

Finalized CY 2021 MEDICARE PHYSICIAN FEE SCHEDULE



FACT SHEET | December 2020

INTRODUCTION

The Center for Medicare and Medicaid Services (CMS) finalized their CY 2021 revisions to the Physicians Fee Schedule (PFS).

The PFS addresses changes CMS made administratively in response to the COVID-19 public health emergency (PHE), and details 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' rule.

One of the most significant areas addressed in the finalized PFS is related to the codes that are eligible for telehealth reimbursement in Medicare. CMS is making permanent reimbursement of certain select codes that are currently on the Medicare temporary telehealth list as a result of the PHE. They are also adding 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 removing the exclusion of telephones, facsimile machines and electronic mail systems from the definition of an 'interactive telecommunication system', they will not continue to reimbursement for telephone codes (99441-99443). However, based on comments received, they are establishing a new HCPCS G-code describing 11-20 minutes of medical discussion to determine the necessity of an in-person visit. CMS also addresses a number of other issues, such as frequency limits for nursing facility visits furnished via telehealth. Clarification is given around issues such as the ability of physical, occupational and speech language pathologists to furnish brief online assessment and management services and certain requirements related to remote physiologic monitoring. CMS also specifies that the telehealth restrictions do not apply when a beneficiary and practitioner are in the same location even if conducted via audio/video technology. 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 finalizing the following codes on a Category 1 basis:

- **G2211** – Visit Complexity with certain office/outpatient evaluation and management services
- **G2212** – Prolonged office or other outpatient evaluation and management service(s).
- **90853** - Group Psychotherapy
- **96121** - Psychological and Neuropsychological Testing
- **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 notes in its response to commenters inquiring about 99347 and 99348 home visits after the COVID-19 PHE, that although the home is not currently an eligible site, it is allowed for patients with substance used disorder and co-occurring mental health disorder and could therefore be used for those patients.

CMS is also finalizing 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. In response to commenters who expressed concern about the codes being added to the list without a fixed end date, CMS focused on the fact that the COVID-19 emergency has been extended into CY 2021 ensuring the codes would at least be valid through the end of 2021.

In the initial proposed rule, CMS proposed only approximately half of the codes they are now finalizing as Category 3, and solicited comments on codes that are currently on the temporary telehealth list during the PHE for COVID-19, but were not proposed to be added on a Category 1 or 3 basis. They specifically pointed 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
- Physical therapy, occupational therapy and speech language pathology codes

In response to the comments they received, CMS has significantly broadened the codes that would be reimbursable under Category 3 after the COVID-19 PHE to the following:

- End-Stage Renal Disease Monthly Capitation Payment- 90952, 90953, 90959, 90962
- Domiciliary, Rest Home, or Custodial Care services, Established patients- 99336 & 99337
- Home Visits, Established Patients- 99349, 99350 (NOTE: CMS stated that these home visits will only be available for the treatment of substance use disorder or co-occurring mental health disorder.)
- Emergency department Visits- 99281, 99282, 99283, 99284, 99285
- Nursing Facility discharge day management- 99315, 99316
- Psychological and Neuropsychological Testing- 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139
- Therapy Services, Physical, and Occupational Therapy – 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521, 92522, 92523, 92524, 92507
- Subsequent Observation and Observation Discharge Day Management – 99217, 99224, 99225, 99226, 99221, 99222, 99223, 99238, 99239
- Critical Care Services – 99291, 99292
- Inpatient Neonatal and Pediatric Critical Care, Subsequent- 99469, 99472, 99476
- Continuing Neonatal Intensive Care Services – 99478, 99479, 99480

While CMS is adding critical care services on a Category 3 basis, they did solicit comments on whether current coding does not reflect additional models of critical care, specifically those that are a combination of remote monitoring and clinical staff (often referred to as tele-ICU). In the finalized rule, CMS notes that they will take the wide range of comments they received under consideration as they evaluate any new CPT coding and AMA RUC recommendations in the future. CMS has also made technical modifications to the telehealth code list that involves replacing codes that Medicare has deleted from the fee schedule with their successor codes.

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:

- **G2250** (*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.*)
- **G2251** (*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). When a private practice physical therapy (PT), occupational therapy (OT) or speech language pathology (SLP) bills the code, they would need to include the corresponding GO, GP or GN therapy modifier to signify that the communication technology-based service is furnished as therapy services under an OT, PT or SLP plan of care. Consent for these codes can be documented by auxiliary staff under general supervision.

AUDIO-ONLY SERVICES & DEFINITION OF 'INTERACTIVE TELECOMMUNICATION SYSTEM'

Although CMS is removing the exclusion of telephones, facsimile machines and electronic mail systems from the definition of an 'interactive telecommunication system', they will not continue reimbursement for telephone codes (99441-99443). CMS expresses that their longstanding interpretation of 'telecommunication system' in statute precludes audio-only technology from being included within the telehealth services they currently reimburse (notwithstanding the COVID-19 PHE). They state that at the end of the PHE, the codes will be assigned a status of 'bundled' and CMS will post the RUC-recommended RVUs for the codes in accordance with their usual practice. However, based on comments received, they are establishing a new HCPCS G-code (G2252) describing 11-20 minutes of medical discussion to determine the necessity of an in-person visit. This code would not fall under the telehealth requirement, and instead be considered communication technology-based services (CTBS), just like the virtual check-in codes (G2021 and G2012).

REMOTE PHYSIOLOGIC MONITORING SERVICES

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

- After the PHE, an established patient-physician relationship will be required for RPM services.
- Consent can be obtained at the time RPM services are furnished permanently.
- Auxiliary personnel are allowed 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.
- Independent Diagnostic Testing Facilities are not allowed to bill for RPM services.

SUPERVISION

CMS is finalizing their proposed clarification that telehealth services may be furnished and billed when provided incident to a distant site physicians' (or authorized NPP's) service under direct supervision of the billing professional provided through their virtual presence. Additionally, CMS will 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.

TEACHING PHYSICIANS

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. After considering the comments they received, CMS is finalizing these policies for the duration of the PHE for COVID-19.

On a permanent basis, the following allowances would be made for residency training sites located outside of a Metropolitan Statistical Area (MSA):

- Teaching physicians can meet the requirements to bill for their services involving residents through virtual presence.
- Medicare may make payment for teaching physician services provided through interactive, audio-video real-time communication (patient must be located in a separate location outside the same MSA or is within a rural area outside of a different MSA). The teaching physician must be in a third location, either within the same rural training site as the resident or outside of that rural training site.
- Medicare may make payment for the teaching physician when the resident furnishes an expanded array of services under the primary care exception. CMS is limiting the permanent expanded array of services under the primary care exception to include communication-technology based services and interprofessional consults. These services are described by CPT codes 99421-99423, and 99452, and HCPCS codes G2010 and G2012. Medicare telehealth services that are furnished by residents in residency training sites located outside of an MSA are also added to the primary care exception.

CMS states that documentation for these services must specify clearly how and when the teaching physician was present for the services. CMS believes that this permanent policy that is exclusive to non-MSAs will improve patient access in rural areas, and will improve teaching capabilities and potentially allow for additional resident education opportunities.

CLARIFICATION OF EXISTING POLICIES

Per requests from the public to clarify certain aspects of existing telehealth policies, CMS offered the following 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 TELEHEALTH-RELATED POLICIES

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

- CMS has revised its frequency limitation in a skilled nursing facility from one visit every 30 days via telehealth to one every 14 days. They had originally proposed one visit every 3 days, but after considering comments that expressed concerns around creating a disincentive for in-person care, it was decided that one visit every 14 days is the right balance between increased access to care through telehealth and maintaining appropriate in-person care.
- Finalized revisions to CMS regulations which were previously made in an interim final rule, based on requirements of the SUPPORT for Patients and Communities Act, which adds the home of an individual as a permissible originating site for telehealth services for individuals with SUD diagnosis and co-occurring mental health disorders.
- CMS will allow additional codes to be billed concurrently with transitional care management (TCM) services, including chronic care management code G2058 when reasonable and necessary. CMS has also revised values for certain TCM codes.
- CMS is adding new codes for the initial month or subsequent months of psychiatric collaborative care model services (G2214).
- CMS has finalized regulations 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, as clinically appropriate, if all other applicable requirements are met.
- CMS will 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 finalizing its proposal in the Shared Savings Program to include new evaluation and management and care management codes in the methodology to assign beneficiaries to ACOs.
- CMS includes a summary of Medicare Diabetes Prevention Program (MDPP) beneficiary options for virtual services related to applicable 1135 waivers during the COVID-19 emergency.
- CMS has finalized changes to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey to integrate one telehealth item to address the increased use of telehealth during the COVID-19 pandemic.
- CMS codified the definition of primary care services used in the Merit-based Incentive Payment System (MIPS) beneficiary assignment methodology to include additional services, including the virtual check-in and remote evaluation of patient video/images. Cost associated with certain telehealth services will be added to cost measures.