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*

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; 21-30 minutes of medical discussion), 99441 (*Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion*), 99442 (*Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion*), and 99443 (*Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion*). We assigned a status indicator of "N" (Noncovered) to these services because: (1) These services are non-face-to-face; and (2) the code descriptors include language that recognizes the provision of services to parties other than the beneficiary for whom Medicare does not provide coverage (for example, a guardian).

We do not believe that we should continue to consider these to be categorically non-covered services. In PFS rulemaking subsequent to CY 2008, we established separate payment for numerous non-face-to-face services, including care management services and prolonged non-face-to-face E/M services. We have also noted, for example in CY 2017, that we recognize that in current medical practice, practitioner interaction with caregivers is an integral part of

treatment for some patients. Accordingly, the descriptions for several payable codes under the PFS include direct interactions between practitioners and caregivers (81 FR 80331).

When we established separate payment for services like virtual check-ins and e-visits, we recognized that non-face-to-face services had become an important part of overall physician care of Medicare beneficiaries, especially relative to care for chronic conditions. The current Medicare policy regarding the CPT codes that describe telephone E/M services predated our ongoing recognition of the need to pay separately for these kinds of services. Despite the fact that these are classified as E/M services in the coding, we do not believe that these codes describe full E/M services, but rather are closely analogous to the virtual check-in services. Although we assigned a "Noncovered" status indicator for the telephone E/M codes, we still established the American Medical Association's RUC-recommended RVUs for them. To establish the payment rate for the virtual check-in service, we used the RUC-recommended valuation for the lowest level telephone E/M code. However, the telephone E/M codes provide additional stratification by time for circumstances when a practitioner spends more than a brief amount of time in direct communication with the patient. We believe that under ordinary circumstances outside of the PHE, if the needs of the patient are significant enough to require the amount of time and attention from the practitioner specified in the codes for higher level telephone evaluations or assessments, either an in-person visit or a telehealth visit would be required. Alternatively, if the needs of the patient are less acute and lengthy, a virtual check-in would suffice. However, in the context of the goal of reducing exposure risks associated with the PHE for the COVID-19 pandemic, especially in the case that two-way, audio and video technology required to furnish a Medicare telehealth service might not be available, we believe there are many circumstances where prolonged, audio-only communication between the practitioner and the patient could be clinically appropriate yet not fully replace a face-to-face visit. We believe that the existing telephone E/M codes, in both description and valuation, are

the best way to recognize the relative resource costs of these kinds of services. Therefore, we are finalizing, on an interim basis for the duration of the PHE for the COVID-19 pandemic, separate payment for CPT codes 98966-98968 and CPT codes 99441-99443. For these codes, we are finalizing on an interim basis for the duration of the PHE for the COVID-19 pandemic, work RVUs as recommended by the AMA Health Care Professionals Advisory Committee (HCPAC) for CY PFS 2008 rulemaking as discussed in the CY 2008 PFS final rule (72 CFR 66371) of 0.25 for CPT code 98966, 0.50 work RVUs for CPT code 98967, and 0.75 for CPT code 98968, and work RVUs as recommended by the AMA Relative Value Scale Update Committee (RUC) of 0.25 for CPT code 99441, 0.50 for CPT code 99442, and 0.75 for CPT code 99443. We are finalizing the HCPAC and RUC-recommended direct PE inputs which consist of 3 minutes of post-service RN/LPN/MTA clinical labor time for each code.

Similar to the CTBS described in section II.D. of this IFC, we believe it is important during the PHE to extend these services to both new and established patients. While some of the code descriptors refer to "established patient," during the PHE we are exercising enforcement discretion on an interim basis to relax enforcement of this aspect of the code descriptors. Specifically, we will not conduct review to consider whether those services were furnished to established patients. CPT codes 98966-98968 described assessment and management services performed by practitioners who cannot separately bill for E/Ms. We are noting that these services may be furnished by, among others, LCSWs, clinical psychologists, and physical therapists, occupational therapists, and speech language pathologists when the visit pertains to a service that falls within the benefit category of those practitioners.

To facilitate billing of these services by therapists, we are designating CPT codes 98966-98968 as CTBS "sometimes therapy" services that would require the private practice occupational therapist, physical therapist, and speech-language pathologist to include the corresponding GO, GP, or GN therapy modifier on claims for these services.