Medicare Telehealth Category Codes

- The Centers for Medicare and Medicaid Services (CMS) has three separate categories of telehealth codes to be considered for permanent coverage under the fee schedule.
- Category 1 codes are services which are similar to professional consultations, office visits, and office psychiatry services that are currently on the Medicare telehealth services list.
- Category 2 codes are services with evidence of clinical benefit if provided as a telehealth service.
- Category 3 codes are services which were added to the Medicare telehealth services list during the public health emergency (PHE), for which there is likely to be clinical benefit when furnished via telehealth, but there is not yet sufficient evidence available to consider the services for permanent addition under the Category 1 or Category 2 criteria.
- The Category 3 codes are added to the Medicare telehealth services list until the end of CY 2023. CMS will collect more information for the potential permanent addition of services to the telehealth list on a Category 1 or Category 2 basis, and for consideration in the CY 2024 PFS rule.
- CPT codes 93797 (Physician or other qualified health care professional (QHP) services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)), and 93798 (Physician or other QHP services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)) and HCPCS codes G0422 (Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session) and G0423 (Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session) are added to the Category 3 Medicare telehealth services list. The definition of QHP includes Nurse Practitioners.
- Information on billing and coding is available on Telehealth.HHS.gov

Mental Health Telehealth

- The 2022 PFS permanently expands telehealth coverage for the diagnoses, evaluation, treatment of mental health disorders. Including the following provisions:
  - The home of a beneficiary is added as an originating site effective for services furnished on or after the first day after the end of the PHE. The definition of home can include temporary lodging. For circumstances where the patient, for privacy or other personal reasons, chooses to travel a short distance from the exact home location during a telehealth service, the service is still considered to be furnished “in the home of an individual.”
  - Geographic restrictions do not apply to these services.
  - A clinician must furnish to the beneficiary an in-person, non-telehealth service within 6 months prior to initiation of mental health services via telehealth. These apply ONLY to telehealth services furnished to a patient in a home originating site.
  - A clinician’s colleague in the same subspecialty in the same group may furnish the in-person, non-telehealth service to the beneficiary if the original practitioner is unavailable.
  - This in-person visit requirement does not apply to telehealth services furnished to a patient with a diagnosed substance use disorder (SUD) (or co-occurring mental health disorder) for the treatment.
  - A subsequent in-person visit will be required every 12 months. An exceptions process will allow for a patient and practitioner consider the risks and burdens of an in-person service.
If it is agreed that these outweigh the benefits, and the clinician documents the basis for that decision in the patient’s medical record, then the in-person visit requirement is not applicable for that 12-month period.

**Audio Only Reimbursement**

- The regulatory definition of “interactive telecommunications system” was revised to permit use of audio-only communications technology for mental health telehealth services under certain conditions.
- An interactive telecommunications system can include interactive, real-time, two-way audio-only technology for telehealth services furnished for the diagnosis, evaluation, or treatment of a mental health disorder when provided to beneficiaries located in their home.
- SUD services are considered mental health services for purposes of the expanded definition of “interactive telecommunications system” to include audio-only services.
- Payment for audio-only services is limited to services furnished by clinicians who have the capacity to furnish two-way, audio/video telehealth services but are providing the mental health services via audio-only communication technology in an instance where the beneficiary is unable to use, or does not have access to two-way, audio/video technology.
- A service-level modifier will be required for use to identify mental health telehealth services furnished to a beneficiary in their home using audio-only communications technology. A clinician must document in patient’s medical record the reason for using audio-only technology to furnish a telehealth service.

**Rural Emergency Hospitals (REHs), Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs)**

- REHs are added as permissible originating sites for telehealth beginning in CY 2023.
- The definition of an RHC and FQHC Mental Health Visit is revised to include visits furnished using interactive, real-time telecommunications technology.
- RHCs and FQHCs will report and be paid for mental health visits furnished via real-time, telecommunication technology in the same way as when these services are furnished in-person.
- RHCs and FQHCs may furnish mental health visits using audio-only interactions in cases where beneficiaries are not capable of, or do not consent to, the use of devices that permit a two-way, audio/video interaction. This aligns with other changes related to coverage for audio-only services.
- A service-level modifier will be implemented for audio-only visits. CMS will track utilization of mental health visits furnished using telecommunication technology at RHCs and FQHCs in order inform future rulemaking.