



Medicare Hospital Version

KEY CONCEPTS OUTLINE

Module 10: Mental Health Services

- I. Partial Hospitalization Programs (PHP) and Intensive Outpatient Programs (IOP)
 - A. A PHP or IOP are distinct, organized programs to provide comprehensive, structured, multimodal treatment for patients who have an acute mental illness, including substance use disorder (SUD), which severely interferes with multiple areas of daily life, including social, vocational, and /or educational functioning. <Medicare Benefit Policy Manual, Chapter 6 § 70.1 B>
 - B. Eligible Patients
 1. Patients eligible for PHP must require 20 hours of treatment per week and would otherwise require inpatient psychiatric care without the program. <Medicare Benefit Policy Manual, Chapter 6 §§ 70.1 B, 70.3 B.1.>
 2. Patients eligible for IOP must require 9 hours of treatment per week but need not be provided in lieu of inpatient hospitalization. <Medicare Benefit Policy Manual, Chapter 6 §§ 70.1 B, 70.4 B.1.>
 3. Patients eligible for PHP or IOP must be able to cognitively and emotionally participate in the active treatment process and be capable of tolerating the intensity of a PHP or IOP program. <Medicare Benefit Policy Manual, Chapter 6 § 70.3 B.1, 70.4 B.1>
 4. Patients must have an adequate support system to sustain/maintain themselves outside the PHP and must not be a danger to themselves or others. <Medicare Benefit Policy Manual, Chapter 6 § 70.3 B.3, 70.4 B.3>
 5. Patients admitted to PHP or IOP generally have an acute onset or decompensation of a covered Axis I mental disorder as defined in the DSM, which severely interferes with multiple areas of daily life. Examples include eating disorders, mood disorders, psychotic disorders, and substance use disorders. <Medicare Benefit Policy Manual, Chapter 6 § 70.3 B.3, 70.4 B.3>
 - C. Documentation Requirements

1. An individualized treatment plan for PHP or IOP, prescribed and signed by the physician, identifying the treatment goals, describing a coordination of services structured to meet the needs of the patient, and reflecting a multidisciplinary team approach. <Medicare Benefit Policy Manual, Chapter 6 § 70.3 B.5, 70.4 B.5>
2. Progress notes to document PHP or IOP services provided, including a description of the nature of the treatment, the patient's response to therapeutic interventions and its relationship to the goals in the treatment plan. <Medicare Benefit Policy Manual, Chapter 6 § 70.3 B.5, 70.4 B.5>
3. Physician Certification for PHP services:
 - a. The initial physician certification upon admission must specify:
 - i. The patient would require inpatient psychiatric hospitalization if PHP were not provided;
 - ii. The patient requires at least 20 hours of services per week;
 - iii. The diagnosis and clinical need for PHP services. <Medicare Benefit Policy Manual, Chapter 6 § 70.3 B.5>
 - b. Recertification for PHP must be made by the 18th calendar day following admission and then no less frequently than every 30 days. <Medicare Benefit Policy Manual, Chapter 6 § 70.3 B.5>
 - i. The recertification must be made by a physician who is treating the patient and has knowledge of the patient's response to treatment; and
 - ii. The recertification should specify:
 - a) The patient would otherwise require inpatient psychiatric care in the absence of continued PHP;
 - b) The patient's response to therapeutic interventions;
 - c) The patient's psychiatric symptoms that continue to place the patient at risk of hospitalization; and
 - d) Treatment goals to facilitate discharge from PHP. <Medicare Benefit Policy Manual, Chapter 6 § 70.3 B.5>
4. Physician Certification for IOP
 - a. The initial physician certification upon admission must specify:

- i. The patient requires at least 9 hours of services per week;
 - ii. The diagnosis and clinical need for IOP services. <Medicare Benefit Policy Manual, Chapter 6 § 70.4 B.5>
 - b. Recertification for IOP is required no less frequently than every 60 days. <Medicare Benefit Policy Manual, Chapter 6 § 70.4 B.5>
 - i. The recertification must be made by a physician who is treating the patient and has knowledge of the patient's response to treatment; and
 - ii. The recertification should specify:
 - a) The patient's response to therapeutic interventions;
 - b) The patient's psychiatric symptoms that continue to require intensive treatment; and
 - c) Treatment goals to facilitate discharge from IOP. <Medicare Benefit Policy Manual, Chapter 6 § 70.4 B.5>
- D. Covered Services under PHP or IOP:
1. Individual or group psychotherapy with physicians, psychologists, or other mental health professionals;
 2. Occupational therapy;
 3. Services, including principal illness navigation, of other staff trained to work with psychiatric patients, including patients with SUD;
 4. Drugs and biologicals that are not self-administered;
 5. Individualized activity therapy that is not primarily recreational or diversionary;
 6. Family counseling services, including for caregivers;
 7. Patient education and patient and caregiver training closely and clearly related to their psychiatric condition;
 8. Medically necessary diagnostic services related to mental health treatment. <Medicare Benefit Policy Manual, Chapter 6 70.3 B.2, 70.4 B.2>
 9. Covered services must be reasonably expected to improve or maintain the individual's condition and functional level and prevent relapse or hospitalization. <Medicare Benefit Policy Manual, Chapter 6 § 70.3 B.3, 70.4 B.3>

E. Coding and Billing for Covered PHP or IOP services

1. Condition Codes

- a. The claim must be reported with condition code 41 for PHP services.
<Medicare Claims Processing Manual, Chapter 4 § 170, 260.1>
- b. The claim must be reported with condition code 92 for IOP services.
<Medicare Claims Processing Manual, Chapter 4 § 170, 261.1>

2. HCPCS Codes

- a. CMS published a list of HCPCS codes that represent PHP or IOP covered services in Table 98 of the CY2024 OPSS Final Rule, included in the materials behind the outline.
 - i. The list of PHP and IOP services is also available in the IOCE Quarterly Data Files, Report-Table folder, Data_HCPCS, column BH “PH_SERVICE”, and column DU “IOP_SERVICE”.
- b. When non-PHP or IOP mental health services or electroconvulsive therapy (ECT) are provided on the same day as PHP or IOP services, the non-PHP or IOP mental health services or ECT should be reported on the PHP or IOP claim. <Medicare Claims Processing Manual, Chapter 4 § 170>

3. PHP and IOP Primary Service

- a. For PHP or IOP services to be paid, a PHP or IOP Primary service must be reported on that date. <IOCE Specifications, Section 6.5.1.1 (Supplement)>
- b. A PHP or IOP claim will be returned to the provider if a PHP or IOP Primary code, respectively, is not reported on the claim. <IOCE Specification, Section 8.2, Edit 190 and 191 (Supplement)>
- c. CMS published a list of the PHP and IOP Primary codes in Table 99 of the CY2024 OPSS Final Rule, included in the materials behind the outline.
 - i. The list of PHP and IOP Primary codes is also available in the IOCE Quarterly Data Files, Report-Table folder, Data_HCPCS, column BG “PH_PRIMARY”, and Column DT “IOP_PRIMARY”.

4. Weekly Editing for PHP and IOP Claims

- a. If a claim is submitted with fewer than 20 hours for PHP or 9 hours for IOP, the claim triggers an informational only line item rejection that does not impact payment on the claim. <IOCE Specifications, Section 6.5.1.3, 6.5.4.3, Section 8.2 Edit 95 and 129 (Supplement)>

F. Payment for PHP and IOP

1. PHP and IOP are paid at two levels depending on the number of services reported on the day.
 - a. If three or less PHP or IOP services are reported on a single date of service, and at least one PHP or IOP Primary code is reported on that date, the Level I PHP or IOP Composite APC is paid. <IOCE Specifications Section 6.5.4.1, 6.5.1.1 (Supplement); Medicare Claims Processing Manual, Chapter 4 § 261.1 F, 260.1 F>
 - i. Level I IOP (APC 5861) and Level I PHP (APC 5863) have the same payment rate. <OPPS Addendum A>
 - b. If four or more PHP or IOP services are reported on a single date of service, and at least one PHP or IOP Primary code is reported on that date, the level II PHP or IOP Composite APC is paid. <IOCE Specifications, Section 6.5.4.1, 6.5.1.1 (Supplement); Medicare Claims Processing Manual, Chapter 4 § 261.1 F, 260.1 F>
 - i. Level II IOP (APC 5862) and Level II PHP (APC 5864) have the same payment rate. <OPPS Addendum A>

II. Remote Mental Health Services

- A. Remote mental health (RMH) services are mental health services provided by hospital staff to patients in their homes <87 Fed. Reg. 72015 >
 1. RMH services include services for the diagnosis, evaluation, or treatment of a mental health or substance use disorder. <87 Fed. Reg. 72015>
 2. Hospital staff providing mental health services to patients in their homes do not need to be physically located in the hospital. <87 Fed. Reg. 72017>
 3. RMH services are reported by timed (15-29 minutes, 30-60 minutes, each additional 15 minutes) codes C7900-C7902, respectively, or an untimed group therapy code, C7903. <88 Fed. Reg. 81870-874>
- B. Communication Technology

1. Hospital staff must have the capability to use an interactive telecommunications system that includes two-way, real-time, interactive audio and video communications. <87 Fed. Reg. 72018-19>
2. Real-time audio-only communication technology may be used if the beneficiary is not capable of or does not consent to two-way audio and video technology. <87 Fed. Reg. 72018-19>

C. Periodic In-Person Visit Requirements

1. There must be an in-person service within 6 months prior to the first remote mental health service. <87 Fed. Reg. 72017-18>
2. There must be an in-person service within 12 months of each RMH service furnished by hospital clinical staff. <87 Fed. Reg. 72017-18>

The in-person visit requirement was delayed until January 1, 2025, by the Consolidated Appropriations Act (CAA) of 2023. Previously, CMS clarified in the CY2023 OPPS Final Rule that the requirement for an in-person visit 6 months prior to the first remote mental health visit did not apply to patients who started their remote visits during a prior delay of the in-person visit requirements. Presumably, this would apply to the delay through January of 2025, however, CMS did not specifically address this in their discussion of the delay in the CY2024 OPPS Final Rule. <87 Fed. Reg. 72018; 88 Fed. Reg. 81874>

- a. An in-person visit is not required within 12 months of the RMH services if the hospital clinical staff and the beneficiary agree that the risks and burdens of an in-person service outweighs the benefits of the in-person visit. <87 Fed. Reg. 72017-18>
- b. Documentation requirements for in-person exception:
 - i. A clear justification documented in the medical record, including the clinician's professional judgment that:
 - a) The patient is clinically stable; and/or
 - b) An in-person visit:
 - 1) Has the risk of worsening the person's condition,
 - 2) Creating undue hardship on the person or their family, or

3) Result in disengaging with care that has been effective in managing the person's illness;

- ii. The patient has a regular source of general medical care; and
- iii. The patient has the ability to obtain any needed point of care testing, including vital sign monitoring and laboratory studies. <87 Fed. Reg. 72017>

D. Remote Mental Health Services Provided with PHP or IOP Services

- 1. RMH services are not considered PHP or IOP services because PHP and IOP services may not be provided in the patient's home by statute. <87 Fed. Reg. 72000; 88 Fed. Reg. 81812-813>
- 2. RMH services may be provided to a patient in PHP or IOP, if documentation continues to support the patient's eligibility for PHP or IOP, all other program requirements are met, and the physician updates the plan of care. <87 Fed. Reg. 72001-002; 88 Fed. Reg. 81813>

III. Payment for non-PHP and non-IOP Mental Health Services

A. With Daily Mental Health Services Composite APC

- 1. If multiple mental health services are provided on a single date of service and the total payment would exceed the amount payable for Level II PHP, payment is capped at the Mental Health Services Composite APC 8010 (equal to Level II PHP). <IOCE Specifications, Section 6.5.3, 6.5.1.6 (Supplement)>
 - a. The APC 8010 will be assigned to one line and all other mental health services are packaged. <IOCE Specifications, Section 6.5.3 (Supplement)>
 - b. Mental health services included in the Daily Mental Health Composite cap have a status indicator Q3. A list of all HCPCS codes that have status indicator Q3 (i.e., codes that are part of composite APCs) is included behind the outline of the OPPS Payment module.
- 2. Remote Mental Health Services and the Daily Mental Health Cap
 - a. RMH services have a status indicator S, rather than Q3, but are counted toward the Daily Mental Health cap. <OPPS Addendum B; IOCE Specifications, Sections 6.5.3.2 (Supplement)>
 - b. If the Mental Health Services Composite APC is triggered, any RMH services will be packaged to the composite APC 8010 and not paid separately. <IOCE Specifications, Sections 6.5.3.2 (Supplement)>

B. Non-PHP and IOP Mental Health Services Reported on PHP or IOP Claims

1. Mental health services that are not part of a PHP or IOP may be billed separately on PHP or IOP claims. <IOCE Specifications, Section 6.5.1.2.1 (Supplement)>
2. If a non-PHP or non-IOP mental health services are billed on the same day as a Level I or II PHP or IOP Composite APC is paid, the mental health services are packaged into the payment for the PHP or IOP. <IOCE Specifications, Section 6.5.1.2.1, 6.5.1.2.3 (Flowchart), 6.5.4.2>
3. If non-PHP or non-IOP mental health services are billed on a day with no Level I or Level II PHP or IOP APC payable, the mental health services process for OPPS payment, subject to the Daily Mental Health cap. <IOCE Specifications, Section 6.5.1.2.1, 6.5.1.2.3 (Flowchart), 6.5.4.2>

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TABLE 98: FINAL HCPCS APPLICABLE FOR PHP AND IOP

HCPCS/CPT	Short Descriptor	Final Action
90785	Psytx complex interactive	
90791	Psych diagnostic evaluation	
90792	Psych diag eval w/med srvc	
90832	Psytx pt&/family 30 minutes	
90833	Psytx pt&/fam w/e&m 30 min	
90834	Psytx pt&/family 45 minutes	
90836	Psytx pt&/fam w/e&m 45 min	
90837	Psytx pt&/family 60 minutes	
90838	Psytx pt&/fam w/e&m 60 min	
90839	Psytx crisis initial 60 min	Add
90840	Psytx crisis ea addl 30 min	Add
90845	Psychoanalysis	
90846	Family psytx w/o patient	
90847	Family psytx w/patient	
90849	Multiple family group psytx	Add
90853	Group psychotherapy	Add
90865	Narcosynthesis	Remove
90880	Hypnotherapy	
90899	Psychiatric service/therapy	Add
96112	Devel tst phys/qhp 1st hr	Add
96116	Neurobehavioral status exam	
96130	Psychological testing evaluation by physician/qualified health care professional; first hour	
96131	Psychological testing evaluation by physician/qualified health care professional; each additional hour	
96132	Neuropsychological testing evaluation by physician/qualified health care professional; first hour	
96133	Neuropsychological testing evaluation by physician/qualified health care professional; each additional hour	
96136	Psychological/neuropsychological testing by physician/qualified health care professional; first 30 minutes	
96137	Psychological/neuropsychological testing by physician/qualified health care professional; each additional 30 minutes	
96138	Psychological/neuropsychological testing by technician; first 30 minutes	
96139	Psychological/neuropsychological testing by technician; each additional 30 minutes	
96146	Psychological/neuropsychological testing; automated result only	
96156	Hlth bhv assmt/reassessment	Add
96158	Hlth bhv ivntj indiv 1st 30	Add
96161	Admin of caregiver-focused hlth risk assmt for ben of patient	Add
96164	Hlth bhv ivntj grp 1st 30	Add
96167	Hlth bhv ivntj fam 1st 30	Add

96202	Multiple-family group behavior management/modification training for parent(s) guardian(s) caregiver(s) with a mental or physical health diagnosis up to 60 minutes	Add
96203	Multiple-family group behavior management/modification training for parent(s) guardian(s) caregiver(s) with a mental or physical health diagnosis each addtl 15 minutes	Add
97151	Bhv id assmt by phys/qhp	Add
97152	Bhv id suprt assmt by 1 tech	Add
97153	Adaptive behavior tx by tech	Add
97154	Grp adapt bhv tx by tech	Add
97155	Adapt behavior tx phys/qhp	Add
97156	Fam adapt bhv tx gdn phy/qhp	Add
97157	Mult fam adapt bhv tx gdn	Add
97158	Grp adapt bhv tx by phy/qhp	Add
97550	Caregiver training 1 st 30 min	Add
97551	Caregiver training ea addl 15	Add
97552	Grp caregiver training	Add
G0023	Navigate srv 60 min per m	Add
G0024	Navigate srv add 30 min per m	Add
G0129	PHP/IOP OT service	Update
G0140	Nav srv peer sup 60 min pr m	Add
G0146	Nav srv peer sup add 30 pr m	Add
G0176	Opps/php/IOP; activity thropy	Update
G0177	Opps/php/IOP; train & educ	Update
G0410	Grp psych PHP/IOP 45-50	Update
G0411	Interactive grp psyc PHP/IOP	Update
G0451	Development test interpt&rep	Add

TABLE 99: FINAL PARTIAL HOSPITALIZATION AND INTENSIVE OUTPATIENT PRIMARY SERVICES

HCPCS/CPT	Short Descriptor	Final Action
90832	Psytx pt&/family 30 minutes	
90834	Psytx pt&/family 45 minutes	
90837	Psytx pt&/family 60 minutes	
90845	Psychoanalysis	Add
90846	Family psytx w/o patient	
90847	Family psytx w/patient	
90853	Group psychotherapy	Add
90865	Narcosynthesis	Remove
90880	Hypnotherapy	
96112	Devel tst phys/qhp 1st hr	Add
96116	Neurobehavioral status exam	Add
96130	Psychological testing evaluation by physician/qualified health care professional; first hour	Add
96132	Neuropsychological testing evaluation by physician/qualified health care professional; first hour	Add
96136	Psychological/neuropsychological testing by physician/qualified health care professional; first 30 minutes	Add
96138	Psychological/neuropsychological testing by technician; first 30 minutes	Add
G0410	Grp psych partial hosp/IOP 45-50	Update
G0411	Inter active grp psych PHP/IOP	Update

BILLING CODE 4150-28-P**D. Payment Rate Methodology for PHP and IOP**

In summary, we proposed for CY 2024 to revise our methodology for calculating PHP payment rates. We proposed to establish four separate PHP APC per diem payment rates: one for CMHCs for 3-service days and another for CMHCs for 4-service days (APC 5853 and APC 5854, respectively), and one for hospital-based PHPs for 3-service days and another for hospital-based PHPs for 4-service days (APC 5863 and APC 5864, respectively). In addition, for hospital-based PHPs, we proposed to calculate payment rates using the broader OPSS data set, instead of hospital-based PHP data only, because we believe using the broader OPSS data set would allow CMS to capture data from claims not identified as PHP, but that also include the service codes and intensity required for a PHP day.

Because we proposed to establish consistent coding and payment between the PHP and IOP benefits, we proposed to consider all OPSS data for PHP days and non-PHP days that include 3 or more of the same service codes. We proposed to establish four separate IOP APC per diem payment rates at the same rates we proposed for PHP APCs: one for CMHCs for 3-service days and another for CMHCs for 4-service days (APC 5851 and APC 5852, respectively), and one for hospital-based IOPs for 3-service days and another for hospital-based IOPs for 4-service days (APC 5861 and APC 5862, respectively). We received public comments on these proposals, which we discuss and provide responses to in the following sections of this CY 2024 OPSS/ASC final rule.

1. Background

The standard PHP day is typically four services or more per day. We

currently provide payment for three services a day for extenuating circumstances when a beneficiary would be unable to complete a full day of PHP treatment. As we stated in the CY 2008 OPSS/ASC final rule with comment period (72 FR 66672), it was never our intention that days with only three units of service should represent the number of services provided in a typical PHP day. Our intention was to cover days that consisted of three units of service only in certain limited circumstances. For example, as we noted in the CY 2009 OPSS/ASC proposed rule (73 FR 41513), we believe 3-service days may be appropriate when a patient is transitioning towards discharge (or days when a patient who is transitioning at the beginning of his or her PHP stay). Another example of when it may be appropriate for a program to provide only three units of service in a day is when a patient is

utilization of mental health services provided by hospital staff to beneficiaries in their homes through communications technology. We also sought comment on whether there are changes commenters believe CMS should make to account for shifting patterns of practice that rely on communications technology to provide mental health services to beneficiaries in their homes.

In response to our comment solicitation, we received approximately 60 comments that were predominantly in support of continuing OPPTS payment for mental health services furnished to beneficiaries in their homes by clinical staff of the hospital through the use of communications technology as a permanent policy post-PHE. These comments stated that the expansion of virtual care broadly during the PHE has been instrumental in maintaining and expanding access to mental health services during the PHE.

4. Current Crisis in Mental Health and Substance Use Disorder

During the COVID-19 pandemic, the number of adults reporting adverse behavioral health conditions has increased sharply, with higher rates of depression, substance use, and self-reported suicidal thoughts observed in racial and ethnic minority groups.¹¹⁷ According to CDC data “[d]uring August 19, 2020–February 1, 2021, the percentage of adults with symptoms of an anxiety or a depressive disorder during the past 7 days increased significantly (from 36.4% to 41.5%), as did the percentage reporting that they needed but did not receive mental health counseling or therapy during the past 4 weeks (from 9.2% to 11.7%)”.¹¹⁸

In addition to the mental health crisis exacerbated by the COVID-19 pandemic, the United States is currently in the midst of an ongoing opioid PHE, which was first declared on October 26, 2017, by former Acting Secretary Eric D. Hargan, and most recently renewed by Secretary Xavier Becerra on April 4, 2022, and is facing an overdose crisis as a result of rising polysubstance use, such as the co-use of opioids and psychostimulants (for example, methamphetamine, cocaine). Recent CDC estimates of overdose deaths now exceed 107,000 for the 12-month period ending in December 2021,¹¹⁹ with overdose death rates surging among

Black and Latino Americans.¹²⁰ While overdose deaths were already increasing in the months preceding the COVID-19 pandemic, the latest numbers suggest an acceleration of overdose deaths during the pandemic. Recent increases in overdose deaths have reached historic highs in this country.¹²¹ According to information provided to CMS by interested parties, these spikes in substance use and overdose deaths reflect a combination of increasingly deadly illicit drug supplies, as well as treatment disruptions, social isolation, and other hardships imposed by the COVID-19 pandemic; but they also reflect the longstanding inadequacy of our healthcare infrastructure when it comes to preventing and treating substance use disorders (SUD) (for example, alcohol, cannabis, stimulants and opioid SUDs). Even before the COVID-19 pandemic began, in 2019, more than 21 million Americans aged 12 or over needed treatment for a SUD in the past year, but only about 4.2 million of them received any treatment or ancillary services for it.¹²²

According to the Commonwealth Fund, the provision of behavioral health services via communications technology has a robust evidence base; and numerous studies have demonstrated its effectiveness across a range of modalities and mental health diagnoses (for example, depression, SUD). Clinicians furnishing tele-psychiatry services at Massachusetts General Hospital Department of Psychiatry during the PHE observed several advantages of the virtual format for furnishing psychiatric services, noting that patients with psychiatric pathologies that interfere with their ability to leave home (for example, immobilizing depression, anxiety, agoraphobia, and/or time consuming obsessive-compulsive rituals) were able to access care more consistently since eliminating the need to travel to a psychiatry clinic can increase privacy and therefore decrease stigma-related barriers to treatment. This flexibility

¹²⁰ Drake, J., Charles, C., Bourgeois, J.W., Daniel, E.S., & Kwende, M. (January 2020). Exploring the impact of the opioid epidemic in Black and Hispanic communities in the United States. *Drug Science, Policy and Law*. doi:10.1177/2050324520940428.

¹²¹ <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>.

¹²² Substance Abuse and Mental Health Services Administration. (2020). Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (HHS Publication No. PEP20-07-01-001, NSDUH Series H-55). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from <https://www.samhsa.org/data/>.

could potentially bring care to many more patients in need, as well as enhance ease of scheduling, decrease rate of no-shows, increase understanding of family and home dynamics, and protect patients and practitioners with underlying health conditions.¹²³

5. CY 2023 OPPTS Payment for Mental Health Services Furnished Remotely by Hospital Staff

a. Designation of Mental Health Services Furnished to Beneficiaries in Their Homes as Covered OPD Services

During the PHE for COVID-19, many beneficiaries may be receiving mental health services in their homes from a clinical staff member of a hospital or CAH using communications technology under the flexibilities we adopted to permit hospitals to furnish these services. After the PHE ends, absent changes to our regulations, the beneficiary would need to physically travel to the hospital to continue receiving these outpatient hospital services from hospital clinical staff. We are concerned that this could have a negative impact on access to care in areas where beneficiaries may only be able to access mental health services provided remotely by hospital staff and, during the PHE, have become accustomed to receiving these services in their homes. We are also concerned about potential disruptions to continuity of care in instances where beneficiaries' inability to continue receiving these mental health services in their homes would lead to loss of access to a specific practitioner with whom they have established clinical relationships. We believe that, given the current mental health crisis, the consequences of loss of access could potentially be severe. We also note that beneficiaries' ability to receive mental health services in their homes may help expand access to care for beneficiaries who prefer additional privacy for the treatment of their condition. We also believe that, given the changes in payment policy for mental health services via telehealth by physicians and practitioners under the PFS and mental health visits furnished by staff of RHCs and Federally Qualified Health Centers (FQHCs), using interactive, real-time telecommunications technology, it is important to maintain consistent payment policies across settings of care so as not to create payment incentives to furnish these services in a specific setting.

¹²³ <https://www.commonwealthfund.org/blog/2020/using-telehealth-meet-mental-health-needs-during-covid-19-crisis>.

¹¹⁷ <https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm>.

¹¹⁸ <https://www.cdc.gov/mmwr/volumes/70/wr/mm7013e2.htm>.

¹¹⁹ <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>.

Therefore, we proposed to designate certain services provided for the purposes of diagnosis, evaluation, or treatment of a mental health disorder performed remotely by clinical staff of a hospital using communications technology to beneficiaries in their homes as hospital outpatient services that are among the “covered OPD services” designated by the Secretary as described in section 1833(t)(1)(B)(i) of the Act and for which payment is made under the OPSS. To effectuate payment for these services, we proposed to create OPSS-specific coding to describe these services. The proposed code descriptors specified that the beneficiary must be in their home and that there is no

associated professional service billed under the PFS. We noted that, consistent with the conditions of participation for hospitals at 42 CFR 482.11(c), all hospital staff performing these services must be licensed to furnish these services consistent with all applicable State laws regarding scope of practice. We also proposed that the hospital clinical staff be physically located in the hospital when furnishing services remotely using communications technology for purposes of satisfying the requirements at 42 CFR 410.27(a)(1)(iii) and (a)(1)(iv)(A), which refer to covered therapeutic outpatient hospital services incident to a physician’s or

nonphysician practitioner’s service as being “in” a hospital outpatient department. We solicited comment on whether requiring the hospital clinical staff to be located in the hospital when furnishing the mental health service remotely to the beneficiary in their home would be overly burdensome or disruptive to existing models of care delivery developed during the PHE, and whether we should revise the regulatory text in the provisions cited above to remove references to the practitioner being “in” the hospital outpatient department. Please see Table 66 for the final codes and their descriptors.



TABLE 66: C-CODE NUMBERS AND LONG DESCRIPTORS
With amendments from the CY2024 OPSS Final Rule added

HCPCS Code	Long Descriptor
C7900	Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, initial 15-29 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable State law(s), when the patient is in their home, and there is no associated professional service
C7901	Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, initial 30-60 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable State law(s), when the patient is in their home, and there is no associated professional service
C7902	Service for diagnosis, evaluation, or treatment of a mental health or substance use disorder, each additional 15 minutes, provided remotely by hospital staff who are licensed to provide mental health services under applicable State law(s), when the patient is in their home, and there is no associated professional service (List separately in addition to code for primary service)

When beneficiaries are in their homes and not physically within the hospital, we do not believe that the hospital is accruing all the costs associated with an in-person service and as such the full OPSS rate may not accurately reflect these costs. We believe that the costs associated with hospital clinical staff remotely furnishing a mental health service to a beneficiary who is in their home using communications technology more closely resembles the PFS payment amount for similar services when performed in a facility, which reflects the time and intensity of the professional work associated with performing the mental health service but does not reflect certain practice

expense costs, such as clinical labor, equipment, or supplies.

Therefore, we proposed to assign placeholder HCPCS codes CXX78 and CXX79 to APCs based on the PFS facility payment rates for CPT codes 96159 (Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)) and 96158 (Health behavior intervention, individual, face-to-face; initial 30 minutes), respectively. We explained that we believe that the APC series that is most clinically appropriate would be the Health and Behavior Services APC series. For CY 2022, CPT code 96159 has a PFS facility payment rate of

around \$20 while CPT code 96158 has a PFS facility payment rate of around \$60. We noted that if we use these PFS payment rates to approximate the costs associated with furnishing C7900 and C7901, these codes should be placed in APC 5821 (Level 1 Health and Behavior Services) and APC 5822 (Level 2 Health and Behavior Services), respectively. As C7902 is an add-on code, payment would be packaged; and the code would not be assigned to an APC. See Table 67 for the final SI and APC assignments and payment rates for HCPCS codes C9700–C7902 (placeholder HCPCS codes CXX78–CXX80 in the proposed rule).

TABLE 67: FINAL CY 2023 SI, APC ASSIGNMENT AND GEOMETRIC MEAN COST FOR HCPCS CODE C7900-C7902

HCPCS Code	Short Descriptor	Proposed SI	Proposed Proxy Service	PFS Facility Rate	Proposed APC	APC GMC
C7900	HOPD mntl hlt, 15-29 min	S	96159	\$19.52	5821	\$30.48
C7901	HOPD mntl hlt, 30-60 min	S	95158	\$56.56	5822	\$77.67
C7902	HOPD mntl hlt, ea addl	N	N/A	N/A	N/A	N/A

We solicited comment on the designation of mental health services furnished remotely to beneficiaries in their homes as covered OPD services payable under the OPPS, and on these proposed codes, their proposed descriptors, the proposed HCPCS codes and PFS facility rates as proxies for hospital costs, and the proposed APC assignments for the proposed codes. We stated that we recognize that, while mental health services have been paid under the OPPS when furnished by hospital staff in person to beneficiaries physically located in the hospital, the ability to provide these services remotely via communications technology when the beneficiary is at home is a new model of care delivery and that we could benefit from additional information to assist us to appropriately code and pay for these services. We invited additional information from commenters on all aspects of this proposal. We stated that we will also monitor uptake of these services for any potential fraud and/or abuse. Finally, we noted this proposal would also allow these services to be billed by CAHs, even though CAHs are not paid under the OPPS.

Comment: Many commenters supported our proposal to designate mental health services furnished by hospital staff to beneficiaries in their homes through communication technology as covered OPD services. Commenters stated that this policy would permit beneficiaries to maintain access to mental health services furnished through PHE-specific flexibilities and that it has the potential to even expand access, particularly in areas where there is a shortage of in-person mental health care. A few commenters requested that CMS allow other services, such as services provided

for the treatment of immunocompromised patients, to be furnished by hospital staff to beneficiaries in their homes through the use of telecommunications technology for other types of services beyond those described by the proposed HCPCS codes.

Response: We thank commenters for their support for this proposal. We will consider any expansions to this policy for future rulemaking.

Comment: Some commenters supported the creation of Medicare-specific HCPCS codes to describe these services, while others stated that the use of C-codes was confusing because existing CPT codes described similar services and did not represent the whole range of mental health services and staff that furnish them in a HOPD. Some commenters recommended that CMS use existing CPT codes and create a modifier to identify when the service is furnished remotely to a beneficiary in their home.

Response: We thank commenters for their support. While we understand that there may be some challenges surrounding when it would be appropriate to bill a Medicare-specific C-code where there are existing CPT codes that describe a similar service, however we believe that creating new codes rather than relying on existing CPT codes will reduce confusion because the CPT codes could also be billed by the hospital to account for the costs hospitals incurred when there is an associated professional service. Furthermore, creation of Medicare-specific coding will allow CMS to monitor these services and make refinements to the coding to more accurately reflect clinical practice.

Comment: A few commenters supported the proposed payment rates,

while many others stated that the proposed rates did not accurately capture all of the costs to the hospital of providing these services. These commenters stated that, even if the beneficiary is not physically in the hospital, the hospital would still be accruing costs associate with staffing and technology and that using the facility payment rate under the PFS is inappropriate and would not account for the additional costs to the hospital of providing these services. Some commenters supported the use of the facility payment rate under the PFS to inform the APC-assignment of these services but recommended that CMS compare them to CPT codes 90832 (Psychotherapy, 30 minutes with patient) through 90838 (Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)), as the commenters believe these codes better reflect the work and costs associated with care, which are consistent across physician office and hospital settings.

Response: We continue to believe that the resources associated with hospital staff furnishing mental health services to beneficiaries in their homes through telecommunications technology is better accounted for through the facility payment rate under the PFS, and that using this payment rate to inform the APC assignment is a reasonable methodology until such time as we have claims data for these services. We acknowledge that there are likely costs to the hospital other than the time of the hospital staff providing the service, including the amount of infrastructure needed to provide the service; however, we believe these costs are likely

minimal given that the beneficiary is in their home and not in the hospital.

Regarding the alternative codes commenters suggested we use to make appropriate APC assignments for the proposed C codes, we note that we do not believe the OPSS rates for these services serve as an appropriate crosswalk for the new mental health codes because these psychotherapy codes are for services performed at the hospital, not remotely.

Comment: Most commenters recommended that CMS revise the requirements at 42 CFR 410.27(a)(1)(iii) and (a)(1)(iv)(A), which refer to covered therapeutic outpatient hospital services incident to a physician's or nonphysician practitioner's service as being "in" a hospital outpatient department to remove references to the services being "in" the hospital. These commenters stated that this would allow for maximum flexibility for practitioners and could increase access to mental health services. One commenter requested clarification as to whether the supervising physician would have to be physically located at the hospital to meet general supervision requirements.

Response: We appreciate the additional information provided by commenters. We agree that not requiring the staff providing the mental health service to the beneficiary in their home to be physically in the hospital would likely maximize flexibility, particularly in areas where there is a shortage of healthcare practitioners. Therefore, we are finalizing an amendment to 42 CFR 410.27(a)(1)(iii) to add the phrase "except for mental health services furnished to beneficiaries in their homes through the use of communication technology" and § 410.27(a)(1)(iv)(A) to add the phrase "or through the use of communication technology for mental health services." The physician supervision level for the vast majority of hospital outpatient therapeutic services is currently general supervision under § 410.27. This means a service must be furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the service.

Comment: A few commenters requested that CMS clarify that when these services are furnished by hospitals that are owned or operated by the Indian Health Service, Indian Tribes, or Tribal Organizations, they are also covered, but will be paid at the applicable OMB rate that is established and published annually by the Indian Health Service rather than under the OPSS, in accordance with 42 CFR

419.20(b) and CMS's longstanding practice.

Response: IHS facilities may be paid at the applicable all inclusive payment rate established and published annually by the Indian Health Service rather than under the OPSS, in accordance with 42 CFR 419.20(b) when billing for these services.

After consideration of the public comments we received, we are finalizing as proposed to assign HCPCS codes C7900 and C7901 to APCs based on the PFS facility payment rates for CPT codes 96159 (Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)) and 96158 (Health behavior intervention, individual, face-to-face; initial 30 minutes), respectively. We are finalizing our proposal with modification to clarify at 42 CFR 410.27(a)(1)(iii) and (a)(1)(iv)(A) that mental health services provided to beneficiaries in their homes through communication technology are exempt from the requirement that therapeutic hospital or CAH services must be furnished in a hospital or CAH or in a department of the hospital or CAH.

b. Periodic In-Person Visits

Section 123(a) of the CAA, 2021 also added a new subparagraph (B) to section 1834(m)(7) of the Act to prohibit payment for a Medicare telehealth service furnished in the patient's home for purposes of diagnosis, evaluation, or treatment of a mental health disorder unless the physician or practitioner furnishes an item or service in person, without the use of telehealth, within 6 months prior to the first time the physician or practitioner furnishes a telehealth service to the beneficiary, and thereafter, at such times as the Secretary determines appropriate. In the CY 2022 PFS final rule, we finalized that, after the first mental health telehealth service in the patient's home, there must be an in-person, non-telehealth service within 12 months of each mental health telehealth service—but also finalized a policy to allow for limited exceptions to the requirement. Specifically, if the patient and practitioner agree that the benefits of an in-person, non-telehealth service within 12 months of the mental health telehealth service are outweighed by risks and burdens associated with an in-person service, and the basis for that decision is documented in the patient's medical record, the in-person visit requirement will not apply for that 12-month period (86 FR 65059). We finalized identical in-person visit requirements for mental health visits

furnished through communications technology for RHCs and FQHCs.

In the interest of maintaining similar requirements between mental health visits furnished by RHCs and FQHCs via communications technology, mental health telehealth services under the PFS, and mental health services furnished remotely under the OPSS, we proposed to require that payment for mental health services furnished remotely to beneficiaries in their homes using telecommunications technology may only be made if the beneficiary receives an in-person service within 6 months prior to the first time the hospital clinical staff provides the mental health services remotely; and that there must be an in-person service without the use of telecommunications technology within 12 months of each mental health service furnished remotely by the hospital clinical staff. We also proposed the same exceptions policy as was finalized in the CY 2022 PFS final rule, specifically, that we would permit exceptions to the requirement that there be an in-person service without the use of communications technology within 12 months of each remotely furnished mental health service when the hospital clinical staff member and beneficiary agree that the risks and burdens of an in-person service outweigh the benefits of it. Exceptions to the in-person visit requirement should involve a clear justification documented in the beneficiary's medical record including the clinician's professional judgement that the patient is clinically stable and/or that an in-person visit has the risk of worsening the person's condition, creating undue hardship on the person or their family, or would otherwise result in disengaging with care that has been effective in managing the person's illness. Hospitals must also document that the patient has a regular source of general medical care and has the ability to obtain any needed point of care testing, including vital sign monitoring and laboratory studies.

Section 304(a) of Division P, Title III, Subtitle A of the Consolidated Appropriations Act, 2022 (Pub. L. 117-103, March 15, 2022) amended section 1834(m)(7)(B)(i) of the Act to delay the requirement that there be an in-person visit with the physician or practitioner within 6 months prior to the initial mental health telehealth service, and at subsequent intervals as determined by the Secretary, until the 152nd day after the emergency period described in section 1135(g)(1)(B) (the PHE for COVID-19) ends. In addition, Section 304 of the Consolidated Appropriations Act, 2022 (CAA, 2022), delayed until

152 days after the end of the PHE similar in-person visit requirements for remotely furnished mental health visits furnished by RHCs and FQHCs. In the interest of continuity across payment systems so as to not create incentives to furnish mental health services in a given setting due to a differential application of additional requirements, and to avoid any burden associated with immediate implementation of the proposed in-person visit requirements, we proposed that the in-person visit requirements would not apply until the 152nd day after the PHE for COVID-19 ends.

Comment: A few commenters supported requirements for in-person visits; however, most opposed the proposal, particularly to require an in-person visit within 6 months prior to the first telehealth service. Commenters stated that CMS should defer to the clinical judgement of the treating practitioner, who is in the best position to understand the individual needs of their patients. Commenters appreciated that CMS proposed to allow exceptions to the subsequent 12-month visit requirement if the patient and practitioner agree that the benefits of in-person, non-telehealth service within 12 months of the mental health telehealth service are outweighed by risks and burdens associated with an in-person service, and the basis for that decision is documented in the patient's medical record.

Response: In section II.D.1.e of the CY 2023 PFS final rule entitled "Implementation of Telehealth Provisions of the Consolidation Appropriations Acts, 2021 and 2022", CMS clarifies that for purposes of the requirement that an in-person visit required within 6 months prior to the initial mental health telehealth services, this requirement does not apply to beneficiaries who began receiving mental health telehealth services in their homes during the PHE or during the 151-day period after the end of the PHE. The requirement for an in-person visit within 6 months of the initial telehealth mental health services takes effect only for telehealth mental health services beginning after the 152nd day after the end of the PHE. For reasons stated in the proposed rule, we believe it is important to maintain similar standards for mental health services furnished to beneficiaries in their homes through the use of telecommunications systems paid under OPPS. Therefore, we are making the same clarification; however, for patients newly receiving mental health services furnished remotely post-PHE, we continue to believe that the initial in-person visit within 6 months prior to the first remote

mental health service is crucial to ensure the safety and clinical appropriateness of the following remote mental health services. We also reiterate that for both patients who began receiving mental health services in their homes during the PHE and those who began treatment post-PHE, we expect that these beneficiaries will receive an in-person, non-telehealth service every subsequent 12 months and that exceptions to this requirement will be documented in the patient's medical record.

After consideration of the public comments we received, we are finalizing as proposed, and clarifying that beneficiaries who began receiving mental health telehealth services in their homes during the PHE or the 151-day period after the end of the PHE before the in-person visit requirements take effect do not need to have an in-person, non-telehealth service within 6 months prior to receiving mental health service in their homes. Instead, the requirement to receive an in-person visit within 12 months of each remote mental health telehealth service would apply.

c. Audio-Only Communication Technology

Section 1834(m) of the Act outlines the requirements for PFS payment for Medicare telehealth services that are furnished via a "telecommunications system," and specifies that, only for purposes of Medicare telehealth services furnished through a Federal telemedicine demonstration program conducted in Alaska or Hawaii, the term "telecommunications system" includes asynchronous, store-and-forward technologies. We further defined the term, "telecommunications system," in the regulation at § 410.78(a)(3) to mean an interactive telecommunications system, which is defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communications between the patient and distant site physician or practitioner.

During the PHE for COVID-19, we used waiver authority under section 1135(b)(8) of the Act to temporarily waive the requirement, for certain behavioral health and/or counseling services and for audio-only evaluation and management (E/M) visits, that telehealth services must be furnished using an interactive telecommunications system that includes video communications technology. Therefore, for certain services furnished during the PHE for COVID-19, we make payment for these telehealth services when they are furnished using audio-only

communications technology. In the CY 2022 PFS final rule, we stated that, given the generalized shortage of mental health care professionals¹²⁴ and the existence of areas and populations where there is limited access to broadband due to geographic or socioeconomic challenges, we believed beneficiaries may have come to rely upon the use of audio-only communications technology in order to receive mental health services, and that a sudden discontinuation of this flexibility at the end of the PHE could have a negative impact on access to care (86 FR 65059). Due to these concerns, we modified the definition of interactive telecommunications system in § 410.78(a)(3) for services furnished for purposes of diagnosis, evaluation, or treatment of a mental health disorder to a patient in their home to include two-way, real-time audio-only communications technology in instances where the physician or practitioner furnishing the telehealth service is technically capable to use telecommunications technology that includes audio and video, but the beneficiary is not capable of, or did not consent to, use two-way, audio/video technology. We stated that we believed that this requirement would ensure that mental health services furnished via telehealth are only conducted using audio-only communications technology in instances where the use of audio-only technology is facilitating access to care that would be unlikely to occur otherwise, given the patient's technological limitations, abilities, or preferences (86 FR 65062). We also made a conforming change for purposes of furnishing mental health visits through telecommunications technology for RHCs and FQHCs. We limited payment for audio-only services to services furnished by physicians or practitioners who have the capacity to furnish two-way, audio/video telehealth services but are providing the mental health services via audio-only communications technology in instances where the beneficiary is not capable of, or does not wish to use, two-way, audio/video technology.

In order to maximize accessibility for mental health services, particularly for beneficiaries in areas with limited access to broadband infrastructure, and in the interest of policy continuity across payment systems so as to not create incentives to furnish mental health services in a given setting due to a differential application of additional requirements, we proposed a similar

¹²⁴ <https://bhwh.hrsa.gov/data-research/review-health-workforceresearch>.

policy for mental health services furnished remotely by hospital clinical staff to beneficiaries in their homes through communications technology. Specifically, we proposed that hospital clinical staff must have the capability to furnish two-way, audio/video services but may use audio-only communications technology given an individual patient's technological limitations, abilities, or preferences.

Comment: Commenters were very supportive of CMS's proposal to allow for audio-only communication technology in instances where the beneficiary did not have access to, or did not wish to use, two-way, audio/video communication technology. A few commenters disagreed with CMS's proposal to require the practitioner to have the capacity to furnish services via two-way, audio/video, stating that this may be problematic for practitioners in rural areas or areas without access to reliable broadband.

Response: As we stated in the CY 2022 PFS final rule, because services furnished via communication technology are generally analogous to and must include the elements of the in-person service, it is generally appropriate to continue to require the use of two-way, real-time audio/video communications technology to furnish the services (86 FR 65061–65062). Therefore, we are maintaining the requirement that hospital staff must have the technical capability to use an interactive telecommunications system that includes two-way, real-time, interactive audio and video communications at the time that an audio-only mental health service is furnished.

 After consideration of the public comments we received, we are finalizing our proposal regarding use of audio-only communications technology as proposed.

B. Comment Solicitation on Intensive Outpatient Mental Health Treatment, Including Substance Use Disorder (SUD) Treatment Furnished by Intensive Outpatient Programs (IOPs)

There are a range of services described by existing coding under the PFS and OPSS that can be billed for treatment of mental health conditions, including SUD, such as individual, group, and family psychotherapy. Over the past several years, in collaboration with interested parties and the public, we have provided additional coding and payment mechanisms for mental health care services paid under the PFS and OPSS. For example, in the CY 2020 PFS final rule (84 FR 62673), we finalized the creation of new coding and payment

describing a bundled episode of care for the treatment of Opioid Use Disorder (OUD) (HCPCS codes G2086–G2088). In the CY 2021 PFS final rule, we finalized expanding the bundled payments described by HCPCS codes G2086–G2088 to be inclusive of all SUDs (85 FR 84642 through 84643). These services are also paid under the OPSS.

Additionally, in the CY 2020 PFS final rule (84 FR 62630 through 62677), we implemented coverage requirements and established new codes describing bundled payments for episodes of care for the treatment of OUD furnished by Opioid Treatment Programs (OTPs). Medicare also covers services furnished by inpatient psychiatric facilities and partial hospitalization programs (PHP). PHP services can be furnished by a hospital outpatient department or a Medicare-certified Community Mental Health Center (CMHC). PHPs are structured to provide intensive psychiatric care through active treatment that utilizes a combination of the clinically recognized items and services described in section 1861(ff) of the Social Security Act (the Act). According to the Medicare Benefit Policy Manual, Chapter 6, Section 70.3, the treatment program of a PHP closely resembles that of a highly structured, short-term hospital inpatient program and is at a level more intense than outpatient day treatment or psychosocial rehabilitation. PHPs work best as part of a community continuum of mental health services, which range from the most restrictive inpatient hospital setting to less restrictive outpatient care and support.

We understand that, in some cases, people who do not require a level of care for mental health needs that meets the standards for PHP services nonetheless require intensive services on an outpatient basis. For example, according to SAMHSA's *Advisory on Clinical Issues in Intensive Outpatient Treatment for Substance Use Disorders*, IOP programs for substance use disorders (SUDs) offer services to clients seeking primary treatment; step-down care from inpatient, residential, and withdrawal management settings; or step-up treatment from individual or group outpatient treatment. IOP treatment includes a prearranged schedule of core services (e.g., individual counseling, group therapy, family psychoeducation, and case management) for a minimum of nine hours per week for adults or six hours per week for adolescents. SAMSHA further states that the 2019 National Survey of Substance Abuse Treatment Services reports that 46 percent of SUD

treatment facilities offer IOP treatment.¹²⁵

We solicited comment on whether these services are described by existing CPT codes paid under the OPSS, or whether there are any gaps in coding that may be limiting access to needed levels of care for treatment of mental health disorders or SUDs, for Medicare beneficiaries. We welcomed additional, detailed information about IOP services, such as the settings of care in which these programs typically furnish services, the range of services typically offered, the range of practitioner types that typically furnish those services, and any other relevant information, especially to the extent it would inform our ability to ensure that Medicare beneficiaries have access to this care.

Comment: Commenters were generally supportive of CMS providing payment for IOP services. Some commenters stated that existing HCPCS coding was adequate to describe IOP services, while other commenters stated that it was necessary for the OPSS to create Medicare-specific coding to describe these services.

Response: We thank commenters for the information provided and will consider their input for future rulemaking.

C. Direct Supervision of Certain Cardiac and Pulmonary Rehabilitation Services by Interactive Communications Technology

In the interim final rule with comment period titled "Policy and Regulatory Provisions in Response to the COVID-19 Public Health Emergency," published on April 6, 2020 (the April 6th COVID-19 IFC) (85 FR 19230, 19246, 19286), we changed the regulation at 42 CFR 410.27(a)(1)(iv)(D) to provide that, during a Public Health Emergency as defined in § 400.200, the presence of the physician for purposes of the direct supervision requirement for pulmonary rehabilitation (PR), cardiac rehabilitation (CR), and intensive cardiac rehabilitation (ICR) services includes virtual presence through audio/video real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider. Specifically, the required direct physician supervision can be provided through virtual presence using audio/video real-time communications technology (excluding audio-only) subject to the clinical judgment of the supervising practitioner. We further amended § 410.27(a)(1)(iv)(D) in the CY

¹²⁵ https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep20-02-01-021.pdf.