA has been seriously concerned about the once-per-lifetime limit of the Medicare benefit. Weight loss is extremely difficult and complex, and some patients may need multiple attempts to be successful at either achieving or maintaining weight loss. These difficulties, and the need to lift the once-per-lifetime limit, will not end when the pandemic ends.

In contrast to the MDPP limit, the Medicare coverage policy for obesity counseling specifically acknowledges the science showing the need for repeated use of healthy lifestyle counseling for weight management in its current coverage policy for obesity counseling. The Medicare obesity counseling benefit states that, “For beneficiaries who do not achieve a weight loss of at least 3kg during the first 6 months of intensive therapy, a reassessment of their readiness to change and BMI is appropriate after an additional 6-month period.” Similar to Medicare coverage of obesity counseling and tobacco cessation, CMS should provide Medicare beneficiaries additional opportunities to participate in and benefit from MDPP. The stress and strains on the health care system from the COVID-19 public health emergency will continue once the PHE is lifted, and it may be a challenge for those patients that previously participated to maintain the MDPP program goals.

The AMA also greatly appreciates the flexibility that CMS has provided for current MDPP suppliers to offer many more of their sessions through a virtual modality. This policy is too limited, however. The requirement for the first core session to always be provided in-person makes it impossible to begin any new cohorts for as long as the stay-at-home policies are in effect. Medicare beneficiaries, the vast majority of whom are over 65, may be unable to participate in in-person sessions even once reopening begins in many localities because they are among those especially vulnerable to a severe impact if they become infected with the novel coronavirus. CMS should broaden the current flexibilities for MDPP suppliers during the public health emergency to allow all sessions to be provided virtually and for the program to be offered to new participants using this modality. CMS should also allow weight loss to be measured and count during the period of time that patients are participating in the program virtually, as these outcomes-based payments are important to the financial sustainability of the model as it is currently structured.

MDPP has the potential to be transformative to the Medicare program but limiting coverage to in-person programs does not realistically consider the changing landscape of health education and behavior modification programs, especially in the wake of COVID-19. Telehealth and remote monitoring are being used during COVID-19 and will remain a key element of the health care delivery system well beyond the public health emergency. The AMA continues to recommend that CMS allow virtual programs to participate in MDPP on a permanent basis. The AMA asks for CMS to consider the flexibilities offered beyond the length of the COVID-19 public health emergency.

## 2. Comprehensive Care for Joint Replacement Model (CJR) Changes

The AMA supports the 3-month extension to the Care for Joint Replacement Model performance year so that the model ends on March 31, 2021, rather than December 31, 2020. The additional time granted under the extreme and uncontrollable circumstances policy will allow the participating hospitals, physicians, and post-acute care providers to deliver needed care and submit the required data once the COVID-19 public health emergency is over.

### **Remote Physiologic Monitoring**

The IFC allows remote patient monitoring (RPM) for new and established patients during COVID-19. This additional flexibility for physicians to use RPM for new Medicare beneficiaries is critically important, especially since these technologies may be useful for monitoring patients who may have contracted COVID-19. The flexibility CMS has provided to allow Medicare beneficiary consent to be obtained at the same time the services are rendered is practical. **The AMA supports both the expansion of RPM and gaining contemporaneous Medicare beneficiary consent for these services.**

There are several kinds of practitioners who furnish services for remote patient monitoring or remote evaluation during the COVID-19 public health emergency. **We greatly appreciate CMS' clarification that the use of RPM can be for physiologic monitoring of patients with acute as well as chronic conditions.** Remote patient monitoring delivers tremendous value and improves patient health outcomes ordinarily and will be especially useful during the COVID-19 public health emergency for patients with barriers to access, co-morbidities, and who have limited ability to travel.

### **Changes to Medicare Shared Savings Program Extreme and Uncontrollable Circumstances Policy**

The COVID-19 public health emergency meets the criteria for triggering the Medicare Shared Savings Program (MSSP) extreme and uncontrollable circumstances (EUC) policy, which provides an alternative quality scoring approach for accountable care organizations (ACOs). In light of the COVID-19 public health emergency, CMS extended the close of the performance March 31, 2020, to April 30, 2020 to allow physicians additional time for the reporting of quality data in MIPS. **The AMA is appreciative of the additional 30 days for physicians to submit their quality data.** For those physicians unable to submit their data by April 30, 2020, CMS will apply the EUC policy and a neutral MIPS payment adjustment will be applied. The AMA acknowledges this is a workable alternative, as a number of physicians may be unable to submit in a timely manner due to the demands on their practices associated with the COVID-19 public health emergency.

CMS also delayed the submission deadline for reporting quality data on MSSP Accountable Care Organizations until April 30, 2020. For the same reasons noted for the MIPS delays, **the AMA is appreciative of the additional time for the submission of MSSP ACO data.** For physicians who do not

reply by the new deadline, CMS has elected to have the Cost performance category weighted at zero percent, the Improvement Activities performance category scored as usual, and the Quality performance category reweighted to zero percent. **The AMA recognizes that alterations to the calculation of MSSP ACO data may need to be altered in light of the COVID-19 public health emergency and believes the proposals from CMS are warranted.** The AMA further believes the EUC policy for disasters within the reporting period warrants review and additional discussion, as the COVID-19 public health emergency has demonstrated the need to consider the merit performance systems for payment under challenging circumstances. The AMA awaits the future notice and comment rulemaking where these issues can be fully explored.

#### **Application of Certain National Coverage Determination and Local Coverage Determination Requirements During the Public Health Emergency for the COVID-19 Pandemic**

The AMA recognizes the flexibility provided in National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) by lessening the requirements for face-to-face and in-person requirements for evaluations, assessments, and other services. CMS similarly will not enforce clinical indications for coverage of respiratory, home anticoagulation management and infusion pump NCDs and LCDs. CMS also finalizes, on an interim basis, that a chief medical officer or the equivalent can authorize another physician specialty or other practitioner to meet supervision requirements ordinarily required to be performed by a specific practitioner type or physician specialty.

The AMA recognizes all of these measures as temporary and limited to the COVID-19 public health emergency. The AMA notes that chief medical officers can only waive these physician supervision requirements as permitted by state-law. The limited changes made by CMS will allow chief medical officers to address facility workforce needs that may arise as a result of the COVID-19 public health emergency. The AMA maintains that patient care is best coordinated by a physician-led team.

#### **Changes to Expand Workforce for Medicaid Home Health Services (§440.70)**

It appears that CMS has issued its rule allowing nurse practitioners and physician assistants to order home health services in Medicare absent any public comment period. The policy in the Interim Final Rule seeks to align the Medicaid policy with the Medicare policy that has not gone through the standard process for input. **The AMA asks CMS to offer an official comment period for stakeholders to provide feedback on this proposed rule specific to Medicare, and also specific to Medicaid.**

The AMA appreciates that the exception to allow nurse practitioners and physician assistants to order home health services during COVID-19 public health emergency is temporary and limited to the duration of the declared public health emergency.

#### **Recommendations for Extending Interim COVID-19 Policies for Delivery of Telecommunications-Based Services**

The AMA commends CMS for quickly implementing a wide range of important changes in Medicare payment policy in response to the coronavirus pandemic. While some of these changes are specific to the virus or disease, such as payment for SARS-CoV-2 diagnostic tests, others are designed to support or respond to (1) the broader changes in societal interactions that are being made to prevent the spread of the disease or (2) limitations in the ability to deliver services for other health issues due to the resources being devoted to testing and treatment for the virus.

When the Secretary's declaration of the national COVID-19 public health emergency ends, some of the interim changes will no longer be needed, but many of the interim policies have important benefits for patients that are not limited to the pandemic; they should be permitted to continue after the COVID-19 public health emergency ends. These changes fall into three broad categories:

1. Facilitating and expanding services to patients in their own homes, including:
  - a. Evaluation and management (E/M) services
  - b. Treatment services
2. Facilitating use of telehealth services outside of the home
3. Allowing physician supervision of patient services using telecommunications technology

AMA recommendations for extending certain policies beyond the public health emergency in each of these areas are discussed below.

### **Delivery of Telecommunication-Based E/M Services to Patients at Home**

Prior to the COVID-19 public health emergency, CMS only paid physicians for delivering two types of virtual E/M services to patients in their homes: the "virtual check-in" (HCPCS G2012) and online E/M (CPT 99421-99423). Although CMS has also paid physicians for delivering traditional office-based, face-to-face E/M services to patients using audio-visual telecommunications technologies, in most cases this is only if the patient is in a physician's office, hospital, or other "originating site" that is located in a rural area, not if the patient is in their own home. The only authorized home-based telehealth E/M services are for patients who are receiving home dialysis, who have symptoms of an acute stroke, or who are being treated for substance use disorder.

During the COVID-19 public health emergency, CMS has made many policy changes to facilitate delivery of E/M services to patients in their own homes:

- Types of Services Permitted
  - Allowing office-based face-to-face E/M services (CPT codes 99201-99205 and 99211-99215) to be delivered to patients in the home via audio-video telehealth.
  - Allowing payment for audio-only E/M services (telephone calls) by physicians (CPT codes 99441-99443) and by non-physician practitioners (CPT codes 98966-98968).
  - Allowing home visits (CPT codes 99341-99345 and 99347-99350) to be delivered by audio-video telehealth.
  - Allowing Rural Health Clinics and Federally Qualified Health Centers to be paid for online digital E/M services (equivalent to CPT codes 99421-99423).
- Amount of Payment
  - Paying office-based physicians the standard office (non-facility) payment amount instead of the facility rate for face-to-face E/M services when delivered in the home via audio-video telehealth.
  - Increasing the payment for audio-only (telephone) E/M services by physicians (CPT 99441-99443) to match the payment amounts for face-to-face E/M services of similar length (99212-99214).

- Eligible Patients
  - Allowing use of audio-only (telephone) E/M services for new patients as well as established patients (99441-99443, 98966-98968).
  - Allowing digital E/M by physicians (CPT 99421-99423) and non-physicians (G2062-G2063) to be delivered to new patients.
  - Allowing use of virtual check-in (HCPCS G2012) for new patients.
  - Allowing remote evaluation of recorded images (G2010) for new patients.
  - Allowing remote physiologic monitoring (CPT 99091, 99453, 99454, 99457, 99458, 99473, 99474) for new patients.
- Non-Physician Providers
  - Allowing payment for virtual check-in (HCPCS G2012) and remote evaluation of recorded images (HCPCS G2010) when performed by non-physician billing clinicians.
- Patient Cost-Sharing
  - Allowing physicians to waive cost-sharing for telehealth E/M services.

**Recommendations for Covering Telecommunications-Enabled E/M Services to Patients at Home After the COVID-19 Public Health Emergency**

1. Continue Telecommunications-Enabled E/M Services for Patients Who Cannot or Should Not Make Office Visits

Two interrelated reasons have been used to justify expanding telehealth services during the coronavirus pandemic:

- Patients who have or are presumed to have the coronavirus should not come to a physician office where they could expose physicians, office staff, or other patients to the virus unless the visit is necessary and appropriate precautions are taken.
- Patients who do not have the coronavirus should not come to a physician office where they could be exposed to office staff or other patients who may have the virus, particularly if the patient is in a high-risk category.

In both cases, the risk of exposure to the virus that other patients and practice staff would experience from in-person care is seen as outweighing potential concerns that E/M services delivered through video or audio connections would be inferior to in-person care. Once the COVID-19 public health emergency ends, CMS should consider whether these same policies should apply to communicable diseases other than the coronavirus, such as the seasonal flu. It would be desirable to allow any patient who may have a communicable disease to be evaluated remotely when appropriate rather than exposing others to the disease, and to allow immunocompromised and other high-risk patients to receive appropriate services remotely rather than potentially being exposed to communicable illnesses. Although the risk of mortality and morbidity from these other diseases may be lower than from the coronavirus, it is not zero.

In addition, there are many patients for whom in-person visits are either risky or difficult even when there is no pandemic or if steps are taken to protect them from exposure to communicable diseases. A frail elderly patient can experience a fall or serious injury in traveling to a physician's office, it can be dangerous for any patient to travel during severe weather, and some patients may not have access to

transportation needed to visit a physician in person and thereby fail to receive timely diagnosis or treatment.

**Consequently, CMS should consider whether to continue to allow physicians to be paid for delivering face-to-face E/M services using telecommunications technology to patients for whom home-based services are safer or more feasible.** For example, the services could be authorized for:

- Established patients with a health condition or functional limitations that make travel to the physician's office difficult or risky;
- New patients whose principal complaint involves symptoms of an infectious disease; and
- New or established patients during infectious disease outbreaks, severe weather, public health emergencies, or other situations where travel is undesirable.

Since physicians are now billing for telehealth E/M services by appending modifier 95 to the appropriate procedure code, the use of the modifier could continue to be used for situations in which telecommunications-supported services to patients in the home are appropriate.

Moreover, if the face-to-face service delivered using telecommunications is equivalent to a service delivered in person, then the payment amount should continue to be equivalent to the payment for a standard office visit, otherwise the physician practice would lose money by delivering services through telehealth. Indeed, the practice's costs may increase due to the need to install and maintain the necessary equipment and software to deliver secure video communications. CMS has recognized the need to pay the same amounts for telecommunication-based services and in-person services during the pandemic, and this should continue after the national emergency ends.

## 2. Continue Coverage for Audio-Only Telephone Instead of Telehealth When Necessary

Expanded use of audio-video telehealth services during the pandemic has also made it clear that requiring the use of a video connection inappropriately limits the number of patients who can benefit from telecommunications-supported services in the home, particularly lower-income patients and those residing in rural and other areas with limited internet access. The non-video E/M services which CMS had authorized prior to the pandemic are designed for either very short (5-10 minute) audio-only interactions or for responding to emails, not for extended audio interactions with the patient, so they can address at most a small subset of the situations in which a patient would ordinarily receive a face-to-face office visit. Although CMS asserts that longer E/M services should be delivered through in-person or telehealth visits rather than telephone calls, this fails to distinguish situations in which a patient cannot visit an office in person or use video services. **Consequently, physicians should continue to be able to deliver E/M services by telephone to patients who need a telecommunications-based service in the home but who do not have access to a video connection or cannot successfully use one.**

During the pandemic, CMS is paying for telephone-based E/M services through the use of a separate set of CPT codes that were created and valued in 2008 but not previously authorized for payment under Medicare. The AMA deeply appreciates CMS' recent action to increase the payment rates for the CPT codes for telephone visits up to the rates paid for in-person or telehealth visits, retroactive to March 1, 2020. This interim approach is appropriate during the COVID-19 public health emergency, when physicians must provide E/M services to patients through whatever means are available while maintaining necessary distance and protection for themselves and their patients. In the future, however, there may

need to be a distinction between an E/M service that should be performed through a video connection but cannot, and an E/M service that does not require a video connection and is being performed by audio-only telephone for the convenience of the patient or physician. CMS may conduct a demonstration or a pilot to consider whether it is inappropriate to continue paying for all telephone-based services at the same rate as video-based services or in-person visits after the COVID-19 public health emergency ends, but at a minimum it is important to continue to maintain parity between audio-only visits and audio-video visits when audio-only visits are the only telecommunications modality that is accessible to the patient.

**Modifications to the CPT codes for telephone visits would need to be considered in this new era of telecommunications-enabled health care by the CPT Editorial Panel for future implementation.**

### 3. Coverage of Video and Telephone E/M for Patients Who Could Make an Office Visit

There are many other situations in which a patient could receive high-quality care through telecommunications technology without making a visit to a physician's office. Many Medicare patients who received care in this way during the COVID-19 public health emergency will likely want to continue using the same approach in appropriate circumstances even when they are able to travel to the physician's office. Physicians have also noted many situations in which telecommunications-supported care can be better than traditional office visits. A recent article in [JAMA Neurology](#) indicated that telemedicine and remote physiologic monitoring can be very beneficial for managing patients with a wide range of neurological conditions because observations in clinical settings often provide an unrealistic perspective of the patient's actual functioning. For example, patients with Parkinson's disease may move well when observed by clinicians despite having debilitating freezing of gait at home, and home visits via telemedicine can also provide new insights into a patient's natural environment.

A key assumption underlying the hesitation to expanded telehealth services more broadly in the past is concern that doing so will increase spending. This has not been an issue during the COVID-19 public health emergency in large part because office visits have declined so dramatically with the request for physicians to suspend non-urgent procedures and surgeries; it is not clear what trends for accessing medical services will emerge when the COVID-19 public health emergency ends. Some studies of telehealth services have found that they result in lower overall spending if they are appropriately targeted. We encourage CMS to continue use of telehealth services after the COVID-19 public health emergency. If CMS has concerns about broader use of telehealth services while mitigating concerns about higher spending, we encourage CMS to explore several options including:

- **Require that telehealth services be delivered to established patients according to a predefined plan of care.** Physicians could be paid for telehealth services only if the purpose and frequency of the services are defined in a plan of care agreed to in advance with the patient during an in-person visit. This is similar to the current requirement that home health services be based on a plan of care established by a physician.
- **Allow telecommunications-enabled services for either new or established patients with specific types of symptoms.** For example, telecommunications-based services could be focused on situations in which timely assessment is important and/or where assessment by video is adequate. For urgent symptoms, access to telecommunications-based services could help to avoid more expensive services, such as urgent care visits.
- **Pay for telecommunications-based services that allow the patient to consult with their regular physician and a referral physician at the same time.** Many missed opportunities to improve care occur when patients are referred from their regular physician to a specialist but

there is poor communication between the two physicians and with the patient.

Telecommunications technology provides a means for all three parties to join together at the same time even when they are not physically nearby, thereby improving care coordination.

- **Allow physicians to choose a monthly per-patient payment in place of E/M payments for some or all patients.** This would give physician practices the flexibility to deliver E/M services to patients through whatever mechanism is most appropriate – through in-person visits, telehealth, telephone, or email, delivered by either physicians or other practice staff – and it would both reduce administrative burdens on the physician practice and create a more predictable revenue stream for the practice. This would also be consistent with the Comprehensive Primary Care Plus and Primary Care First models being tested by the Center for Medicare & Medicaid Innovation.

### **Authority to Pay for Telecommunications-Based E/M Services to Patients in Their Homes After the COVID-19 Public Health Emergency**

During the national emergency, CMS has expanded telehealth E/M services to patients in their own homes in response to the Telehealth Services During Certain Emergency Periods Act of 2020, enacted by Congress as part of the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020. The law amended section 1834(m) of the Social Security Act, which requires that Medicare pay the same amounts for a service delivered through telecommunications as it pays for face-to-face services, but only in certain circumstances. The amendment gave the HHS Secretary the authority to extend the requirements of section 1834(m) to services delivered to patients in their own homes.

Although the amendment will no longer be effective after the COVID-19 public health emergency ends, this does not mean that CMS can no longer pay for the E/M services delivered to patients in their own homes. Section 1834(m) does not *require* CMS to pay for delivery of face-to-face office-based E/M services using telecommunications connections to patients in their homes, but it also does not *prohibit* CMS from doing so. In fact, CMS has created payments for a number of telecommunications-based E/M services to patients in their own homes as part of its annual rulemaking for physician payments, and CMS authorized payments for telephone-based E/M services as part of its first Interim Final Rule using its standard statutory authority. Moreover, although section 1834(m) *requires* that payment be the same only for telehealth services authorized under that section, it does not *prohibit* payments from being the same for other telecommunications-based services if CMS deems those payments to be appropriate.

### **Delivery of Telehealth Treatment Services to Patients at Home**

In addition to E/M services, CMS has also implemented policies to facilitate the ability of patients to receive treatment and support services in their own homes during the national emergency:

- Opioid Treatment Programs
  - Patients in Opioid Treatment Programs can receive therapy and counseling by telephone if the patient does not have access to video services.
  - Patients in Opioid Treatment Programs can receive periodic assessments by telehealth or telephone if appropriate/necessary.
- Diabetes Prevention Program
  - Patient enrolled in the Diabetes Prevention Program can participate in virtual sessions.

- End Stage Renal Disease (ESRD)
  - Patients can receive monthly physician care by telehealth (CPT codes 90952-90953, 90959, 90962)
- Home-Based Care Planning, Testing, and Therapy:
  - Care Planning for Patients with Cognitive Impairment (99483)
  - Psychological and Neuropsychological Testing (CPT codes 96130-96133, 96136-96139)
  - Physical Therapy, if delivered by a physician (CPT codes 97161-97164)
  - Occupational Therapy, if delivered by a physician (CPT codes 97165-97618)
  - Speech Therapy, if delivered by a physician (CPT codes 92521-92524, 92507)
  - Other Therapy, if delivered by a physician (CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761)
- Hospital Inpatient/Outpatient Services
  - Hospitals can be paid for delivering outpatient services to patients in their home that would ordinarily be delivered in a hospital outpatient department by designating the patient's home as a "provider-based department."
  - Hospitals can provide inpatient services outside the hospital, including potentially to patients in their homes.
- Home Health and Hospice Services
  - Rural Health Clinics and FQHCs can deliver visiting nurse services to patients in their service area without the need for a certification that home health agency services are not available.
  - Home Health Agencies can deliver services to patients via telecommunications if they are authorized in the physician's plan of care and do not reduce the minimum number of in-person visits required for payment.
  - Patients can be considered homebound and eligible for home health services if they are confined to home either because they are under quarantine or are at risk during an infectious disease outbreak or other circumstances.
  - Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialists can authorize home health care.
  - Hospice agencies can deliver services to patients through telehealth.
- Ambulance Services
  - Patients can be transported by ambulance to a physician's office or clinic if medically necessary.

**Recommendations for Covering Telecommunications-Based Treatment to Patients at Home After the COVID-19 Public Health Emergency**

1. **Ability to Deliver Telecommunications-Based Services to Patients in Their Homes Who Cannot or Should Not Travel to a Provider Site**

The same considerations that made these changes appropriate during the pandemic apply to communicable diseases other than the coronavirus, such as the seasonal flu. In addition, the same considerations that make it appropriate to continue allowing telecommunications-based E/M services to

be provided to patients in their homes after the COVID-19 public health emergency also apply to treatment services. Patients who may have a communicable disease can avoid exposing others to it by receiving treatment in their home instead of coming to a medical practice, opioid treatment program, Rural Health Clinic, FQHC, or hospital, and immunocompromised and other high-risk patients can avoid exposure to communicable illnesses by receiving treatment in their homes through telecommunications technology when appropriate. Although the risk of mortality and morbidity from these other diseases may be lower than from the coronavirus, it is not zero.

In addition, there are many patients for whom travel to a clinic or hospital is either risky or difficult even when there is no pandemic or if steps are taken to protect them from exposure to communicable diseases. Frail patients can experience falls or serious injuries while traveling, and some patients may not have barriers to accessing transportation and thereby fail to receive timely diagnosis or treatment. Allowing these patients to receive treatment at home through telemedicine, or to receive ambulance transportation to the site of service, would not only be beneficial to the patient but could potentially reduce overall Medicare spending by allowing more timely treatment and avoidance of complications and unnecessary trips to an emergency department. We ask CMS to continue the flexibilities that have been put in place and have served both physicians and their patients well during the COVID-19 PHE and encourage CMS to consider how these services can be extended beyond the public health emergency.

## 2. Ability to Deliver Inpatient Care in the Home

A number of other countries pay for delivering services equivalent to hospital inpatient care to patients in their own homes. These “hospital at home” services have been successful in allowing patients with specific types of conditions that qualify for inpatient care to receive services in the home and avoid the risks associated with an inpatient admission. The services are more intensive than can be supported through traditional home health care payments. Although some hospitals in the U.S. have been delivering hospital at home care and some Medicare Advantage plans are paying for it, the service is difficult to sustain or expand without payment support from Medicare because a minimum number of patients need to participate in order for the service to be cost-effective. The Physician-Focused Payment Model Technical Advisory Committee has recommended two different “hospital at home” payment models to HHS, but neither has been implemented to date.

During the pandemic, CMS has allowed hospitals to deliver services in non-traditional settings. It would be desirable to continue this flexibility after the national emergency ends for the subset of patients who meet the criteria used in hospital at home programs in the U.S. and other countries.

### **Supporting Telecommunications-Based Services Outside of the Home**

Prior to the pandemic, CMS paid physicians to deliver office-based E/M services by telehealth if the patient was located in an eligible “originating site.” These originating sites did not include the patient’s home, and as discussed previously, a number of changes have been made during the COVID-19 public health emergency to expand services to patients located in their home. CMS has also made several changes to expand and facilitate delivery of E/M services to patients at originating sites other than their homes during the COVID-19 public health emergency:

- Eligible Patients

- Patients at originating sites located in Metropolitan Statistical Areas and areas not designated as rural health professional shortage areas.
- Amount of Payment
  - Paying office-based physicians the standard office (non-facility) payment amount instead of the facility rate for E/M services when delivered via audio-video telehealth.
  - No facility fee is paid to originating sites unless they are located outside of Metropolitan Statistical Areas or in designated rural health professional shortage areas.
- Types of Services Permitted
  - All services described earlier for delivery in the home
  - Emergency Department visits (CPT codes 99218-99285)
  - Observation care (CPT codes 99217-99230, 99224-99226, 99234-99236)
  - Hospital care (CPT codes 99221-99223, 99238-99239)
  - Nursing facility (CPT codes 99304-99306, 99315-99316)
  - Critical care (CPT codes 99291-99292)
  - Domiciliary care (CPT codes 99327-99328, 99334-99337)
  - Inpatient Neonatal and Pediatric Critical Care (CPT codes 99468-99469, 99471-99472, 99473, 99475-99476)
  - Infant Intensive Care (CPT codes 99477-99480)
  - Group Psychotherapy (CPT code 90853)
  - Radiation Treatment Management (CPT code 77427)
- Frequency of Services Permitted
  - Subsequent inpatient telehealth visits are no longer limited to once every 3 days.
  - Subsequent nursing facility telehealth visits are no longer limited to once every 30 days.
  - Critical care consultation services via telehealth are no longer limited to once per day.

### **Recommendations for Covering Telecommunications-Based Services Outside the Home After the COVID-19 Public Health Emergency**

#### **1. Payment for Telehealth Services by Office-Based Physicians at the Office Payment Rate**

Prior to the national emergency, CMS only paid an office-based physician providing an authorized telehealth service at the lower “facility” rate for the service, rather than the standard office (“non-facility”) amount, even though the law says that the amount should be “equal to the amount that ... would have been paid ... had such service been furnished without the use of a telecommunications system.” Facility rates are approximately 30 percent below the corresponding office rates, which means that if an office-based physician spends an hour on virtual visits rather than in-person visits, practice revenue would be 30 percent lower. This creates a financial penalty for office-based physicians who deliver telehealth services, but not for physicians who practice at hospitals or other facilities.

If the face-to-face service delivered through telehealth is equivalent to a service delivered in person, then the payment amount should be at least equivalent, otherwise the physician practice would lose money by delivering services through telehealth. Indeed, the practice’s costs may increase due to the need to install and maintain the necessary equipment and software to deliver secure video communications. **CMS has**

**recognized the need to pay the same amount for telehealth services as in-person services during the pandemic and should consider whether to continue this after the national emergency ends.**

2. Payment for Telecommunication-Based Services at Home for At-Risk Patients in All Communities

The need to use telehealth services to protect patients from exposure to an infectious disease not only justifies national expansion of telehealth during the pandemic, but it also justifies continued use of telecommunication-based services for patients with communicable diseases other than the coronavirus, such as the seasonal flu. It would be desirable to allow any patient who may have a communicable disease to receive services through telecommunications technology in one facility rather than forcing the patient to travel to a different facility or forcing the physician to travel to the patient's location. Similarly, if there is an outbreak of an infectious disease in a particular community, it would be desirable to minimize exposing vulnerable patients to the disease. Although the risk of mortality and morbidity from these other diseases may be lower than from the coronavirus, it is not zero.

In addition, there are many patients for whom travel to a physician's office is either risky or difficult even when there is no pandemic or if steps are taken to protect them from exposure to communicable diseases. Allowing these patients to obtain one or more specialist consultations in their primary care physician's office, rather than having to arrange for one or more additional trips on additional days, will reduce their risks of travel as well as result in more rapid diagnosis and/or treatment.

Since physicians are billing for telehealth services during the national emergency by appending modifier 95 to the appropriate procedure code, the modifier could continue to be used for telecommunications-based services after the COVID-19 public health emergency, but outside of rural areas, use of the modifier could be limited to patients who have a communicable disease, are at risk of traveling, or live in communities or circumstances in which travel to receive health care is difficult or undesirable. Although CMS expanded telehealth E/M services to patients outside of rural areas in response to the Telehealth Services During Certain Emergency Periods Act of 2020, the termination of the COVID-19 public health emergency does not mean that CMS can no longer pay for telecommunications-based services delivered at originating sites outside of rural areas. Section 1834(m) of the Social Security Act does not *prohibit* CMS from paying for delivery of face-to-face office-based E/M services using telecommunications connections to patients in urban areas, it simply does not *require* CMS to do so. **CMS has created payments for a number of telecommunications-based services to patients as part of its annual physician payment rule, and it could use the same process to continue expanded use of telecommunications services after the COVID-19 public health emergency.**

3. Payment for Expanded Telecommunications-Based Services in Rural and Underserved Communities

An additional rationale for expanding use of telehealth services during the pandemic is the limited availability of physicians to provide services in communities with a high incidence of coronavirus cases. However, many rural and underserved communities had difficulties recruiting and retaining physicians before the pandemic and will likely have even greater difficulties in the future. While it is obviously preferable to have services such as emergency visits, hospitalist services, critical care, etc. performed by physicians who are physically in the same room as the patient, that may not be possible if an emergency or disease outbreak occurs in a community, if a physician becomes ill, or if there is a delay in filling a vacant position. In these situations, the only option may be to have an emergency physician, hospitalist, or critical care specialist located in a distant city determine diagnoses and direct patient treatment. This

option is only feasible if there is a way for the physician at the distant site to be paid adequately for their time and expertise. Although Medicare currently pays for telehealth consultations on patients in the emergency department or during an inpatient admission, the physician providing the consultations cannot be the physician of record. **Consequently, payment for the additional billing codes when the services are delivered in rural areas should continue after the COVID-19 public health emergency ends.**

### **Physician Authorization and Supervision of Patient Services Via Telecommunications**

CMS pays for a variety of patient services that need not be performed directly by a physician, but where a physician is required to supervise the delivery of the service by appropriate staff. In many cases, the physician is required to provide “direct supervision” of the services, which means that the physician must be in the same office suite or facility (but not necessarily in the same room as the patient), and be immediately available to furnish assistance and direction during the performance of the test or procedure. Other services do not require direct supervision by a physician, but they can only be delivered to a patient if a physician authorizes the service following a face-to-face encounter or evaluation of the patient.

During the COVID-19 public health emergency, CMS has made the following changes for these types of services:

- Allowing direct supervision to be performed by audio/video real-time communications when necessary.
- Allowing “general supervision” rather than direct supervision of non-surgical extended duration therapeutic services, such as cardiac and pulmonary rehabilitation.
- Allowing physicians to recertify hospice services based on a telehealth encounter between the hospice physician and patient.
- Allowing supervision of rehabilitation services in an Inpatient Rehabilitation Facility to be performed through telehealth.
- Waiving the requirement for face-to-face evaluation by a physician to determine whether a patient meets the clinical requirements for coverage of a treatment or medical device under a National Coverage Determination or Local Coverage Determination.

### **Recommendations for Modified Supervision Policies After the COVID-19 Public Health Emergency**

One of the rationales for making the changes to the direct supervision requirements during the COVID-19 public health emergency is that the physician who needs to supervise the service may be isolated and unable to perform the supervision in person. In many rural and underserved areas, however, patients may already have limited access to these types of services because the only physician available has to supervise or deliver services at multiple locations and may not be available to supervise services when all patients need them. **In these communities, it would be desirable to allow physicians to perform direct supervision of services by telecommunications when that is the only cost-effective way to allow delivery of the services.**

### **Recommendations for Medicare Advantage Risk Adjustment**

The AMA supports and greatly appreciates the CMS policy announced in a memorandum of April 10, 2020, allowing Medicare Advantage (MA) organizations and other organizations that submit diagnoses for risk adjusted payment to submit diagnoses for risk adjustment that are from telehealth visits when those visits meet all criteria for risk adjustment eligibility, which include being from an allowable inpatient, outpatient, or professional service, and from a face-to-face encounter. This new policy pertains to diagnoses resulting from telehealth services when the services are provided using an interactive audio and video telecommunications system that permits real-time interactive communication. As telehealth services have become much more commonly utilized in patient care, the AMA recommends that CMS continue to allow patient diagnoses, conditions and symptoms documented during telehealth visits to be incorporated into MA plan risk scores after the COVID-19 public health emergency has concluded. Diagnoses that are recorded when patients may be too sick or infectious to come to the physician's office in-person should not be omitted from the Hierarchical Condition Category system.

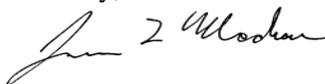
The AMA further recommends that the current allowance for diagnoses to be documented from services using an interactive audio and video telecommunications system be extended to include documentation from audio-only services when the patient is unable to safely participate in an in-person visit or is incapable, due to lack of connectivity, technology or for other reasons, to participate in an audio and video visit. As CMS has recognized in providing coverage for audio-only visits in the Medicare fee-for-service program, failure to properly cover services for patients who do not have the connectivity or technology to participate from home in audio and video telecommunications-based services could exacerbate existing inequities for rural and low-income patients. It would also be inequitable not to account for patient diagnoses that are documented through these audio-only visits, as it would lead to inaccurate risk adjustment for potentially high-risk patient populations.

The AMA further recommends that the allowable documentation from audio-only visits include new diagnoses as well as diagnoses previously documented, as long as these new diagnoses are confirmed by lab tests, connected to diagnostic test results, standardized assessments, or if the patient is actively on medication. For example, hypertension can be documented via remote monitoring and mental health conditions can be diagnosed via standardized assessments conducted during audio-only visits.

### **Conclusion**

The AMA greatly appreciates the opportunity to share our views regarding the proposals, issues, and questions which CMS has raised in this Interim Final Rule. We strongly encourage CMS to explore what should be continued and consider the recommendations we have provided to extend a number of flexibilities beyond the COVID-19 public health emergency. If you have any questions please contact Margaret Garikes, Vice President of Federal Affairs, at [margaret.garikes@ama-assn.org](mailto:margaret.garikes@ama-assn.org) or 202-789-7409.

Sincerely,



James L. Madara, MD