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# Medicare Home Health Prospective Payment System

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## 2023 Final Payment Rule Summary by the Wisconsin Hospital Association

### Overview and Resources

On October 31, 2022 the Centers for Medicare and Medicaid Services (CMS) released its final calendar year (CY) 2023 payment rule for the Medicare Home Health Prospective Payment System (HH PPS). The final rule includes updates to the Medicare fee-for-service (FFS) HH PPS payment rates based on changes set forth by CMS and those previously adopted by the US Congress. Among the finalized updates are:

- Recalibration of the Patient-Driven Grouping Model (PDGM) case-mix weights, low utilization payment adjustment (LUPA) thresholds, functional levels, and comorbidity adjustment subgroups;
- Payment adjustments to reflect the impact of differences between assumed behavior changes and actual behavior changes on estimated aggregate payment expenditures under the HH PPS;
- Creation of a permanent 5% cap on wage index decreases;
- Updates to the expanded HH value-based purchasing (HH VBP) program;
- Updates to the HH quality reporting program (QRP); and

A link to this final rule and other resources related to the HH PPS are available on the CMS website <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Home-Health-Prospective-Payment-System-Regulations-and-Notices.html>.

An online version of this final rule is available at <https://www.federalregister.gov/public-inspection/2022-23722/medicare-program-calendar-year-2023-home-health-prospective-payment-system-rate-home-health-quality>.

A brief summary of the final rule is provided below. Program changes adopted by CMS are effective for services provided on or after January 1, 2023, unless otherwise noted. CMS estimates the overall economic impact of this final payment rate to be an increase of \$125 million (proposed as a decrease of \$810 million) in aggregate payments to Home Health Agencies (HHA) in CY 2023 over CY 2022.

**Note:** Text in italics are extracted from the Display version of the final rule found in the October 31, 2022 *Federal Register*, unless otherwise stated.

### HH PPS Payment Rates

*Display pages 6, 18 – 56, 75 – 78, 98 – 110, 114 – 124, and 137 – 145*

The tables below show the final CY 2023 30-day standard payment rate compared to the final CY 2022 30-day standard payment rate and the components of the annual update factor:

	Final CY 2022	Final CY 2023	Percent Change
<b>30-Day Period Standard Payment Rate</b>	<b>\$2,031.64</b>	<b>\$2,010.69</b> (proposed at 1,904.76)	<b>-1.03%</b> (proposed at -6.25%)

Final CY 2023 Update Factor Components	30-Day Standard Rate
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Marketbasket (MB) Update	4.1% (proposed at 3.3%)
Affordable Care Act (ACA)-Mandated Productivity MB adjustment	-0.1 percentage points (PPTs) (proposed at -0.4 PPTs)
Permanent Behavior Assumption Adjustment	0.96075 (proposed at 0.9231)
Wage Index Budget Neutrality	1.0001 (proposed at 0.9975)
Case-Mix Weights Recalibration Budget Neutrality	0.9904 (proposed at 0.9895)
<b>Overall Final Rate Update</b>	<b>-1.03%</b> (proposed at -6.25%)

The final marketbasket update percentage is based on IHS Global Inc.'s third quarter 2022 forecast with historical data through second quarter 2022.

## Behavioral Assumptions and Adjustments

Display pages 18 – 56

Starting in CY 2020, CMS was required to change the unit of payment from a 60-day episode to a 30-day period of care. Part of this statute required CMS to make assumptions about behavior changes that could occur as a result of implementing a 30-day unit of payment and case-mix adjustment factors that eliminated the use of therapy thresholds when calculating the CY 2020 standard payment amount. These behavior assumptions were finalized in the CY 2019 HH PPS final rule with comment period and are as follows:

- *Clinical Group Coding: The clinical group is determined by the principal diagnosis code for the patient as reported by the HHA on the home health claim. This behavior assumption assumes that HHAs will change their documentation and coding practices and put the highest paying diagnosis code as the principal diagnosis code in order to have a 30-day period be placed into a higher-paying clinical group.*
- *Comorbidity Coding: The PDGM further adjusts payments based on patients' secondary diagnoses as reported by the HHA on the home health claim. The [Outcome and Assessment Information Set] (OASIS) only allows HHAs to designate 1 principal diagnosis and 5 secondary diagnoses while the home health claim allows HHAs to designate 1 principal diagnosis and up to 24 secondary diagnoses. This behavior assumption assumes that by considering additional ICD-10- CM diagnosis codes listed on the home health claim (beyond the 6 allowed on the OASIS), more 30-day periods of care will receive a comorbidity adjustment.*
- *LUPA Threshold: This behavior assumption assumes that for one-third of LUPAs that are 1 to 2 visits away from the LUPA threshold HHAs will provide 1 to 2 extra visits to receive a full 30-day payment.*

CMS is also required by law to determine the impact of differences between assumed and actual behavior on estimated aggregate expenditures, beginning in CY 2020 and ending with CY 2026, and make permanent and temporary adjustments as necessary through notice and rulemaking. In the CY 2022 HH PPS proposed rule, CMS sought comments on its repricing method for evaluating budget-neutrality when using CY 2020 claims data, with respect to behavior assumptions, as well as any alternate approaches to annually determine the difference between assumed and actual behavior changes and their effect on HH PPS expenditures. These comments are summarized in the CY 2023 HH PPS proposed rule on *Federal Register* pages 37,615 – 37,620 with additional comments on Display pages 24 – 46.

CMS analyzed the CY 2020 and CY 2021 30-day payment rates to account for changes in actual versus assumed behavior that would have caused payments to be different than what were finalized for those two years. Based on claims data, CMS found that the CY 2020 30-day payment rate with actual behavior changes would be \$1,742.52, compared to \$1,864.03 when using the assumed behavioral changes that had been adopted in the CY 2020 final rule. Using this new CY 2020 rate, CMS recalculated a CY 2021 30-day payment rate of \$1,777.19 using the adopted update factors and with assumed behavior changes from the CY 2021 final rule. CMS then analyzed CY 2021 claims data to determine a 30-day payment rate of \$1,751.90 (proposed at \$1,754.99) to account for actual behavior changes, which is -7.85% lower than the adopted CY 2021 rate of \$1,901.12. Based on comments received outlining the potential hardship of implementing the full -7.85% in a single year, CMS finalized a permanent

adjustment of 0.96075 (proposed at 0.9231) to be applied to the CY 2023 30-day base payment rate, which accounts for only half of the -7.85% difference in previous rates. Since this adjustment will not fully account for differences in past behavior changes, CMS will make further adjustments to account for behavior changes as necessary in future rulemaking.

The same CMS analysis also found that, due to updating these rates for actual behavior in CYs 2020 – 2021, estimated payments for these two years were higher than they should have been. CMS estimates these overpayments to be \$873 million for CY 2020 and \$1.211 billion for CY 2021, which includes budget neutrality. This results in a combined \$2.084 billion in temporary payment reconciliation, requiring a temporary adjustment to the 30-day payment rate as well. However, in order to avoid significant negative adjustments in a single year, CMS adopted to only implement the permanent adjustment to the CY 2023 30-day rate. CMS believes this could mitigate the need for a larger adjustment and could reduce the amount of any temporary adjustment in future years. CMS sought comments on how to best implement the temporary reconciliation adjustment in the future. Comments can be found on Display pages 55 – 56.

## National Per-Visit Amounts

*Display pages 75 – 78, 98 – 110, and 141 – 145*

CMS uses national per-visit amounts by service discipline to pay for LUPA periods of care as well as to compute outliers. LUPA payments are made when the number of visits is less than the LUPA threshold for their PDGM classification. This threshold is set at either 2 visits, or the 10<sup>th</sup> percentile value of visits, whichever is higher. CMS typically uses the most current utilization data available to set LUPA thresholds at the time of rulemaking.

After reviewing CY 2021 home health claims, CMS believes that visit patterns have stabilized and that CY 2021 patterns will be more indicative of visit patterns in CY 2023 compared to using CY 2018 data pre-PDGM. As such, CMS will update LUPA thresholds using CY 2021 home health claims data. Of these thresholds, 282 case-mix groups will have no change in threshold, 16 will go up by one visit, 121 groups will have their threshold go down by one visit, 11 go down by two visits, and 2 go down by three visits. A list of all adopted LUPA thresholds can be found in Table 16 on Display pages 98 – 110 and on the CMS website <https://www.cms.gov/files/zip/cy-2023-final-home-health-pdgm-case-mix-weights-and-lupa-thresholds.zip>.

The final CY 2022 national per-visit rates compared to the final CY 2023 national per-visit rates are shown below and do not include the permanent behavior adjustment.

Per-Visit Amounts	Final CY 2022	Final CY 2023	Percent Change	Final CY 2023 with LUPA Add-On*
Home Health Aide	\$71.04	\$73.93 (proposed at \$73.04)	+4.07% (proposed at +2.82%)	N/A
Medical Social Services	\$251.48	\$261.72 (proposed at \$258.57)		N/A
Occupational Therapy (OT)	\$172.67	\$179.70 (proposed at \$177.54)		\$300.10 (1.6700 adj.) (proposed at \$296.49)
Physical Therapy (PT)	\$171.49	\$178.47 (proposed at \$176.32)		\$298.04 (1.6700 adj.) (proposed at \$294.45)
Skilled Nursing (SN)	\$156.90	\$163.29 (proposed at \$161.32)		\$301.29 (1.8451 adj.) (proposed at \$297.65)
Speech Language Pathology (SLP)	\$186.41	\$194.00 (proposed at \$191.66)		\$315.56 (1.6266 adj.) (proposed at \$311.75)

\* For OT, PT, SN, or SLP visits in LUPA episodes that occur as the only episode or an initial episode in a sequence of adjacent episodes, CMS will continue to use the LUPA add-on factors established in the CY 2014 final rule.

The Consolidated Appropriations Act (CAA) of 2021 included a provision allowing occupational therapists to conduct initial and comprehensive assessments to home health beneficiaries. CMS will allow these assessments

when the plan of care does not initially include SN, but does include PT or SLP. Due to this, CMS established a LUPA add-on factor to be used for payment for the first OT visit in LUPA periods that occurs as the only period of care or the initial 30-day period of care in a sequence of adjacent 30-day periods of care. In CY 2022 rule making, CMS stated that due to insufficient data regarding initial and comprehensive visits conducted by occupational therapists, the PT LUPA add-on factor of 1.6700 will be used as an appropriate proxy for the OT add-on factor until there is sufficient data to create a distinct OT add-on factor. CMS estimates that CY 2022 data will need to be available before a distinct OT add-on factor can be established. As such, CMS will continue to use the PT LUPA add-on factor as a proxy for OT for CY 2023.

## **Wage Index and Labor-Related Share**

*Display pages 124 – 137, 138, 139 – 140, and 142*

As has been the case in prior years, CMS will use the most recent inpatient hospital wage index, which is the Federal Fiscal Year (FFY) 2023 pre-rural floor and pre-reclassified hospital wage index, to adjust payment rates under the HH PPS for CY 2023. The wage index is applied to the labor-related portion of the HH payment rate. CMS previously finalized that for CY 2019 and subsequent years that the labor-related share will be set at 76.1%.

The wage index and labor-related share budget neutrality factors were finalized to be 1.0001 (proposed at 0.9975) for the standard rate and 1.0007 (proposed at 0.9992) for the per-visit rates for CY 2023 to ensure that aggregate payments made under the HH PPS are not greater or less than will otherwise be made if wage adjustments had not changed.

In the past, CMS implemented wage index transition policies with limited duration in order to phase in significant changes to labor market areas with the intent to mitigate short-term negative impact to affected providers. Additionally, CMS recognizes that there are also year-to-year fluctuations in wage indexes that can occur due to external factors beyond a provider's control. In order to reduce large swings in year-to-year wage index changes and increase the predictability of HH PPS payments, CMS adopted a 5% cap on any decrease of the CY 2023 HH PPS wage index, and all future HH PPS wage indexes, compared with the previous year's final wage index. The cap will be applied regardless of the reason for the decrease and implemented in a budget neutral manner. This also means that if an HHA's prior CY wage index is calculated with the application of the 5% cap, the following year's wage index will not be less than 95% of the HHA's capped wage index in the prior CY.

A complete list of the wage indexes adopted for CY 2023 is available on the CMS website <https://www.cms.gov/files/zip/cy-2023-final-hh-pps-wage-index.zip>.

## **Patient-Driven Grouping Model**

*Display pages 14 – 46, 57 – 75, and 78 – 114*

CMS assigns HH stays into PDGM 30-day period of care groupings that are consistent with how clinicians differentiate between patients and the primary reason for needing home health care. Case-mix adjustments for home health payment are based solely on patient characteristics, relying more heavily on clinical characteristics and other patient information to place patients into 432 clinically meaningful payment categories.

Each year CMS recalibrates the PDGM case-mix weights to ensure that the case-mix weights reflect current home health resource use and change in utilization patterns. For CY 2023, CMS recalibrated case-mix weights based on data from CY 2021 as CMS believes that CY 2021 is reflective of PDGM utilization and patient resource use. Compared to CY 2022 weights, 419 groups will see a +/- 5% difference, 12 groups will change between +5% and +10%, and 1 group will see a change below -5% for CY 2023. A budget neutrality factor of 0.9904 (proposed at 0.9895) is applied to the standardized 30-day period payment rate to ensure that PDGM case-mix weights are implemented in a budget neutral manner.

Details on these reassignments can be found in the following supplemental file on the HH PPS webpage <https://www.cms.gov/files/zip/cy-2023-final-home-health-clinical-group-and-comorbidity-adjustment-diagnosis-list.zip>.

CMS finalized their update to functional impairment levels and functional points by clinical group using CY 2021 claims data. Tables 11 and 12 on Display pages 79 – 81 show the adopted OASIS points and thresholds for functional levels by clinical group, respectively, for CY 2023. Due to finalized coding changes, CMS also updated the comorbidity adjustment applicable to 30-day periods of care to include 22 (proposed at 23) low comorbidity adjustment subgroups and 91 (proposed at 94) high comorbidity subgroups. These groups are listed on tables 13 and 14, respectively, on Display pages 85 – 92.

The final case-mix weights for CY 2023 are listed in Table 16 on Display pages 98 – 111 and on the CMS website <https://www.cms.gov/files/zip/cy-2023-final-home-health-pdgm-case-mix-weights-and-lupa-thresholds.zip>.

## **Outlier Payments**

*Display pages 145 – 148*

Outlier payments are intended to mitigate the risk of caring for extremely high-cost cases. An outlier payment is provided whenever an HHA's cost for an episode of care exceeds a fixed-loss threshold, defined as the HH PPS payment amount for the episode plus a fixed dollar loss (FDL) amount.

Currently, there is a cap of 8 hours or 32 units per day (1 unit = 15 minutes), summed across the six disciplines of care, on the amount of time per day that will be counted toward the estimation of an episode's costs for outlier. The discipline of care with the lowest associated cost per unit is first discounted in the calculation of episode cost, in order to cap the estimation of an episode's cost at 8 hours of care per day.

The FDL amount is an FDL ratio multiplied by the wage index-adjusted 30-day period payment. This is added to the HH PPS payment amount for that episode. If calculated cost exceeds the threshold, the HHA receives an additional outlier payment equal to 80% of the calculated excess costs over the fixed-loss threshold.

Each HHA's outlier payments are capped at 10% of total PPS payments. By law, a limit of 2.5% of total HH PPS payments is set aside for outliers. CMS adopted a FDL ratio of 0.35 (proposed at 0.44) for CY 2023, based on CY 2021 data.

## **Expanded Home Health Value-Based Purchasing Model**

*Display pages 181 – 200*

On January 8, 2021, CMS announced the certification of the HHVBP for national expansion as well as its intent to expand the model through notice and comment rulemaking. In the original model, CMS implemented an ACA mandated HHVBP demonstration model for certain Medicare-certified HHAs, which started on January 1, 2016 and concludes on December 31, 2022, with the last year of data collection having ended on December 30, 2020.

The Medicare-certified HHAs required to participate in the original demonstration are from 9 randomly selected states: Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington. The demonstration program resembled the inpatient acute care hospital VBP program. CMS found that this model resulted in an average 4.6% improvement in HHA quality scores while also saving Medicare an average of \$141 million annually without denying or limiting coverage to beneficiaries.

CMS will expand the HH VBP model to all 50 states, the District of Columbia (DC), and all territories, starting with performance adjustments in CY 2025, and it will be budget neutral by cohort. This will apply to all HHAs certified before January 1, 2022 and will be based on the HHAs' CMS Certification Numbers (CCN). CY 2022 is a pre-implementation year which will allow HHAs to prepare and learn about the model with support from CMS. Each

HHA will have a reduction or increase to their Medicare payments by up to 5%, dependent on their performance on specified quality measures relative to other similar, competing HHAs.

CMS adopted a change to the existing baseline year definition: “...the year against which measure performance in a performance year will be compared.” This definition will be replaced by two definitions in an effort to lessen the confusion between the two types of baseline years used in the expanded HHVBP Model:

- HHA baseline year: “...the calendar year used to determine the improvement threshold for each measure for each individual competing HHA...”
- Model baseline year: “...the calendar year used to determine the benchmark and achievement threshold for each measure for all competing HHAs.”

## Performance Standards and Scoring

*Display pages 185 – 196*

For HHAs certified by Medicare before January 1, 2019 and for HHAs certified during January 1, 2019 – December 31, 2021, CMS adopted a change to the HHA baseline year for all applicable measures used in the expanded Model from CY 2019 and CY 2021, respectively, to CY 2022 beginning with the CY 2025 program year. For any HHA certified on or after January 1, 2022, the HHA baseline year will be the first full CY of services beginning after the date of Medicare certification and the first performance year will be the first full CY following the HHA baseline year. CMS intends to make HHA baseline data available as soon as administratively possible and will anticipate providing HHAs with their final individual improvement thresholds in the summer of CY 2023.

Medicare Certification Date	HHA Baseline CY	Performance CY	Payment CY
Prior to January 1, 2019	2022	2023	2025
January 1, 2019 - December 31, 2021	2022	2023	2025
January 1, 2022 – December 31, 2022	2023	2024	2026
January 1, 2023 – December 31, 2023	2024	2025	2027

Consistent with the updated baseline year for HHA certified by Medicare prior to January 1, 2022, CMS is also adopting to change the Model baseline year from CY 2019 to CY 2022 for the CY 2025 program year. CMS expects that HHAs will receive their final achievement thresholds and benchmarks in the July 2023 interim performance report (IPR) in the summer of CY 2023.

## Health Equity in the Expanded HHVBP Model – Request for Comments

*Display pages 196 – 200*

CMS requested comments on what policy changes should be considered for incorporating adjustments into the expanded HHVBP Model to reflect the varied patient populations that HHAs serve and tie health equity outcomes to the payment adjustments made based on HHA performance under the Model. A summary of comments received by CMS can be found on Display pages 198 – 200.

## Home Health Quality Reporting Program

*Display pages 157 – 180*

CMS collects quality data from HHAs on processes, outcomes, and patient experience of care. HHAs that do not successfully participate in the HH QRP are subject to a 2.0 percentage point reduction to the marketbasket update for the applicable year.

<b>Summary of Measure Currently Adopted for the CY 2023 HH Quality Reporting Program</b>	
<b>Measures</b>	<b>Data Source</b>
Improvement in Ambulation/Locomotion (NQF #0167)	OASIS
Application of Percent of Residents Experiencing One or More Falls with Major Injury (Long Stay) (NQF #0674)	OASIS
Application of Percent of Long-Term Care Hospital (LTCH) Patients with an Admission and Discharge Functional Assessment and a Care Plan That Addresses Function (NQF #2631)	OASIS
Improvement in Bathing (NQF #0174)	OASIS
Improvement in Bed Transferring (NQF #0175)	OASIS
Drug Regimen Review Conducted with Follow-Up for Identified Issues - Post Acute Care (PAC) HH QRP	OASIS
Improvement in Dyspnea	OASIS
Influenza Immunization Received for Current Flu Season	OASIS
Improvement in Management of Oral Medications (NQF #0176)	OASIS
Changes in Skin Integrity PAC	OASIS
Timely Initiation Of Care (NQF #0526)	OASIS
Transfer of Health Information to Provider-PAC	OASIS
Transfer of Health Information to Patient-PAC	OASIS
Acute Care Hospitalization during the First 60 Days of HH (NQF #0171)	Claims-based
Discharge to Community- PAC HH QRP (NQF #3477)	Claims-based
Emergency Department Use without Hospitalization during the First 60 Days of HH (NQF #0173)	Claims-based
Total Estimated Medicare Spending Per Beneficiary (MSPB)— PAC HH QRP	Claims-based
Potentially Preventable 30-Day Post-Discharge Readmission Measure for HH Quality Reporting Program	Claims-based
Home Health Within Stay Potentially Preventable Hospitalization	Claims-based
How well did the home health team communicate with patients	HHCAHPS
How do patients rate the overall care from the home health agency	HHCAHPS
How often the home health team gave care in a professional way	HHCAHPS
Did the home health team discuss medicines, pain, and home safety with patients	HHCAHPS
Will patients recommend the home health agency to friends and family	HHCAHPS

CMS adopted its proposal, with modification, to end the suspension of non-Medicare/Medicaid OASIS data collection for purposes of the HH QRP. All HHA's will be required to submit all-payer OASIS data beginning with the CY 2026 QRP program year, and will be phased-in in two parts. For the CY 2026 HH QRP, HHAs will be able to submit this data for all patients discharged between January 1, 2025 and June 30, 2025, but the data will not be used to make a compliance determination. Beginning with the CY 2027 HH QRP, HHAs will be required to report

OASIS data on all patients, regardless of payer, discharged during the applicable 12-month performance period (July 1, 2025 – June 30, 2026)

## Request for Information – Health Equity in the HH QRP

*Display pages 172 – 180*

CMS sought public comments on their effort to advance health equity within the HH QRP for all patients regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

Additionally, CMS considered adopting a structural composite measure for the HH QRP that could include organizational activities to address access to, and quality of, HH care for underserved populations. The three domains under consideration for such a measure are on Display pages 177 – 178.

A summary of comments received by CMS can be found on Display pages 179 – 180.

## Home Infusion Therapy Services – Annual Payment Updates

*Display pages 201 – 202*

National HIT services payment rates for initial and subsequent visits in each of the HIT payment categories for CY 2023 are required to be the CY 2022 rate adjusted by the percentage increase in the Consumer Price Index for all urban consumers for the 12-month period ending with June of the preceding year, which is then reduced by a productivity adjustment. These payment amounts are then adjusted using the geographic adjustment factor (GAF). The GAF is a weighted composite of each region's Geographic Practice Cost Indices (GPCIs) which include work, practice expense (PE), and malpractice (MP). The GAF is calculated as:

$$GAF = (0.50886 \times \text{Work GPCI}) + (0.44839 \times \text{PE GPCI}) + (0.04295 \times \text{MP GPCI}).$$

Addendum D from the CY 2023 PFS final rule contains a list of adopted GAFs and can be found at <https://www.cms.gov/files/zip/cy-2023-pfs-final-rule-addenda.zip>.

In future years, CMS will not include a section in the HH PPS rule on home infusion therapy if no changes are being proposed to the payment methodology. Rates will instead be updated each year in a change request and posted on the HIT website <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Home-Infusion-Therapy/Overview>.

## Data on the Use of Telecommunications Technology under the Medicare Home Health Benefit – Request for Comment

*Display pages 148 – 156*

CMS believes that collecting data on the use of telecommunications technology on home health claims would allow for analysis of the characteristics of the beneficiaries utilizing remotely furnished services, including a broader understanding of the social determinants that affect who benefits most from these services and any barriers that may exist for subsets of beneficiaries. Additionally, in their March 2022 Report to the Congress, MedPAC recommended tracking the use of telehealth on home health claims in order to impact payment accuracy. CMS requested comments on the collection of such data on home health claims with a targeted start date of January 1, 2023. This collection will begin on a voluntary basis, and will then become a reporting requirement by July 2023.

CMS also requested comments on how appropriate the use of telecommunications technology would be for certain home health services, noting that such services would not be considered “visits” for purposes of eligibility or payment. CMS believes that certain forthcoming G-codes do not lend themselves to the use of this technology,



due to the hands-on nature of the services. For other services, CMS intends to use comments received in order to clearly delineate when the use of such technology would be appropriate.

Lastly, CMS requested comments on future refinement of these G-codes beginning July 1, 2023. Specifically, whether these codes should differentiate the type of clinician performing the service via telecommunications and whether these codes should differentiate the type of service being performed.

A summary of the comments received by CMS can be found on Display pages 153 – 156.

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