

# Proposed CY 2021 PHYSICIAN FEE SCHEDULE



FACT SHEET | August 2020

## INTRODUCTION

**On Aug. 4, 2020, the Center for Medicare and Medicaid Services (CMS) published their CY 2021 proposed revisions related to the Physicians Fee Schedule (PFS).** Comments on the proposals are

due no later than 5 pm on October 5, 2020. The proposed PFS addresses changes CMS made administratively in response to the COVID-19 public health emergency (PHE), and proposes how these changes will be dealt with on a provisional basis until the end of the PHE, and in some cases whether or not the policy will become permanent. There are some temporary policy changes that occurred during the PHE, such as limitations around the eligible provider types and patient location, that require congressional action to be extended beyond the PHE, and are thus not addressed in CMS' proposals.

One of the most significant areas addressed in the proposed PFS is related to the codes that are eligible for telehealth reimbursement in Medicare. CMS is proposing to add **certain select codes** that are currently on the Medicare telehealth list as a result of the PHE, on a permanent basis. They are also proposing to add additional codes provisionally which would be eligible for reimbursement until the end of the year in which the PHE ends. This would give enough time for CMS to thoroughly assess the codes qualifications to be allowed permanently. Other codes that are currently eligible for telehealth reimbursement under the PHE would expire when the PHE ends. Although CMS is proposing to remove the exclusion of telephones, facsimile machines and electronic mail systems from the definition of an 'interactive telecommunication system', they are not proposing to continue reimbursement for telephone codes (99441-99443). However, they are seeking comment on whether CMS should develop alternate coding and payment for a service similar to the virtual check-in but for a longer unit of time and with a higher value.

CMS has also made clarifications and modifications around remote physiologic monitoring and regarding the ability of clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists to furnish brief online assessment and management services, virtual check-ins and remote evaluation. Requests for comments and proposals also relate to supervision requirements, as well as requirements for residents and teaching physicians. Each of these elements is discussed in detail below, as well as additional telehealth-related topics which are bulleted as the final section of this factsheet.

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## ADDITION OF MEDICARE TELEHEALTH SERVICES

CMS has an established process for adding codes to the list of Medicare telehealth services eligible for reimbursement. The process includes assigning qualifying requests to either one of two categories. Category 1 is reserved for services that are similar to services already approved on the Medicare telehealth list such as professional consultations, office visits and office psychiatry services. Category 2 (which entails a more extensive qualification process) is for services that are not similar to current telehealth services on the Medicare list, but pose a significant benefit for the patient. For CY 2021, CMS is proposing to add the following codes on a Category 1 basis:

- **GPC1X** – Visit Complexity with certain office/outpatient evaluation and management services
- **99XXX** – Prolonged Services
- **90853** – Group Psychotherapy
- **96121** – Neurobehavioral Status Exam
- **99483** – Care Planning for Patients with Cognitive Impairment
- **99334** – Domiciliary, Rest Home, or Custodial Care services
- **99335** – Domiciliary, Rest Home, or Custodial Care services
- **99347 & 99348** – Home Visits

CMS is also proposing to create a third category of criteria for adding services to the Medicare telehealth list on a temporary basis. They are including codes in the list that were added during the PHE for which there is likely to be clinical benefit when furnished via telehealth, but for which there is not yet sufficient evidence available to consider the services as permanent additions under Category 1 or Category 2 criteria. Category 3 services would remain on the Medicare eligible telehealth services list through the calendar year in which the PHE ends. To become permanent, they would need to meet the qualifications of Category 1 or 2. Proposed Category 3 additions include:

- **99336 & 99337** - Domiciliary, Rest Home, or Custodial Care services, Established patients
- **99349, 99350** – Home Visits, Established Patients. NOTE: CMS stated that these home visits will only be available for the treatment of substance use disorder or co-occurring mental health disorder.
- **99281, 99282, 99283** – Emergency department Visits
- **99315, 99316** – Nursing Facility discharge day management
- **96130** - Psychological and Neuropsychological Testing
- **96131, 96132, 96133** – Psychological testing evaluation services

CMS is soliciting comments on codes that are currently on the telehealth list during the PHE for COVID-19, but for which they have not been proposed to be added on a Category 1 or 3 basis. They specifically point out concerns with the following types of codes when delivered via telehealth:

- Initial and final/discharge interactions
- Higher level emergency department visits
- Hospital, Intensive Care Unit, Emergency care, Observation stays

Additionally, they are interested in comments regarding physical therapy, occupational therapy and speech language pathology codes, since those types of professionals are not eligible to provide those services under current statute, although they could potentially be billed as ‘incident to’ by a physician or other eligible practitioner.

## NEW COMMUNICATION TECHNOLOGY-BASED SERVICES (CTBS)

CMS clarifies that clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists can furnish brief online assessment and management services, virtual check-ins and remote evaluation. CMS has created two new codes to accommodate for this including:

- **G20X0** (*Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment.*)
- **G20X2** (*Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion*)

These codes would be valued the same as G2010 and G2012 respectively. The aforementioned practitioners can also bill the online digital evaluation services (eVisit) codes meant for non-physician healthcare professionals (G2061, G2062 and G2063). Consent for these codes can be documented by auxiliary staff under general supervision.

## AUDIO-ONLY SERVICES & DEFINITION OF ‘INTERACTIVE TELECOMMUNICATION SYSTEM’

Although CMS is proposing to remove the exclusion of telephones, facsimile machines and electronic mail systems from the definition of an ‘interactive telecommunication system’, they are not proposing to continue reimbursement for telephone codes (99441-99443). However, they are seeking comment on whether CMS should develop coding and payment for a service similar to the virtual check-in but for a longer unit of time and with a higher value. They are also seeking comment on whether telephone only services should be provisional policy during the PHE or if it should be a permanent payment policy.

## REMOTE PHYSIOLOGIC MONITORING SERVICES

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The proposed rule makes several modification and clarifications regarding remote physiologic monitoring:

- After the PHE, an established patient-physician relationship will be required for RPM services.
- CMS is proposing to make the ability to obtain consent at the time RPM services are furnished permanent.
- CMS is proposing to allow auxiliary personnel to furnish 99453 and 99454 under a physician's supervision, which would include contracted employees.
- CMS clarifies that a medical device that is part of 99454 must meet the definition of a medical device of the Federal Food, Drug and Cosmetic Act, and data must be collected and transmitted rather than self-reported to the provider.
- After the PHE, there will be a requirement for at least 16 days of data collection within each 30-day period for codes 99453 and 99454.
- Only physicians and practitioners eligible to furnish evaluation and management services may bill for RPM services.
- Acute as well as chronic conditions qualify for RPM services.
- The definition of 'interactive communication' in CPT Codes 99457 and 99458 is real-time and includes synchronous two-way interaction that can be enhanced with video or other kinds of data, as described in CPT code G2012.

CMS is seeking comment on whether the current RPM codes accurately describe the full range of clinical scenarios where RPM may benefit patients.

## SUPERVISION

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CMS is proposing to allow direct supervision to be provided using real-time, interactive audio and video technology through the later of the end of the calendar year in which the PHE ends or December 31, 2021. They are interested in the appropriateness of this and whether additional guardrails are necessary, and whether the policy should be extended beyond the PHE. CMS also clarifies that services that may be billed incident-to may be provided via telehealth incident to a physicians' service and under the direct supervision of the billing professional.

## TEACHING PHYSICIANS

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During the PHE, CMS has allowed teaching physicians to interact with residents through virtual means. Residents at primary care centers may also furnish an expanded set of services to beneficiaries, including levels 4-5 services and allow for the delivery of services outside of their approved graduate medical education (GME) program, including transitional care management, online digital evaluation, interprofessional telephone/internet/EHR services, the virtual check-in and remote evaluation. Also allowed was PFS payment to the teaching physician for services furnished by residents via telehealth if the services were on the eligible telehealth list. CMS is considering whether these policies should be extended through Dec. 31, 2021 and if they should be made permanent.

## ADDITIONAL TELEHEALTH-RELATED PROPOSALS

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Proposals around telehealth, virtual care and CTBS are found throughout the fee schedule. These are some additional proposals of note:

- CMS is proposing to revise its frequency limitation in a skilled nursing facility from one visit every 30 days via telehealth to one every 3 days. They are seeking comments on this proposal as well as if a frequency limitation is necessary at all.
- CMS is proposing to allow additional codes to be billed concurrently with transitional care management services, including chronic care management code G2058.
- CMS is proposing new codes for the initial month or subsequent months of psychiatric collaborative care model services (GCOL1).
- CMS is proposing to revise regulation in order to allow periodic assessments, which are part of opioid use disorder treatment services for OTPs to be furnished via two-way interactive audio-video communication technology if all other applicable requirements are met.
- CMS is proposing to allow FQHCs and RHCs to bill for principal care management beginning Jan. 1, 2021 through HCPCS code G2064 and G2065, which would be incorporated into G0511 which is the general care management code used by RHCs and FQHCs.
- CMS is proposing in the Shared Savings Program to include new evaluation and management and care management codes in the methodology to assign beneficiaries to ACOs.
- CMS is proposing changes to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey to account for the increased use of telehealth during the COVID-19 pandemic including adding a measure that assesses patient-reported usage of telehealth services.

## PROPOSED CLARIFICATION OF EXISTING POLICIES

Per requests from the public to clarify certain aspects of existing telehealth policies, CMS offered the following proposed clarification:

- Services that are provided via technology where the physician/practitioner is in the same location as the beneficiary (example: when trying to minimize risk of exposure) – Even though technology was used, it should be billed as though it was furnished in-person and telehealth limitations would not apply.

## ADDITIONAL COMMENTS REQUESTED

**In addition to comment requests by CMS already addressed above, the following are additional comment requests made in the PFS:**

- CMS is seeking comments on whether additional coding is needed for critical care services to reflect different forms of care delivery, especially remote monitoring.
- CMS is seeking comments on the waiver of the requirement for a physician and nonphysician practitioners to personally perform required visits for nursing home residents, allowing visits to be conducted via telehealth during the PHE and whether that should be made permanent.
- Through a separate request for information (RFI) solicitation, CMS is requesting feedback on whether CMS should include exceptions to the electronic prescribing of controlled substances requirements and under what circumstances.
- CMS is seeking comment on whether there are additional services that fall outside the scope of telehealth services under section 1834(m) of the Act where it would be helpful to clarify that the services are inherently non-face-to-face, so do not need to be on the Medicare telehealth services list in order to be billed and paid when furnished using telecommunications technology rather than in person with the patient present.

**Comments are due October 5, 2020 by 5 pm EST.**

Comments can be submitted on the regulation at <https://www.regulations.gov> and following the 'submit a comment' instructions, or by regular mail using the address provided on page 2-3 of the proposed rule.