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In Proposed Physician Rule, Telehealth Expands and Contracts, Limited by Statute, PHE

By Nina Youngstrom

Telephone-only evaluation and management (E/M) services as a type of telehealth will disappear next year or whenever the COVID-19 public health emergency (PHE) ends, according to the 2021 proposed Medicare Physician Fee Schedule (MPFS) regulation,[1] which is scheduled to be published in the Aug. 17 *Federal Register*. And CMS plans to add and remove telehealth services in different ways, across three categories, partly by making some PHE telehealth services permanent. The glitch, however, is Medicare coverage again will be limited to originating sites—essentially rural areas—and audiovisual technology after the PHE. CMS's hands are tied, because a permanent telehealth expansion to all corners of the country and to telephone calls requires a change in the Social Security Act, which only Congress can make, attorneys said. For the same reason, a patient's home won't be a telehealth originating site when the regulation takes effect Jan. 1 if the PHE expires by then. In fact, a number of Medicare payment proposals are contingent on which comes first: the end of the PHE or 2021—a testament to the turbulence of the times.

"We are starting to see a little bit of the unwinding plan and what can remain permanent versus what is likely to get reeled back and returned to pre-COVID rules," said Richelle Marting, an attorney in Overland Park, Kansas. CMS also is asking for an unusual amount of feedback as it figures out how to proceed, said attorney David Glaser, with Fredrikson & Byron in Minneapolis. "They are soliciting comment more actively than they ever have before, so there is an opportunity for people to chime in."

The proposed MPFS has changes all over the map. Two are on the supervision front, and both were seen as positive. One is a telehealth addition that, if finalized, would allow physicians to provide direct supervision virtually, using real-time, interactive audiovisual technology, said attorney Thomas Ferrante, with Foley & Lardner in Tampa, Florida. That's a game changer for billing incident to the physician's services, he said. Physicians wouldn't have to be physically present to provide direct supervision for incident-to billing or other services. Virtual supervision would be allowed, if finalized, until Dec. 31, 2021, or the end of the PHE, whichever is later, Ferrante said.

The other supervision proposal, which would be permanent, is unrelated to telehealth. Glaser said CMS would permanently change supervision requirements to allow nonphysician practitioners (NPPs) to supervise diagnostic tests. "That would be a great thing," he said. "This is long overdue. NPPs can do the tests, but they can't supervise them." According to the proposed regulation, NPPs (e.g., nurse practitioners, certified nurse midwives) who are authorized to perform the tests under their scope of practice would also be authorized to supervise the tests.

Meanwhile, CMS didn't deviate from its plans to move ahead with radical changes to coding and documenting office/outpatient visits. Starting in 2021, physicians and other clinicians will base their office visit E/M levels of service on the documentation of time or medical decision-making only, with new definitions of both, so they don't have to factor in the history and exam, although they still must be medically appropriate.[2] New American Medical Association guidelines for medical decision-making will rule the day. The changes affect nine CPT

codes: four for new patients (CPT 99202-99205)—99201 will be deleted—and five for established patients (99211-99215).

Some providers may be tempted to hold bills from a compliance perspective until robust auditing clears them to bill, but that's probably unnecessary, said Valerie Rock, a principal with PYA in Atlanta, Georgia. Although providers have to make some adjustments, the new documentation guidelines probably won't skew their E/M levels of service to the point it affects cash flow, she said. But providers should start training and auditing, Rock said. "There will be some providers who will be impacted more than others."

CMS Sets Out Three Categories for Telehealth

Parts are moving with Medicare coverage of telehealth, between the uncertain PHE end date, how that fits with the proposed MPFS rule, and eight or nine bills pending in Congress to eliminate the originating-site requirement. "There's a lot of good stuff in here, but I don't want this to give people a false sense of achievement," Ferrante said. "There's work to get done."

For example, CMS currently limits the provision of subsequent nursing facility visits to once every 30 days. In the MPFS rule, CMS is proposing to revise this frequency limitation to once every three days. That's far more generous, Ferrante said, but again, this won't benefit Medicare beneficiaries who want to receive health care from their home.

As explained in the proposed MPFS rule, there have traditionally been two categories for additions to telehealth coverage, and this year CMS added a third and then grouped telehealth services into three lists:

1. Nine codes that will become permanent.
2. Seventy-four codes that will be removed when the PHE expires.
3. Thirteen codes (dubbed category 3 codes) that will be added on a temporary basis.

According to the MPFS, category 1 services "are similar to professional consultations, office visits, and office psychiatry services that are currently on [the] Medicare telehealth services list." CMS is proposing to cover as category 1 services the telehealth services that were added in the March 31 interim final rule for the COVID-19 PHE. On top of that, CMS added nine new category 1 codes, including GPC1X (complexity inherent to the visit) and 96121 (neurobehavioral status exam). These services will be added permanently, assuming they're finalized, when the rule takes effect Jan. 1.

Next up are category 2 codes, which are for "services that are not similar to those on the current Medicare telehealth services list." CMS is proposing to remove 74 codes when the PHE ends, because it believes these services are unlikely to satisfy category 2 criteria to justify continuing forever, Ferrante said. They include initial and subsequent observation and observation discharge day management (CPT codes 99217-99220, 99224-99226, and 99234-99236); initial hospital care and hospital discharge day management (CPT codes 99221-99223 and 99238-99239); and radiation treatment management services (CPT code 77427), among others.

Some New Telehealth Codes Are Temporary

Then there's category 3, which are telehealth services CMS would add temporarily—either through the end of the PHE or the end of 2021, whichever is later. For example, if the PHE expires in February 2021, these codes will be covered through the end of 2021, Ferrante said. So unlike the 74 codes in category 2, which will be dropped when the PHE ends, CMS is giving category 3 codes until at least the end of 2021. CMS explained that it's trying to collect information on telehealth delivery of these services for possible future coverage. They are:

- 99336 and 99397 (domiciliary, rest home, or custodial care services for established patients).
- 99349 and 99350 (home visits for established patients).
- 99281-99283 (emergency department visits).
- 99315-99316 (nursing facility discharge day management).
- 96130-96133 (psychological and neuropsychological testing).

There's a potential snafu, however, Marting said. If the PHE expires in October without another extension, there will be a gap in telehealth coverage because the 2021 MPFS doesn't take effect until Jan. 1, which CMS acknowledged in the proposed rule, she said. "In an election year, it's difficult to predict how the administration will handle the extension of the PHE in October," Marting noted. In July, HHS Sec. Alex Azar waited until the day before the PHE expired to extend it for another 90 days.

CMS Proposes Big Shift in Payment Rates

The proposed regulation includes a big bump in pay for office/outpatient E/M services (CPT 99202 to 99215), with a corresponding drop for other types of services, such as surgery. Medicare pays for physician services based on relative value units (RVUs), which are a combination of work, practice expenses and malpractice RVUs. CMS comes up with payment for a CPT code by multiplying the total RVUs by a conversion factor. CMS proposed to reduce the conversion factor by about 11% next year, from $36.09 to $32.36, Rock said.

An 'Olive Branch' for Primary Care Physicians

"CMS is trying to give an olive branch to primary care physicians, but now is not the right time to have a negative impact on surgical specialties," she said. The proposed rule plans a big hike for rheumatology (up 16%), family practice (up 13%) and endocrinology (up 17%). Physicians who don't bill E/M services primarily will take a hit, including surgeons, at a time they already have lost revenue from the reduction in elective surgeries because of the pandemic, Rock said. Other specialties facing a drop in their Medicare payments include infectious disease (down 4%) and emergency medicine (down 6%).

In keeping with this tilt toward primary care and chronic care management, CMS added GPC1X, a complexity code, for orchestrating the patient's care across the continuum. "It's distinct from the chronic care management or preventive care codes. You can still bill all of those services, but this is giving you additional revenue for managing all the patient's care," Rock explained. Physicians are permitted to bill this code even if patients only have one complex chronic condition. That's different from chronic care management, which is reimbursable only if patients have two or more chronic conditions. "CMS is saying the code would be added every time you bill an E/M service. The issue is that a lot of different physicians may feel like they are the center point. Should everyone bill it? Or should one person bill it? I think it adds to the complexity of the billing process unnecessarily, especially when the point is burden reduction," Rock said.

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1 CMS, "Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs;

Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy," proposed rule, RIN 0938-AU10, last accessed August 13, 2020, https://bit.ly/2XWlWAZ.
2 Nina Youngstrom, "New E/M Documentation Guidelines, Table Take Effect Soon; 'There Is a Different Mindset,'" *Report on Medicare Compliance* 29, no. 19 (May 18, 2020), https://bit.ly/2BIbF3C.