

ALLIANCE SUMMARY OF CY 2021 PHYSICIAN FEE SCHEDULE AND QUALITY PHYSICIAN PAYMENT FINAL RULE

The Centers for Medicare and Medicaid Services issued the final Physician Fee Schedule (PFS) and Quality Physician Payment rule on December 1, 2020. A brief summary follows including areas in which the Alliance commented along with the outcome of our comments. As you can imagine, much of the final rule addresses telehealth. CMS is covering 144 services via telehealth as part of the COVID-19 Public Health Emergency (PHE), and the Agency has seen a significant increase in use under the pandemic. Prior to COVID-19, about 15,000 fee-for-service beneficiaries received care via telehealth per week. Due to the pandemic, between mid-March and mid-October more than 24.5 million Medicare beneficiaries have used telehealth, nearly half of the Medicare population.

Medicare Telehealth and Other Services Involving Communications Technology

CMS does not have statutory authority to expand telehealth coverage beyond a rural benefit in Medicare permanently and, as such, will require action by Congress in order to address expanded coverage beyond rural areas. Most of the expanded services will revert back to rural areas once the PHE is over – unless Congress intervenes. Similarly, a patient’s home will not be able to be an originating site once the PHE is over unless Congress intervenes.

What CMS has done, however, is finalize the addition of more than 60 services to the Medicare telehealth list. The following list of services were added to the Medicare telehealth list on a Category 1 basis – meaning they are permanent. These services are similar to ones already on the telehealth list including but not limited to:

- Group Psychotherapy (CPT code 90853)
- Psychological and Neuropsychological Testing (CPT code 96121)
- Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT codes 99334-99335)
- Home Visits, Established Patient (CPT codes 99347-99348)
- Cognitive Assessment and Care Planning Services (CPT code 99483)
- Visit Complexity Inherent to Certain Office/Outpatient Evaluation and Management (E/M) (HCPCS code G2211)
- Prolonged Services (HCPCS code G2212)

CMS also finalized a new category of telehealth benefits under the Physician Fee Schedule. The new Category 3 list will include telehealth services covered by Medicare during the public health emergency and through the calendar year in which the emergency declaration expires.

So far, the Category 3 list includes services like home visits for established patients, emergency department visits levels one through five, hospital discharge day management, critical care services, and nursing facility discharge day management.

However, CMS walked back the proposed frequency limitation for subsequent nursing facility visits furnished via telehealth from one visit every three days to one visit every 14 days.

CMS added the following list of services to the Medicare telehealth list on a Category 3 basis:

- Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT codes 99336-99337)
- Home Visits, Established Patient (CPT codes 99349-99350)
- Emergency Department Visits, Levels 1-5 (CPT codes 99281-99285)
- Nursing facilities discharge day management (CPT codes 99315-99316)
- Psychological and Neuropsychological Testing (CPT codes 96130-96133; CPT codes 96136-96139)
- Therapy Services, Physical and Occupational Therapy, All levels (CPT codes 97161-97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507)
- Hospital discharge day management (CPT codes 99238-99239)
- Inpatient Neonatal and Pediatric Critical Care, Subsequent (CPT codes 99469, 99472, 99476)
- Continuing Neonatal Intensive Care Services (CPT codes 99478-99480)
- Critical Care Services (CPT codes 99291-99292)
- End-Stage Renal Disease Monthly Capitation Payment codes (CPT codes 90952, 90953, 90956, 90959, 90962)
- Subsequent Observation and Observation Discharge Day Management (CPT codes 99217; CPT codes 99224-99226)

The following services will **NOT** be added to the Medicare telehealth list either permanently or temporarily.

- Initial Nursing Facility Visits, All Levels (Low, Moderate, and High Complexity) (CPT 99304-99306)
- Initial hospital care (CPT 99221-99223)
- Radiation Treatment Management Services (CPT 77427)
- Domiciliary, Rest Home, or Custodial Care services, New (CPT 99324- 99328)
- Home Visits, New Patient, all levels (CPT 99341- 99345)
- Inpatient Neonatal and Pediatric Critical Care, Initial (CPT 99468, 99471, 99475, 99477)
- Initial Neonatal Intensive Care Services (CPT 99477)
- Initial Observation and Observation Discharge Day Management (CPT 99218 – 99220; CPT 99234-99236)
- Medical Nutrition Therapy (CPT G0271)

In the March 31, 2020 COVID-19 interim final rule with comment (IFC), CMS established separate payment for audio-only telephone (E/M) services. While the Agency did not propose to continue to recognize these codes for payment under the PFS in the absence of the COVID-19 PHE, it recognized that the need for audio-only interactions could remain after the PHE as beneficiaries continue to try to avoid sources of potential infection, such as a doctor's office. As such, **CMS established payment on an interim final basis for a new HCPCS G-code describing 11-20 minutes of medical discussion to determine the necessity of an in-person visit.** G2062 will be designated as "sometimes therapy" services to facilitate billing of communication technology-based services (CTBS) by therapists. **The Alliance recommended that CMS continue to pay for audio only telephone E/M services after the PHE expires.**

Direct Supervision by Interactive Telecommunications Technology

For the duration of the COVID-19 PHE, for purposes of limiting exposure to COVID-19, CMS adopted an interim final policy revising the definition of direct supervision to include virtual presence of the supervising physician or practitioner using interactive audio/video real-time communications technology. In this final rule, for CY 2021, CMS is allowing direct supervision to be provided using real-time, interactive audio and video technology (excluding telephone that does not also include video) through the latter of the end of the calendar year in which the PHE ends or December 31, 2021.

Payment for Office/Outpatient Evaluation and Management (E/M)

As finalized in the CY 2020 PFS final rule, in CY 2021 CMS will be largely aligning the E/M visit coding and documentation policies with changes laid out by the CPT Editorial Panel for office/outpatient E/M visits, beginning January 1, 2021 and finalized revisions to the times used for rate-setting for the office/outpatient E/M visit code set.

Changes to the E/M code set include the following:

- Reducing to 4 levels of E/M codes for new patients (99202-99205) and deleting code 99201
- Retaining 5 levels for established patients (99211-99215)
- Introducing an add-on code (G2212) for prolonged visits billed with level 5 codes only
- Use of G2212 will replace 99417
- Introducing a G code (G2211) to be billed with complex visits
- Adopting the AMA RUC recommendations to reduce administrative burden and increase reimbursement for the majority of these E/M codes in 2021

CMS also finalized separate payment for a new HCPCS code, G2212, describing prolonged office/outpatient E/M visits to be used in place of CPT code 99417 (formerly referred to as CPT code 99XXX) to clarify the times for which prolonged office/outpatient E/M visits can be reported.

Policies Regarding Professional Scope of Practice and Related Issues

Supervision of Diagnostic tests by Certain Non-physician Practitioners (NPPs)

CMS has made permanent the provision to allow nurse practitioners (NPs), clinical nurse specialists (CNSs), physician assistants (PAs), and certified nurse-midwives (CNMs) to supervise the performance of diagnostic tests within their scope of practice and state law and added certified registered nurse anesthetists (CRNAs) to this list. These practitioners must maintain the required statutory relationships under Medicare with supervising or collaborating physicians.

Billing for Telehealth Services for Certain Providers Including PTs

CMS also clarified in the final rule that licensed clinical social workers, clinical psychologists, physical therapists (PTs), occupational therapists (OTs), and speech-language pathologists (SLPs) can deliver brief online assessment and management services, as well as virtual check-ins and remote evaluation services. The final rule includes two new codes to support billing for telehealth services delivered by these providers - G2010 and G2012

Therapy Assistants Furnishing Maintenance Therapy

Similarly, physical therapists (PT) and occupational therapists (OT) can delegate the furnishing of maintenance therapy services, as clinically appropriate, to a physical therapy assistant (PTA) or an occupational therapy assistant (OTA). This Part B policy allows PTs/OTs to use the same discretion to delegate maintenance therapy services to PTAs/OTAs that they utilize for rehabilitative services. **The Alliance recommended that CMS permit therapy assistants to furnish maintenance therapy at the request of APTA.**

Medical Record Documentation

In the CY 2020 PFS final rule, CMS finalized broad modifications to the medical record documentation requirements for physicians and certain NPPs. In this CY 2021 PFS final rule, CMS clarified that physicians and NPPs, including therapists, can review and verify documentation entered into the medical record by members of the medical team for their own services that are paid under the PFS and clarified that therapy students, and students of other disciplines, working under a physician or practitioner who furnishes and bills directly for their professional services to the Medicare program, may document in the record so long as the documentation is reviewed and verified (signed and dated) by the billing physician, practitioner, or therapist.

Removal of Outdated National Coverage Determinations (NCDs)

CMS finalized the removal of six outdated or obsolete National Coverage Determinations (NCDs). Removing outdated NCDs means that the Medicare Administrative Contractors no longer are required to follow those outdated coverage policies when it comes to covering services for beneficiaries. The NCDs that were removed include:

1. 20.5 – Extracorporeal Immunoabsorption (ECI) using Protein A Columns
2. 30.4 – Electrosleep Therapy

3. 100.9 – Implantation of Gastroesophageal Reflux Device
4. 110.19 – Abarelix for the Treatment of Prostate Cancer
5. 220.2.1 – Magnetic Resonance Spectroscopy
6. 220.6.16 – FDG PET for Inflammation and Infection

Physician Payment/Conversion Factor

The CY 2021 conversion factor is \$32.41, a decrease of \$3.68 from the 2020 PFS conversion factor of \$36.09. This amounts to a reduction of 10.2%. The decrease stems from the statutory requirement that the Physician Fee Schedule remains budget neutral and since CMS increased RVUs for common office/outpatient E/M services, including maternity care bundles, emergency department visits, end-stage renal disease capitated payment bundles, and physical and occupational therapy evaluation services, the Agency had to offset it somewhere. As you may recall, the Alliance strongly urged CMS to waive the budget neutrality so that physicians would not see such a drastic decrease – especially during a Public Health Emergency (PHE). However, CMS moved ahead with the decrease nevertheless.