apply for fracture and non-fracture episodes when a major disaster declaration is declared, we believe applying equal financial safeguards for both episodes during the COVID-19 pandemic is more appropriate due to its nationwide impact on hospitals and post-acute care facilities ability to provide care for beneficiaries during this PHE.

We are codifying these provisions at § 510.305 (k)(3) and (4).

3. Alternative Payment Model treatment under the Quality Payment Program

As has been described previously in this IFC, we are seeking to give entities and individuals that provide services to Medicare beneficiaries needed flexibilities to respond effectively to the serious public health threats posed by the spread of the COVID-19, and to address the needs of health care providers specific to this declared national emergency. We further recognize that flexibilities may be necessary and appropriate in the context of Alternative Payment Models (APMs), including applicable model tests conducted under section 1115A of the Act by the CMS Center for Medicare and Medicaid Innovation (Innovation Center), as well as the Medicare Shared Savings Program. We note that aspects of APM policies under the Quality Payment Program are designed to follow on from the specific designs, policies, and operations of individual APMs. We recognize that our current regulations may be insufficient for purposes of adequately responding to the still-emerging COVID-19 national emergency and that additional action may be necessary and appropriate to prevent APM participants from facing undue burden in or negative consequences through the Quality Payment Program.

We acknowledge that possible changes might be needed to address issues that may arise for APM participants in light of the current emergency. We will consider undertaking additional rulemaking, including possibly another interim final rule, to amend or suspend APM QPP policies as necessary to ensure accurate and appropriate application of Quality Payment Program policies in light of the PHE due to COVID-19.

R. Remote Physiologic Monitoring

In recent years, we have finalized payment for seven CPT codes in the Remote Physiologic Monitoring (RPM) code family. We finalized payment in the CY 2018 PFS final rule for CPT code 99091 (*Collection and interpretation of physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation requiring a minimum of 30 minutes of time*). The following year, we finalized payment for CPT codes 99453 (*Remote monitoring of physiologic parameter(s)(e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment*), 99454 (*Remote monitoring of physiologic parameter(s)(e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days*), and 99457 (*Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes*)). Most recently, for the CY 2020 PFS final rule (84 FR 62645 and 62646), we finalized a treatment management add-on code (CPT code 99458 *Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20* minutes) and two self-measured blood pressure monitoring codes, CPT code 99473 (*Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration*) and CPT code 99474 (*Separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient*).

We are concerned that under the PHE for the COVID-19 pandemic, physicians and other health care professionals are faced with challenges regarding potential exposure risks for themselves and their patients. In response, the CDC has urged health care professionals to make every effort to interview patients by telephone, text monitoring, or video conferencing instead of in-person. We believe that RPM services support the CDC's goal of reducing human exposure to the novel coronavirus while also increasing access to care and improving patient outcomes.

RPM services are considered to be CTBS and, as such, would be billable only for established patients. Our goal during the PHE for the COVID-19 pandemic is to reduce exposure risks to the novel coronavirus for practitioners and patients and to increase access to services by eliminating as many obstacles as possible to delivering necessary services. Allowing RPM services to be furnished only to established patients could be an obstacle to delivery of reasonable and necessary care particularly during current conditions. Thus, in response to the PHE for the COVID-19 pandemic, we are finalizing on an interim basis, that RPM services can be furnished to new patients, as well as to established patients.

In addition to current policy that there be an established patient-practitioner relationship, we require for CTBS at least verbal consent from a Medicare beneficiary to receive the services. We finalized this requirement to avoid scenarios where beneficiaries are unexpectedly responsible for copays for services that do not involve the typical in-person, face-to-face service that a patient receives during an office visit. We continue to believe that patient consent is important. However, we also believe that acquiring patient consent should not interfere with the provision of RPM services during the PHE for the COVID-19 pandemic. Therefore, we are finalizing on an interim basis that consent to receive RPM services can be obtained once annually, including at the time services are furnished, during the duration of the PHE for the COVID-19 pandemic. However, to enhance beneficiary protection, for both new and established patients, we suggest that the physician or other health care practitioner review

consent information with a beneficiary, obtain the beneficiary's verbal consent, and document in the medical record that consent was obtained.

Finally, we are clarifying that RPM codes can be used for physiologic monitoring of patients with acute and/or chronic conditions. The typical patient needing RPM services may have a chronic condition (for example, high blood pressure, diabetes, COPD). However, RPM can be used for other conditions. For example, RPM services allow a patient with an acute respiratory virus to monitor pulse and oxygen saturation levels using pulse oximetry. Nurses, working with physicians, can check-in with the patient and then using patient data, determine whether home treatment is safe, all the while reducing exposure risk and eliminating potentially unnecessary emergency department and hospital visits.

S. Telephone Evaluation and Management (E/M) Services

For CY 2008, the CPT Editorial Panel created CPT codes to describe E/M services furnished by a physician or qualified healthcare professional via telephone or online, including CPT codes 98966 (*Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion*), 98967 (*Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion*), 98968 (*Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and*