ConnectedHealthInitiative

SUMMARY –Digital Health Developments in CY2023 Physician Fee Schedule and Quality Payment Program (effective Jan 1, 2023)

Link: https://public-inspection.federalregister.gov/2022-23873.pdf

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Resources:

- CMS announcement: https://www.cms.gov/newsroom/press-releases/hhs-finalizes-physician-payment-rule-strengthening-access-behavioral-health-services-and-whole
- CMS fact sheet for PFS: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-final-rule
- CMS fact sheet for QPP: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2136/2023%20Quality%20Payment%20Program%20Final%20Rule%20Resources.zip
- CMS fact sheet for MSSP: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-final-rule-medicare-shared-savings-program
- Full 2023 PFS and QPP rule: https://www.cms.gov/files/document/cy2023-physician-fee-schedule-final-rule-cms-1770f.pdf

Key Takeaways: CY 2023 Physician Fee Schedule & Quality Payment Program Final Rule

Physician Fee Schedule:

General Payment Policy: CMS' CY2022 PFS conversion factor is 33.0607, a notable decrease of 1.55 from the CY 2022 PFS conversion factor of 34.6062.

Remote Physiologic Monitoring: No proposals were offered by CMS in the draft CY 2023 PFS, and no new policy changes have been made in the final rule. While there are further ways to improve Medicare's support for RPM that CHI has worked to create over the last five years or so, no changes to existing RPM policy are generally helpful.

Remote Therapeutic Monitoring: Consistent with CHI's focused advocacy on RTM over the last two years, CMS has pulled back its proposal to make (1) create four new HCPCS G codes for RTM and (2) make existing RTM CPT codes (98980 and 98981) non-payable. Instead, CMS is retaining, and now permitting general supervision for, all RTM codes (98975, 98976, 98977, 98980, and 98981). Further, CMS is adopting the RUC recommendation of contractor pricing for cognitive behavioral therapy CPT code 98978, and will work with MACs to improve understanding. CMS' changes to RTM policy for CY 2023 are a significant win for the CHI community, and represent the removal of a major bottleneck to RTM uptake in Medicare.

Care Management Codes for Chronic Pain Management (CPM) and General Behavioral Health Integration (GBHI): CMS finalized its proposal for new support for CPM (HCPCS codes G3002 and G3003) and GBHI (HCPCS code G0323). CMS has clarified that CPM HCPCS codes may

be billed for the same patient/in same month as RPM and RTM (when reasonable and necessary). CHI, which supported the extension of support to both areas, and requested clarification on their relationship to RPM and RTM, views these developments as positive for the digital health community.

Medicare Telehealth Services: CMS found that none of the requests received met its Category 1 or Category 2 criteria for permanent addition to the Medicare Telehealth Services List, but did add some to the Category 3 list (services CMS temporarily includes on the Medicare Telehealth Services List on a Category 3 basis will continue to be included through the end of CY 2023, and CMS will revisit this policy should the PHE be extended "well into" CY 2023). Both before CMS and Congress, CHI continues to advocate for the permanence of PHE waivers for Medicare telehealth services.

Virtual Presence/Supervision: CMS is not making the virtual presence/supervision PHE allowances permanent at this time. CMS states that it expects to continue to permit direct supervision through virtual presence through at least the end of CY 2023 under its previously finalized policy which continues through the end of the calendar year in which the PHE ends. The CHI has strongly advocated for a permanent allowance of virtual presence to the maximum extent possible, so the continued allowance through the end of 2023 is helpful, but more work remains to be done.

Artificial Intelligence: CMS commits to continued engagement on AI and related policy proposals for PFS support of AI use. CHI continues to engage with CMS specialists on AI and ways that the Medicare system can evolve to support AI's use, when reasonable and necessary, on a condition-agnostic basis. In the context of this PFS rulemaking, no notable changes from CMS on its AI policy are helpful in that they represent CMS' unwavering commitment to expanded support for AI tools outside of the diabetic retinopathy use case.

Medicare Diabetes Prevention Program: CMS has again refused to provide support for a virtual modality in the MDPP. CHI has continued to note that a lack of progress in the MDPP context is an increasingly glaring problem for Medicare. CMS is, however, removing the Medicare enrollment fee for suppliers, providing larger payments up front to suppliers, and paying more for attendance-only achievements.

Medicare Shared Savings Program:

From both an administrative/quality reporting as well as incentive standpoint, CMS has made various changes to the Medicare Shared Savings Program (MSSP) intended to increase the percentage of people with Medicare in accountable care arrangements and to balance incentives and participation options to serve a dual purpose of sustaining participation by existing ACOs and increasing program growth. In line with this and health equity goals, CMS' MSSP updates, while not digital health specific, appear to continue CMS' incremental support for the flexible uptake of digital health tools and services, both synchronous and asynchronous, in the MSSP.

Quality Payment Program:

In its CY 2023 rule, CMS has continued to develop MIPS Value Pathways (MVPs), expanding the MVP inventory by finalizing 5 new MVPs and revising the 7 previously finalized MVPs to account for the addition of new measures and activities, the removal of measures and activities, and the expansion of an MVP topic that would allow additional specialties to report the MVP. MVPs continue to include the promoting interoperability performance category as a foundational element and incorporate population health claims-based measures, along with relevant measures and activities for the quality, cost, and improvement activities performance categories. CMS is also finalizing several policies for Advanced APMs, for example, permanently establishing the 8% minimum Generally Applicable Nominal Risk standard for Advanced APMs, which is currently set to expire in 2024. CHI views CMS' MSSP and QPP policy updates as moderately helpful to enabling the flexible uptake of a wide range of digital health tools in value-based care, though CHI continues to work with CMS as well as Congress to advance more meaningful policy updates to the same effect.

Remote Therapeutic Monitoring Code Excerpts
CMS-1770-F 754

"In this year's proposed rule, as a means of increasing beneficiary access to RTM services, as well as to more clearly define the services of RTM for qualified nonphysician healthcare practitioners whose Medicare benefit category does not include services provided incident to their own services, we proposed to create two new codes that would expressly facilitate RTM services furnished by qualified nonphysician healthcare professionals who cannot bill under Medicare Part B for services furnished incident to their professional services. These codes would not include "incident to" activities in the PE. Neither of the two proposed new codes included clinical labor inputs in the direct PE. We also proposed to make the current CPT codes 98980 and 98981 codes non-payable by Medicare. We proposed the following two HCPCS G codes:

- **GRTM3** *(Remote therapeutic monitoring treatment assessment services, first 20 minutes furnished personally/directly by a nonphysician qualified health care professional over a calendar month requiring at least one interactive communication with the patient/caregiver during the month).*

- **GRTM4** *(Remote therapeutic monitoring treatment assessment services, additional 20 minutes furnished personally/directly by a nonphysician qualified health care professional over a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month (List separately in addition to code for primary procedure)).*

For CY 2023, we proposed a work RVU of 0.62 for the base code, HCPCS code GRTM3, which is the RUC-recommended work RVU we established for CPT code 98980 in the CY 2022 PFS final rule. Similarly, for the add-on code, HCPCS code GRTM4, we proposed a work RVU of 0.61, which is the RUC-recommended value we established for CPT code 98981. We proposed to remove the clinical labor inputs in the direct PE for both codes, which will facilitate the use of these codes by qualified nonphysician healthcare practitioners who cannot bill under Medicare Part B for services furnished incident to their professional services. See Table 34: Summary of Proposed HCPCS G Codes for Remote Therapeutic Monitoring Services for more detailed information about the codes."

CMS-1770-F 755

"Additionally, we noted that all the RTM codes including proposed HCPCS codes GRTM3 and GRTM4 would be designated as "sometimes therapy" codes, which means that the services could be billed outside a therapy plan of care by physicians and certain NPPs. We noted that when the services described by proposed HCPCS codes GRTM3 and GRTM4 are furnished by PTs, OTs, or SLPs, the services would always need to be furnished under a therapy plan of care. We reminded readers that RTM services that relate to devices specific to therapy services should always be furnished under a therapy plan of care regardless of who provides them. See the Medicare Benefit Policy Manual Chapter 15, Section 230 for more information about the practice of PT, OT, and SLP. Summary of the proposal to develop two HCPCS G codes allowing general supervision of auxiliary personnel. As we described in the proposed rule, since the CY 2022 PFS final rule was published, we have continued to hear concerns from interested

parties that, as for most "incident to" services, the clinical labor activities described in the direct PE of CPT codes 98980 and 98981 must be furnished under the direct supervision of the billing practitioner, which imposes burden on physicians and NPPs who are delivering services to other patients. Thus, for CY 2023, we proposed to create two HCPCS G codes, one base code and one add-on code, that include clinical labor activities (that is, incident to services such as communicating with the patient, resolving technology concerns, reviewing data, updating and modifying care plans, and addressing lack of patient improvement) that can be furnished by auxiliary personnel under general supervision. These two new G codes, GRTM1 and GRTM2, include physician work and direct PE inputs as currently described in CPT codes 98980 and 98981 but allow general supervision of the clinical labor found in the direct PE inputs. See Table 34: Summary of Proposed HCPCS G Codes for Remote Therapeutic Monitoring Services for more detailed information about the codes and use of the codes. We proposed the following two HCPCS G codes:

● **HCPCS code GRTM1** *(Remote therapeutic monitoring treatment management services, physician or NPP professional time over a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes of evaluation and management services).* ● **HCPCS code GRTM2** *(Remote therapeutic monitoring treatment management services, physician or NPP professional time over a calendar month requiring at least one interactive communication with the patient/caregiver over a calendar month; each additional 20 minutes of evaluation and management services during the calendar month (List separately in additional to code for primary procedure).*

For CY 2023, we proposed a work RVU of 0.62 for HCPCS code GRTM1, which reflects the work RVU for CPT code 98980 that we finalized in the CY 2022 PFS final rule. For HCPCS code GRTM2, we proposed a work RVU of 0.61, which is the RUC-recommended value we finalized for the similar CPT code 98981. We proposed the direct PE inputs associated with CPT codes 98980 and 98981 without refinement for HCPCS codes GRTM1 and GRTM2, respectively. As stated previously, we proposed to make the current CPT codes 98980 and 98981 codes non-payable by Medicare."

Medicare Telehealth Services

CMS-1770-F 135

"We received several requests to permanently add various services to the Medicare Telehealth Services List effective for CY 2023. We found that none of the requests we received by the February 10th submission deadline met our Category 1 or Category 2 criteria for permanent addition to the Medicare Telehealth Services List. We also assessed the appropriateness of adding these services to the Medicare Telehealth Services List on a Category 3 basis instead. We did not propose changes to the length of time the services that we temporarily included on a Category 3 basis will remain on the Medicare Telehealth Services List; the services we temporarily included on the Medicare Telehealth Services List on a Category 3 basis will continue to be included through the end of CY 2023. In the CY 2023 PFS proposed rule, we noted that in the event that the PHE extends well into CY 2023, we may consider revising this policy. We proposed to add some services to the Medicare Telehealth Services List on a

Category 3 basis through the end of 2023, some of which we had not previously added to the Medicare Telehealth List during the PHE, but have been added on a subregulatory basis as provided in § 410.78(f) of our regulations. For some of these services, we received information from interested parties suggesting potential clinical benefit. For others, we continue to believe there is sufficient evidence of potential clinical benefit to warrant allowing additional time for interested parties to gather data to support their possible inclusion on the Medicare Telehealth Services List on a Category 1 or 2 basis. The Medicare Telehealth Services List requests for CY 2023 are listed in Table 11. Additionally, the Consolidated Appropriations Act, 2022 (CAA, 2022) (Pub. L. 117-103, March 15, 2022) amended section 1834(m) of the Act to extend a number of flexibilities that are in place during the PHE for COVID-19 for 151 days after the end of the PHE. To align the availability of these services with those flexibilities extended under the Act, we proposed to continue to allow certain telehealth services that would otherwise not be available via telehealth after the expiration of the PHE to remain on the Medicare Telehealth Services List for 151 days after the expiration of the PHE."

CMS-1770-F 168

"…we proposed to create HCPCS codes G0316 (listed as GXXX1 in our proposed rule)(Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99223, 99233, and 99236 for hospital inpatient or observation care evaluation and management services). (Do not report G0316 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 993X0). (Do not report G0316 for any time unit less than 15 minutes)), G0317 (listed as GXXX2 in our proposed rule)(Prolonged nursing facility evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99306, 99310 for nursing facility evaluation and management services). (Do not report G0317 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 993X0,). (Do not report G0317 for any time unit less than 15 minutes)), and G0318 (listed as GXXX3 in our proposed rule)(Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99345, 99350 for home or residence evaluation and management services). (Do not report G0318 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99417). (Do not report G0318 for any time unit less than 15 minutes)) to describe prolonged services associated with certain types of E/M services. These codes will be replacing existing codes that describe prolonged services, specifically inpatient prolonged services CPT codes 99356 (Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient or observation Evaluation and Management service)) and 99357 (Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service;

each additional 30 minutes (List separately in addition to code for prolonged service)). These services are similar to services currently on the Medicare Telehealth Services List, such as CPT codes 99356 and 99357, which were added to the Medicare Telehealth Services List on a Category 1 basis in the CY 2016 rule (80 FR 71060 – 71062), as well as O/O prolonged service HCPCS code G2212 (Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)), which was added to the Medicare Telehealth Services List on a Category 1 basis in the CY 2021 rule (85 FR 84506). Similarly, we believe that these proposed HCPCS G codes will be sufficiently similar to psychiatric diagnostic procedures or O/O visits currently on the Medicare Telehealth Services List to qualify for inclusion on the list on a Category 1 basis. **Therefore, we proposed to add proposed HCPCS codes G0316, G0317, and G0318 to the Medicare Telehealth Services List on a Category 1 basis.**

CMS-1770-F 170

Table 12 lists the services that we are finalizing for addition to the Medicare Telehealth Services List on a Category 3 basis.

TABLE 12: Services Finalized for Addition to the Medicare Telehealth Services List on a Category 3 Basis Through the End of CY 2023

HCPCS	Short Descriptor
90875	Psychophysiological therapy
90901	Biofeedback train any meth
92012	Eye exam estab pat
92014	Eye exam & tx estab pt 1/>vst
92507	Speech/hearing therapy
92550	Tympanometry & reflex thresh
92552	Pure tone audiometry air
92553	Audiometry air & bone
92555	Speech threshold audiometry
92556	Speech audiometry complete
92557	Comprehensive hearing test
92563	Tone decay hearing test
92565	Stenger test pure tone
92567	Tympanometry
92568	Acoustic refl threshold tst
92570	Acoustic immitance testing
92587	Evoked auditory test limited
92588	Evoked auditory tst complete
92601	Cochlear implt f/up exam <7
92625	Tinnitus assessment
92626	Eval aud funcj 1st hour
92627	Eval aud funcj ea addl 15
94005	Home vent mgmt supervision
95970	Alys npgt w/o prgrmg
95983	Alys brn npgt prgrmg 15 min
95984	Alys brn npgt prgrmg addl 15
96105	Assessment of aphasia
96110	Developmental screen w/score
96112	Devel tst phys/qhp 1st hr
96113	Devel tst phys/qhp ea addl
96127	Brief emotional/behav assmt
96170	Hlth bhv ivntj fam wo pt 1st
96171	Hlth bhv ivntj fam w/o pt ea
97129	Ther ivntj 1st 15 min
97130	Ther ivntj ea addl 15 min
97150	Group therapeutic procedures
97151	Bhv id assmt by phys/qhp
97152	Bhv id suprt assmt by 1 tech
97153	Adaptive behavior tx by tech
97154	Grp adapt bhv tx by tech
97155	Adapt behavior tx phys/qhp
97156	Fam adapt bhv tx gdn phy/qhp
97157	Mult fam adapt bhv tx gdn
97158	Grp adapt bhv tx by phy/qhp
97530	Therapeutic activities
97537	Community/work reintegration
97542	Wheelchair mngment training
97763	Orthc/prostc mgmt sbsq enc
98960	Self-mgmt educ & train 1 pt
98961	Self-mgmt educ/train 2-4 pt
98962	Self-mgmt educ/train 5-8 pt
99473	Self-meas bp pt educaj/train
0362T	Bhv id suprt assmt ea 15 min
0373T	Adapt bhv tx ea 15 min

Table 13 lists the services we are finalizing for permanent addition to the Medicare Telehealth Services List on a Category 1 basis."

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TABLE 13: Services Finalized for Permanent Addition to the Medicare Telehealth Services List on a Category 1 Basis

HCPCS	Short Descriptor
G0316	Prolonged inpatient or observation services by physician or other QHP
G0317	Prolonged nursing facility services by physician or other QHP
G0318	Prolonged home or residence services by physician or other QHP
G3002	Chronic pain tx monthly b
G3003	Addition 15m pain mang

General Behavioral Health Integration
CMS-1770-F 445

We received public comments on new coding and payment for general behavioral health integration (BHI) billed by Clinical Psychologists (CPs) and Clinical Social Workers (CSWs). The following is a summary of the comments we received and our responses.

Comment: Many commenters supported our proposed coding and payment for BHI that would recognize psychologists' role in integrated care. The commenters expressed support for recognizing multiple evidence-based models of integrated care, stating this allows psychologists the flexibility required to support the behavioral health needs of the broader community. Other commenters noted that by providing access to behavioral health and health behavior services within primary care settings, BHI services can be particularly helpful in addressing treatment disparities affecting members of racial and ethnic minorities, and those living in underserved and vulnerable communities with inadequate access to mental and behavioral health specialists. A few commenters stated this proposal will provide additional flexibility to primary care practices to design their workflows to best suit the needs of beneficiaries and the care team's capacities. Commenters noted that the establishment of this code will also help to recognize psychologists' role in integrated care and allow psychologists the flexibility required to support the behavioral health needs of the broader community. Other commenters pointed out that a potential advantage of the proposed service code is that HCPCS code GBHI1 appropriately adds additional autonomy to CP and CSW clinical practice, which has the potential to improve job satisfaction and retention. Additionally, commenters stated that allowing for reimbursement of measurement-based care, interprofessional coordination, and care management services may incentivize more CPs and CSWs to participate in the Medicare behavioral health clinician network, which would in turn increase patient access to care management services and behavioral health treatment driven by validated outcome measurements. Commenters also expressed support for allowing these services to be furnished under general supervision.

Response: We thank the commenters for their support and feedback. After consideration of the comments received, we are finalizing this code as proposed. **We note that the code GBHI1**

was a placeholder code and that the final code number will be HCPCS code G0323 (Care management services for behavioral health conditions, at least 20 minutes of clinical psychologist or clinical social worker time, per calendar month. (These services include the following required elements: Initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, coordination with and/or referral to physicians and practitioners who are authorized by Medicare to prescribe medications and furnish E/M services, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team.))

Additionally, we are finalizing our proposal to add HCPCS code G0323 to the list of designated care management services for which we allow general supervision.

Comment: Several commenters stated they agreed with CMS that CPT code 90791 (psychiatric diagnostic evaluation) could appropriately serve as the initiating visit, noting that psychologists and social workers are not able to bill E/M services. A few commenters also requested that CPT code 96156, health behavior assessment and reassessment, also serve as an allowable initiating visit for the newly proposed BHI code. Another commenter urged CMS to broaden the types of visits that can serve as an initiating visit for HCPCS code GBHI1, stating that a visit with a primary care provider or social worker would also be appropriate initial visit types and that limiting the initiating visit to a psychiatric diagnostic evaluation undermines CMS' intent to expand access to wraparound services for individuals receiving mental health services.

Response: We appreciate the commenters suggestion about considering other CPT codes such as 96156 (health behavior assessment, or reassessment), as well as E/M visit codes in addition to CPT code 90791 (psychiatric diagnostic evaluation) to serve as the initiating visit for GBHI1. However, when considering that CPs and CSWs cannot bill the program for E/M visits because they are not licensed by the States to furnish such services and, that the range of health behavior assessment and intervention codes are for billing primarily for physical illnesses rather than psychiatric illnesses, we believe that 90791 is the best option that aligns with the services that CPs and CSWs are authorized to furnish under State law and scope of practice. Accordingly, recognizing a code for which CPs and CSWs can bill as an initiating visit for HCPCS code G0323 offers them greater access and opportunity to furnish integrated care management services.

Comment: A few commenters expressed concern about the medical management of patients in models of care without psychiatric involvement and suggested that the ability to receive immediate advice on prescribing from a psychiatrist or child psychiatrist, as is the case in the existing evidence-based psychiatric CoCM model, should be a mandatory element in all other collaborative care models to ensure patient safety and high-quality patient care. A commenter also pointed to the existing interprofessional consultation codes (CPT codes 99446-99449, 99451-99452) and urged CMS to emphasize the importance of consultative relationships between psychiatrists, primary care physicians, clinical psychologists, and clinical social workers in order to ensure high-quality care.

Response: We thank the commenters for this feedback. In the CY 2017 PFS final rule (81 FR 80236 through 80238), we noted that we created the General BHI code in order to allow

payment for models of integrated care other than the psychiatric collaborative care (CoCM) code. We agree with the comment regarding the importance of consultative relationships between various members of the care team, including psychiatrists, primary care physicians, clinical psychologists, and clinical social workers.

Comment: Many commenters supported the proposed valuation based on a crosswalk to CPT code 99484. A few commenters opposed the proposed valuation, stating that CPT code 99484 describes clinical staff time and is valued assuming the service is performed by a behavioral health care manager and that those assumptions do not accurately reflect the cost when the service is performed by a clinical psychologist or clinical social worker. Another commenter stated they do not believe this proposed value accurately reflects the resource costs involved in furnishing these models of care as the amount of time needed to complete the required elements will take far longer than 20 minutes per month and there is a substantial amount of work that occurs outside of the office. The commenter urged CMS to consider a code that permits multiple billable units of 20 minutes per unit per month capped at 10 units per month to better acknowledge the amount of time it takes to adequately perform the required elements, as well as the critical effort that occurs outside the office visit.

Response: We thank the commenters for this feedback. After consideration of the comments, for CY 2023, we are finalizing the value of HCPCS code G0323 as proposed, however we may consider changes in how this code is valued for future rulemaking. We note that the commenter's suggestion regarding codes that permit multiple billable units of 20 minutes per unit per month is outside of the scope of the proposal. Comment: A few commenters requested that CMS clarify whether HCPCS code GBHI1 may be billed in conjunction with codes describing remote monitoring services. The commenter stated they support the new code but sought clarification on whether HCPCS code GBHI1 could be billed in conjunction with the following services: remote patient monitoring (CPT code 99091), remote physiologic monitoring (CPT codes 99453, 99454, 99457, 99458), or remote therapeutic monitoring (CPT codes 98975, 98976, 98977, 98980, 98981 and as proposed GRTM1/2/3/4) codes.

Response: HCPCS code G0323, and the services describing remote patient monitoring, remote physiologic monitoring, and remote therapeutic monitoring, are distinct types of services, although there may be some overlap in eligible patient populations. There may be some circumstances where it is reasonable and necessary to provide both services in a given month. The BHI codes, including HCPCS code G0323, could be billed for the same patient in the same month as the RPM or RTM services. All applicable requirements for the individual codes must be met, including obtaining informed consent from the beneficiary, for both the remote monitoring and BHI. In this circumstance, appropriate billing in a given month means that time and effort cannot be counted more than once when using BHI codes with RPM or RTM. Billing practitioners should remember that cost sharing applies to each service independently. If all requirements to report each service are met, without time or effort being counted more than once, both may be billed.

Comment: Several commenters requested that CMS clarify that providers of peer support services (also known as peer support specialists and peer recovery specialists) may bill as part of behavioral health integration codes including the new GBHI1 code and collaborative care codes.

Response: While there is no statutory benefit category under Medicare law that authorizes direct billing and payment to peer support specialists for their professional services under the Medicare Part B program, it may be possible for peer support specialists to provide their services in an "incident to" capacity. That is, if a peer support specialist meets the definition of auxiliary personnel as defined under the "incident to" regulations at § 410.26, then they could be eligible to provide behavioral health services within their scope of practice in accordance with State law under the supervision of a physician or certain nonphysician practitioners.

Chronic Pain Management
CMS-1770-F 152-153

Comment: Numerous commenters requested that we add many services that are temporarily available for the PHE to the Medicare Telehealth Services List that are currently on the list on a temporary basis, but that we did not propose to continue on the list to be available as Medicare telehealth services be added on a Category 3 basis.

Response: As discussed above, we identified the services we considered appropriate for addition to the Medicare Telehealth Services List on a Category 3 basis by conducting an internal review to assess those services that may, outside of the circumstances of the PHE, be furnished using the full scope of service elements for their respective service/code via two-way, audio-video communication technology, as though the service were provided in-person. The commenters did not present new information indicating that our analysis was incomplete. Furthermore, because we did not propose to add the services requested by these commenters to the Medicare Telehealth Services List on a Category 3 basis, we found these comments to be outside the scope of the proposed rule.

As discussed in section II.E. of this final rule, we proposed to create two HCPCS G-codes to describe monthly Chronic Pain Management and Treatment services: HCPCS code G3002 (Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing e.g. physical therapy and occupational therapy, complementary and integrative approaches, and community-based care, as appropriate. Required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; first 30 minutes personally provided by physician or other qualified health care professional, per calendar month. (When using G3002, 30 minutes must be met or exceeded.)) and HCPCS code G3003 (Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month (List separately in addition to code for G3002). (When using G3003, 15 minutes must be met or exceeded.)).

CMS-1770-F 361

In consideration of the comments and invoices received, we are finalizing changes to codes G0308, G0309, 0446T, and 0448T. G codes G0308 and G0309 will be deleted effective January 1, 2023. CPT codes 0446T and 0448T will have supply input SD334 valued at $3,000. CPT

code 0446T equipment EQ392 will have equipment minutes equal to 60 minutes * 24 hours * 30 days * 6 months / 1 out of every 5 minutes = 51,840 minutes. (33) Chronic Pain Management and Treatment (CPM) Bundles (HCPCS G3002 and G3003, formerly GYYY1 and GYYY2, respectively)

CMS-1770-F 371-373

Beginning for CY 2023, we proposed to create two HCPCS G-codes to describe monthly CPM services. The codes and descriptors for the proposed G-codes are:

● HCPCS code G3002: Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care, e.g. physical therapy and occupational therapy, and community based care, as appropriate. Required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; first 30 minutes personally provided by physician or other qualified health care professional, per calendar month. (When using G3002, 30 minutes must be met or exceeded.)

● HCPCS code G3003: Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month. (List separately in addition to code for G3002. When using G3003, 15 minutes must be met or exceeded.) We were interested in hearing from commenters regarding our proposed inclusion of “administration of a validated pain assessment rating scale or tool,” as an element of the proposed CPM services, and including it within the descriptor of the proposed HCPCS code G3002. We also solicited comment on whether a repository or list of such tools would be helpful to practitioners delivering CPM services. 32 https://www.medicare.gov/what-medicare-covers/what-part-b-covers.

We proposed to include, as an element of the CPM codes, the development of and/or revisions to a person-centered care plan that included goals, clinical needs, and desired outcomes, as outlined above and maintained by the practitioner furnishing CPM services. We proposed to include health literacy counseling as an element of the CPM codes, because we believe it will enable beneficiaries with chronic pain to make well-informed decisions about their care, increases pain knowledge, and strengthens self-management skills. Health literacy is the degree to which individuals have the ability to find, understand, and use information and services to inform health-related decisions and actions for themselves and others.33 Adequate health literacy may improve the person’s capability to take responsibility for their health, including pain-related health issues such as adherence to treatment regimens and medication administration, and have a positive influence on health outcomes, and health disparities. CMS’ Network of Quality Improvement and Innovation Contractors have used health literacy counseling to improve health counseling34, and health literacy counseling has been used to treat arthritis.35 We noted in the proposed rule that we were interested in hearing from commenters about how pain and health literacy counseling is or may be effectively used as a service element to help beneficiaries with chronic pain make well-informed decisions about their

own care, weigh risks and benefits, make decisions, and take actions that are best for them and their health. For HCPCS code G3002, we proposed to include an initial face-to-face visit of at least 30 minutes, provided by a physician or other qualified health professional, to a beneficiary who has chronic pain, as defined above, or is being diagnosed with chronic pain that has lasted more than 3 months at the time of the initial visit. After consultation with our medical officers, we believe the management of a new patient with chronic pain would involve an initial face-to-face visit of at least 30 minutes due to the complexity involved with the initial assessment. We believe 33 https://health.gov/healthypeople/priority-areas/health-literacy-healthy-people2030#:~:text=Health%20literacy%20is%20a%20central,well-being%20of%20all.%E2%80%9D. 34 https://qi.ipro.org/health-equity/health-literacy/. 35 https://www.ahrq.gov/health-literacy/improve/precautions/1stedition/tool3.html. follow-up or subsequent visits could be non-face to face. HCPCS code G3003 describes an additional 15 minutes of CPM and treatment by a physician or other qualified health care professional, per calendar month (listed separately in addition to G3002). We solicited comment on the appropriateness of the proposed 30-minute duration per calendar month for G3002, and also on the proposed duration and frequency for G3003. We also solicited comment on whether we should consider specifying a longer duration of time for G3002 (for example, one hour - or 45 minutes). Similarly, we solicited comment on whether we should consider specifying a longer duration of time for G3003 (for example, 20-minute increments). We also welcomed comment on our proposal to permit billing of CPM services for beneficiaries who have already been diagnosed with chronic pain, and for people who are being diagnosed with chronic pain during the visit.

CMS-1770-F 384-385

Comment: We received a few comments regarding our proposal to define chronic pain as “persistent or recurrent pain lasting longer than 3 months.” Most commenters agreed with our proposed definition. We received several suggestions related to the specification of 3 months duration, including one month, 90 days, and the addition of “expected to last longer” to our definition. A few others suggested we broaden the definition generally, to ensure that patients with cancer, neuropathic pain, psychogenic pain, and headaches would also benefit from this proposal to create HCPCS codes that describe CPM services, while another commenter congratulated us on using language that it noted was inclusive of all types of pain treatment. One commenter asked us to integrate acute pain and biopsychosocial factors into our definition, and stated that risk indicators of pain are apparent early, potentially limiting robust interventions for the prevention of chronic pain. One commenter opined that our definition of chronic pain was overly broad and did not address the many types of conditions that pain patients may experience. A commenter who agreed with our definition noted that in the International Classification of Disease, 11th edition (ICD-11)39, chronic pain has its own diagnosis, independent of an underlying disease or condition. Still, another commenter, who also agreed with our definition, noted there are ICD-10 diagnostic codes for chronic pain, the G89.xx series. Another commenter agreed that the proposed definition is largely in line with their understanding, adding more context to include, “persistent or recurrent pain without a serious progression or 39 https://icd.who.int/en. exacerbation of an underlying pathologic condition and without tolerability over time.” Another commenter stated that at a high level, they believe the metric of “time” is not the dispositive component to define a chronic pain diagnosis, but the definition should instead take into account a complex series of associated factors like amount of suffering or hindrance of function, and that not all recurrent pain should be considered chronic

pain; instead chronic pain as a diagnosis should be utilized for an individual who does not understand how to manage or live their life with their current, recurring, episodic symptoms.

Response: We appreciate all the commenters' suggestions and observations. As we described in the proposed rule, we reviewed definitions from the Centers for Disease Control and Prevention, the National Institutes of Health, the World Health Organization40, and in the Institute of Medicine's "Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research." For operational ease and consistency with the proposed rule and various sources, we are finalizing as proposed the definition of chronic pain as "persistent or recurrent pain lasting longer than 3 months."
CMS-1770-F 392-393

Comment: Several commenters questioned if clinicians are required to furnish all appropriate elements of the code bundle in each encounter for HCPCS code G3002, including medication management. One commenter stated that we should allow clinicians flexibility for any of the services listed, in any order and over any time period to best manage the person's pain condition(s) and that should allow for omission of certain ones when they are not appropriate or not desired by the patient (for example, medication management, behavioral counseling). Another commenter stated that its stakeholders were concerned that HCPCS code G3002 seems to indicate that all listed services must be completed to bill for the code.

Response: We are clarifying that clinicians will be required to furnish all appropriate elements of the code bundle, but also clarifying that we do not expect that all elements of the code bundle will be appropriate for every patient. Therefore, we can confirm that if medication management is appropriate for a specific patient, then a clinician who bills HCPCS code G3002 will be required to furnish medication management to that patient. As described later in this preamble, we will be finalizing the descriptor of HCPCS code G3002 as follows, with the two modifications shown in italics: Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care, for example, physical therapy and occupational therapy, complementary and integrative approaches, and community-based care, as appropriate. We believe that the services enumerated as examples accurately summarize the components of some elements of key care for people with Medicare living with pain.

Artificial Intelligence
CMS-1770-F 681-683

Comment: Some commenters suggested that the indirect PE allocations for the proposed GRTM codes do not adequately consider the costs of the included use of various computer software, and stated that certain types of software are incorrectly categorized within the PFS; or that the concepts related to software, and devices themselves, should not be addressed as categorical questions specific to RTM. Among these comments, some also expressed concern about the definition of "device" in the RTM codes. One commenter noted that CMS does include specific software costs as supplies within direct PE for other codes, and suggested that this

should be a basis for both reconsidering our GRTM proposals and the current RPM valuations. Other commenters requested more clarity about what specific devices would be appropriate for purposes of RTM services. Many commenters recommended that we separately consider Software as a Medical Device (SaMD), use of artificial intelligence (AI)/machine learning algorithms (ML), and related topics as part of a standalone RFI which would later inform updates to specific codes because the influence of these topics have impacts far beyond the RTM codes alone.

Response: Historically, we have considered most computer software and associated licensing fees to be indirect costs. We refer readers to our previous discussions of this topic in our CY 2019 final rule. (83 FR 59577). Further, we continue to believe that licensing fees that would not be allocated to the use of a specific piece of software/equipment/device for an individual patient for an individual service, are better understood as forms of indirect costs similar to office rent or administrative expenses. Refer to our discussion of this aspect of licensing specifically in our CY 2019 proposed rule (83 FR 35771). As we noted in section II.B. of this final rule (the RFI for Updates to PE Methodology section), interested parties have routinely expressed concerns with allocations of indirect costs, especially for evolving technologies that rely primarily on software and licensing fees with minimal costs in equipment or hardware. We continue to engage in discussions and conduct further research into these topics of AI, SaMD, and other related evolving technologies, to understand ways that we may refine our allocations of cost for software and licensing. We remind readers that in finalizing valuations for the current family of RTM codes, we have considered the RUC-recommended inputs for the codes, and in doing so, considered all elements of RTM described by the AMA in CPT code descriptors. For more detail on this discussion, refer to last year's proposed rule (86 FR 39173). Within the RTM family of codes, the structure of the code set relies on use of device codes (PE only) that are used in conjunction with the remainder of the RTM codes. CPT code 98976 and 98977 are intended to report a 30-day device supply with scheduled recordings or program alert transmission to monitor the respiratory system (98976) or musculoskeletal system (98977). In the CY 2022 PFS final rule, we finalized refinements to payment for the three PE-only RTM codes: CPT code 98975 (Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment); CPT code 98976 (Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days); and CPT code 98977 (Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days).

We refer readers to the publicly available FDA guidance and explanations for medical devices, including explanations of SaMD. As SaMD, as a broader topic, is outside the scope of our proposed policies, we are not issuing any specific guidance. FDA guidance on SaMD is available at https://www.fda.gov/medical-devices/digital-health-center-excellence/softwaremedical-device-samd. Additionally, we refer readers to CPT Appendix S: AI taxonomy for medical services & procedures (available at https://www.ama-assn.org/practicemanagement/cpt/cpt-appendix-s-ai-taxonomy-medical-services-procedures). We note that our proposals do not include a specific RTM device list, nor specific examples of RTM devices that would be appropriate for use when furnishing RTM services. We believe that a possible unintended consequence of express reference to a device, or list of devices, may

include a preference or shift toward use of one device or class of device simply because of its inclusion on a list. We believe that the pace of innovation and evidence-based clinical decision-making inherent to use of the devices that support furnishing RTM services calls for medical and behavioral health professionals, groups of behavioral health and medical professionals, or professional societies, each to study carefully the needs of the populations under their care, and identify guidelines that shape selection and use of any specific device in clinical practice.

Virtual Presence/Supervision
CMS-1770-F170-178

We further proposed that, beginning January 1, 2023, a physician or other qualified health care practitioner billing for telehealth services furnished using audio-only communications technology shall append CPT modifier “93” (Synchronous Telemedicine Service Rendered Via T not be able to bill using the POS code fields, as the CMS-1450 (UB-04) institutional claim form does not permit use of POS code fields. The commenter noted that this may have been an oversight.

Response: We thank commenters for offering feedback on technical issues associated with our proposed policies for use of modifiers that allow claims processing and billing for professional services under Part B, which includes Medicare telehealth services. We reiterate that 151 days after the end of the PHE, Medicare telehealth services will once again be subject to the statutory requirements in section 1834(m) of the Act. As such, only physicians and the practitioners specified in section 1834(m)(4)(E) of the Act will be able to serve as distant site practitioners to furnish and bill for Medicare telehealth services, and those services would be billed on the professional, not the institutional, claim form. Thus, beginning on the 152nd day after the PHE ends, only certain types of practitioners will be permitted to furnish and bill for Medicare telehealth services, and none of those practitioners would be “facility-based providers.”

Comment: Many commenters requested that we continue to allow for services that would have been furnished in a non-facility setting outside of the circumstances of the PHE to be billed at the non-facility rate for telehealth services following the end of the PHE. Commenters stated that they were concerned that reverting to the facility rate for telehealth services will lead practitioners to offer telehealth less frequently and inhibit access. According to these commenters, many patients in rural and underserved areas are now able to access mental health services, often for the first time. Many commenters emphasized their concerns that mental health services would be particularly impacted, as there is already high demand for these services and relatively low numbers of available practitioners. One commenter requested that we maintain payment at the non-facility-based rate for telehealth services furnished in office settings through the end of 2023, stating that changing payment to the facility rate would result in a nearly 30 percent cut for some services, which they believed will harm access to telehealth services. Some commenters, including MedPAC, expressed concern that payment at the facility rate will create the unintended effects of shifting beneficiaries toward both higher intensity and volume of virtual care modalities that would be inappropriate for beneficiaries. In MedPAC’s comment, they offered their March 2022 MedPAC Report to Congress (https://www.medpac.gov/wpcontent/uploads/2022/03/Mar22_MedPAC_ReportToCongress_v2_SEC.pdf), which noted that Medicare spending can be sensitive to shifts in the site of care, and that the negative impact of the pandemic on E/M services may have been more significant in 2020 were it not for Medicare telehealth. Some commenters, including MedPAC, provided examples and explanations that raised questions about uncertainty of clinical benefit and

possible overpayment for Medicare telehealth and offered evidence that many patients who used telehealth during the PHE would prefer inperson visits, once it is safe to do so.

Response: We acknowledge the commenters' concerns. We note that there are many nuances to this issue, and we seek to minimize confusion and practitioner burden during the period immediately following the PHE. We are concerned about issues raised by commenters related to payment stability in the post-PHE period, as care delivery will potentially be transitioning between virtual, hybrid, and in-person models. As such, we are finalizing that we will continue to allow for payment be made for Medicare telehealth services at the place of service for telehealth services that ordinarily would have been paid under the PFS, if the services were furnished in-person, through the latter of the end of the of CY 2023 or the end of the calendar year in which the PHE ends. For those services furnished in a facility as an originating site, POS 02 may be used, and the corresponding facility fee can be billed, per pre-PHE policy, beginning the 152nd day after the end of the PHE. Comment: Some commenters expressed concern that our proposals to transition to the use of new modifiers would create confusion and administrative burden, without sufficient time to allow for the sufficient training education of clinical and administrative staff to implement new billing practices. Others supported immediate implementation.

Response: We appreciate commenters' feedback. We believe that the use of these modifiers following the end of the PHE, when implemented, will enable practitioners to better report (and allow CMS to better understand) how they practice and when certain services are furnished via telehealth. We do not agree that these modifiers/codes would cause confusion; rather, they will provide clarity. Moreover, education regarding these modifiers/codes will be made available, as necessary. After consideration of public comments, we are finalizing our proposals, with some modifications regarding the use of telehealth modifiers/codes and the payment rates. Practitioners will continue to bill with modifier 95 along with the POS code corresponding to where the service would have been furnished in-person through the later of the end of the year in which the PHE ends or CY 2023. As stated earlier, for those services furnished in a facility as an originating site, POS 02 may be used, and the corresponding facility fee can be billed, per pre-PHE policy, beginning the 152nd day after the end of the PHE.

Additionally, effective on and after January 1, 2023, CPT modifier "93" can be appended to claim lines, as appropriate, for services furnished using audio-only communications technology in accordance with our regulation at § 410.78(a)(3). All providers, including RHCs, FQHCs, and OTPs must append Medicare modifier "FQ" (Medicare telehealth service was furnished using audio-only communication technology) for allowable audio-only services furnished in those settings. However, consistent with our proposal for audio-only services furnished under the PFS, we are also finalizing to require all providers including RHCs, FQHCs, and OTPs to use modifier "93" when billing for eligible mental health services furnished via audio-only telecommunications technology. Providers have the option to use the "FQ" or the 93" modifiers or both where appropriate and true, since they are identical in meaning. Supervising practitioners continue to be required to append the "FR" modifier on any applicable telehealth claim when they provide direct supervision for a service using virtual presence through real-time, audio and video telecommunications technology. In response to the issues raised by commenters related to payment stability in the post PHE period, we are reiterating that we are finalizing that, for Medicare telehealth services, we will continue to maintain payment at the POS had the service been furnished in-person, and this will allow payments to continue to be made at the non-facility-based rate for Medicare telehealth services through the latter of the end of CY

2023 or the end of the calendar year in which the PHE ends. 2. Other Non-Face-to-Face Services Involving Communications Technology under the PFS a. Expiration of PHE Flexibilities for Direct Supervision Requirements Under Medicare Part B, certain types of services, including diagnostic tests, services incident to physicians' or practitioners' professional services, and other services, are required to be furnished under specific minimum levels of supervision by a physician or practitioner. For professional services furnished incident to the services of the billing physician or practitioner (see § 410.26) and many diagnostic tests (see § 410.32), direct supervision is required. Additionally, for pulmonary rehabilitation services (see § 410.47) and for cardiac rehabilitation and intensive cardiac rehabilitation services (see § 410.49), direct supervision of a physician is required (see also § 410.27(a)(1)(iv)(D) for hospital outpatient services).

Outside the circumstances of the PHE, direct supervision requires the immediate availability of the supervising physician or other practitioner, but the professional need not be present in the same room during the service. We have established this "immediate availability" requirement to mean in-person, physical, not virtual, availability (please see the April 6, 2020 IFC (85 FR 19245) and the CY 2022 PFS final rule (86 FR 65062)). Through the March 31, 2020 COVID-19 IFC, we changed the definition of "direct supervision" during the PHE for COVID-19 (85 FR 19245 through 19246) as it pertains to supervision of diagnostic tests, physicians' services, and some hospital outpatient services, to allow the supervising professional to be immediately available through virtual presence using real-time audio/video technology, instead of requiring their physical presence. In the CY 2021 PFS final rule (85 FR 84538 through 84540), we finalized continuation of this policy through the later of the end of the calendar year in which the PHE for COVID-19 ends or December 31, 2021. In the March 31, 2020 IFC (85 FR 19246) and in our CY 2022 PFS final rule (see 85 FR 65063), we also noted that the temporary exception to allow immediate availability for direct supervision through virtual presence facilitates the provision of telehealth services by clinical staff of physicians and other practitioners' incident to their own professional services. This is especially relevant for services such as physical therapy, occupational therapy, and speech language pathology services, since those practitioners can only bill Medicare for telehealth services under Medicare telehealth waivers that are effective only during the PHE for COVID-19 (based on the emergency waiver authority established in section 1135(b)(8) of the Act), and for 151 days after the final day of the PHE for COVID-19, as specified by provisions of the CAA, 2022. We noted that sections 1834(m)(4)(D) and (E) of the Act specify the types of clinicians who may furnish and bill for Medicare telehealth services. Outside of the PHE and the 151-day period after the PHE ends, such clinicians include only physicians as defined in section 1861(r) of the Act and practitioners described in section 1842(b)(18)(C) of the Act. We remind readers that after December 31 of the year in which the PHE ends, the pre-PHE rules for direct supervision at § 410.32(b)(3)(ii) would apply. As noted in the CY 2022 PFS final rule (86 FR 65062), this means the temporary exception to allow immediate availability for direct supervision through virtual presence, which facilitates the provision of telehealth services by clinical staff of physicians and other practitioners incident to their professional services, will no longer apply. As such, after the end of the calendar year in which the PHE ends, Medicare telehealth services can no longer be performed by clinical staff incident to the professional services of the billing physician or practitioner who directly supervises the service through their virtual presence. While we did not propose to make the temporary exception to allow immediate availability for direct supervision through virtual presence permanent, as with last year's rulemaking (86 FR 39149 through 50), we continue to solicit information on whether the flexibility to meet the immediate availability requirement for direct supervision through the use of real-time, audio/video technology should potentially be

made permanent. We also solicited comment regarding the possibility of permanently allowing immediate availability for direct supervision through virtual presence using real-time, audio/video technology for only a subset of services, as we recognize that it may be inappropriate to allow direct supervision without physical presence for some services due to potential concerns over patient safety. As discussed in last year's final rule (86 FR 65063), and based on gaps in the currently available evidence, we are in need of more information as we consider whether to make permanent a temporary exception to our direct supervision policy. We received public comments on expiration of PHE flexibilities for direct supervision requirements. The following is a summary of the comments we received and our responses.

Comment: Commenters offered a variety of perspectives and suggestions for possible ways that CMS could modify the direct supervision requirements. Many commenters that recommended a permanent change to direct supervision rules supported their feedback by raising issues such as health care workforce shortages and concern with clinician burnout that would possibly occur from implementing the pre-PHE direct supervision requirements. Others noted that certain NPPs, such as PAs, and advanced practice nurse practitioners are authorized under state law statutory requirements in many states to practice independently under virtual supervision of a physician. Still others based their recommendations that we establish a permanent virtual direct supervision on a specialty-level or service-level analysis. For example, commenters identified a certain specialty or family of codes that would be typically low-risk for patient safety issues, and indicated that those specialties or services would be appropriate candidates for a permanent virtual direct supervision policy. Some commenters mentioned that virtual direct supervision may also reduce the burden and overhead costs associated with enrolling their practitioners through multiple MAC jurisdictions.

Response: We continue to gather information on this topic, and we appreciate the information provided by commenters. We remind readers that, as described earlier in this section, our current temporary policy to permit immediate availability for purposes of direct supervision through the virtual presence of the billing clinician was adopted to address the circumstances of the PHE for COVID-19. We believe allowing additional time to collect information and evidence for direct supervision through virtual presence will help us to better understand the potential circumstances in which this flexibility could be appropriate permanently, outside of the PHE for COVID-19. We realize that direct supervision through virtual presence is probably not something that we would have contemplated without our experience in implementing this policy during the PHE, and we hope to learn more about this in the near future. We also note that the Secretary renewed the PHE for the COVID-19 pandemic for a 90-day period beginning on October 13, 2022,9 which means that the PHE would expire on January 11, 2023, absent any further action by the Secretary regarding the PHE for COVID-19. As such, we expect to continue to permit direct supervision through virtual presence through at least the end of CY 2023 under our previously finalized policy which, as specified in § 410.32(a)(3)(ii), continues through the end of the calendar year in which the PHE ends. With that said, CMS will consider the comments received from the proposed rule for potential future PFS rulemaking.

CMS-1770-F 407-408

Comment: Many commenters asked us to clarify if the proposed CPM services would be available for billing/reporting in conjunction with remote patient monitoring (CPT code 99091), remote physiologic monitoring (CPT codes 99453, 99454, 9457, 99458), or remote therapeutic monitoring (CPT codes 98975, 98976, 98977, 98980, 98981 and as proposed GRTM1/2/3/4 codes. One commenter also requested clarification surrounding what virtual presence/remote

supervision is permitted, who can order these services, what documentation is required, and whether billing is permitted for individual services in addition to the management components of CPM. A commenter noted that patients with chronic pain may also benefit from remote therapy monitoring to monitor their pain levels, medication adherence, and response to prescribed therapy regimens.

Response: HCPCS codes G3002 and G3003, and the services describing remote patient monitoring, remote physiologic monitoring, and remote therapeutic monitoring, are distinct types of services, although there may be some overlap in eligible patient populations. There may be some circumstances where it is reasonable and necessary to provide both services in a given month. Thus, HCPCS codes G3002 and G3003, could be billed for the same patient in the same month as the Remote Physiologic Monitoring (RPM) or Remote Therapeutic Monitoring (RTM) services. All applicable requirements for the individual codes must be met, per the elements of each individual code, for both types of remote monitoring and CPM services. Additionally, the time and effort cannot be counted more than once when billing CPM codes concurrently with RPM or RTM. Billing practitioners should remember that cost sharing applies to each service independently. If all requirements to report each service are met, without time or effort being counted more than once, then CPM and RPM or RTM may be billed.