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Final Physician Rule Changes Supervision, Adds Telehealth Codes, Some Permanently

By Nina Youngstrom

In the 2021 final Medicare Physician Fee Schedule (MPFS) rule,[1] CMS made both permanent and temporary changes to supervision, telehealth and other provisions, capturing the fluidity of COVID-19 pandemic times. The rule, which was announced Dec. 1, extended the shelf life of some additions and revisions, which won't expire until the end of the year in which the public health emergency (PHE) is over, presumably Dec. 31, 2021.

That gives providers more room to breathe, but it complicates compliance as they track the end dates of new services and other flexibilities. "Providers are going to have to sort through what's permanent, what's temporary for the duration of the PHE and what's temporary through the end of the calendar year of the PHE," said Richelle Marting, an attorney and certified coder in Olathe, Kansas. "If the PHE is simply allowed to expire, you may wake up on a Monday and literally not have the same coverage you had on a Friday."

A CMS official explained in a Dec. 1 national call on the MPFS that "we didn't feel we should cut off access [to telehealth services] immediately after the end of the PHE." But CMS can only go so far on a permanent basis. At some point after the PHE, Medicare telehealth coverage again will be limited by the originating site and rural area requirements, he noted. The originating site requirement restricts coverage to services delivered to patients at hospitals and other provider locations (not patient homes), and the rural area requirement limits coverage to counties outside a metropolitan statistical area or in a rural health professional shortage area. Only Congress can eliminate these requirements. For now, though, Medicare pays for telehealth services in all corners of the country.

The CMS official noted, however, that "there aren't the same limitations in Medicare Advantage. We are seeing Medicare Advantage plans expanding telehealth offering in ways not tied to the public health emergency."

In the MPFS rule, CMS finalized, as proposed, the permanent addition of seven groups of telehealth services, which CMS added because they're similar to services currently on the telehealth list (known as category one). They are:

- Group psychotherapy (CPT 90853).
- Domiciliary, rest home, or custodial care services, established patients (CPT 99334-99335).
- Home visits, established patients (CPT 99347-99348).
- Cognitive assessment and care planning (CPT 99483).
- Visit complexity inherent to certain office/outpatient evaluation and management services (HCPCS G2211).
- Psychological and neuropsychological testing (CPT 96121).
- Prolonged visits (G2212).

CMS also finalized the long list of telehealth services that are temporarily covered until the end of the calendar year in which the PHE is over (category three). Here are a few:

- Emergency department visits (CPT 99281-99285).
- End-stage renal disease services (CPT 90952, 90953, 90956, 90959, 90962).
- Initial hospital care and hospital discharge (99221-99223; 99238-99239).
- Critical care (CPT 99291, 99292, 99469, 99472, 99476).

Telehealth Is OK for Incident-to Billing

But coverage for audio-only telehealth visits by physicians (CPT 99441-99443) and nonphysician practitioners (CPT 98966-98968) will disappear when the PHE ends (not at the end of the calendar year). As a compromise, CMS permanently created a new code (G2252) for longer virtual check-ins (11 to 20 minutes), Marting said.

Telehealth visits also are going away for the initial visit with patients in skilled nursing facilities (SNFs) after the PHE. But CMS will allow more frequent subsequent SNF visits by telehealth, every 14 days instead of 30, when the rule takes effect Jan. 1.

Independent of the PHE, the final rule clarified that telehealth services can be delivered incident to the services of a physician. To bill Medicare for services provided incident to the physician's services, the physician must provide direct supervision, which requires immediate availability in the office suite where services are provided. CMS gave it the green light on incident-to telehealth services if the supervising physician is immediately available to intervene using live, two-way, audio-visual technology (e.g., a Zoom call with the patient, nonphysician practitioner and physician).

Although the list of Medicare telehealth services will take a hit at the end of the calendar year in which the PHE is over, attorney Jacob Harper predicts that a permanent version of the way things are now is coming. "CMS, I think, is very subtly laying the groundwork for meaningful telehealth expansion in the future," said Harper, with Morgan Lewis in Washington, D.C. CMS doesn't have the statutory authority to end geographic and originating site limitations, but it and other stakeholders are gathering evidence of cost-benefit for lawmakers to eventually take that leap, he said. When it unveiled the final rule, CMS announced it has commissioned a study of telehealth provided during the PHE to look for "new opportunities for services where telehealth and virtual care supervision, and remote monitoring can be used to more efficiently bring care to patients and to enhance program integrity, whether they are being treated in the hospital or at home."

Medicare watchdogs will have their say too, and CMS is expected to build in guardrails with input from the HHS Office of Inspector General.[2]

More Flexibility for Teaching Physicians

The final rule also made significant changes to scope of practice and supervision. "There's extensive discussion about resident supervision and teaching physician services," Marting said. For one thing, CMS will allow teaching physicians to virtually supervise residents when they perform the key portions of the service until the end of the PHE. Teaching physicians must use real-time, audiovisual communication. "They can't just join by telephone," she explained. Also, CMS said in rural training settings, teaching physicians can meet virtually with residents to review the services provided to patients during or after the visit—but just for the duration of the PHE, underscoring how dizzying it can be to keep straight which provisions are temporary and which are permanent.

In rural training settings, teaching physicians will be able to meet the presence and supervision requirement virtually even after the PHE is over. They must show in the medical records when the teaching physician was virtually present via audio-visual telecommunications technology for the key portion of the services, like they do when in person, Marting said.

In another permanent change, Medicare will pay teaching physicians for services provided by the residents in rural training settings. "What's interesting is we are talking about rural areas where internet access is not reliable," she said. CMS said if the audiovisual connection with the teaching physician fails, it expects physicians to pause the encounter until it can be resumed or rescheduled. "That's a pretty significant limitation because often when there's a disruption, you can't get reconnected quickly. The alternative is to pick up the phone and finish your conversation. But CMS would not allow the teaching physician to bill for the encounter in that situation because the physical presence requirement would not have been met," Marting said.

In an unrelated but permanent move, CMS changed supervision requirements for diagnostic tests. Nonphysician practitioners (NPPs), such as nurse practitioners and certified nurse midwives, who are authorized to perform diagnostic tests under their scope of practice also may now supervise the tests, and certified registered nurse anesthetists were added to the list of NPPs who have supervision authority, Marting said.

Additions to Medicare coverage of communication technology-based services (e-visits, virtual check-ins) were finalized. NPPs, including psychologists; licensed clinical social workers; and physical, occupational and speech therapists, will be able to provide e-visits permanently. CMS also changed e-visit codes from G2061-G2063 to 98970-98972 and added them as "sometimes therapy" services because therapists must add modifiers when they're billing for e-visits. Marting reminded providers to get patient consent for e-visits, although it can be verbal as long as it's documented. "Patients must understand the service provided involves cost sharing and agree to proceed," she explained.

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1 CMS and HHS, "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; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy; Coding and Payment for Virtual Check-in Services Interim Final Rule Policy; Coding and Payment for Personal Protective Equipment (PPE) Interim Final Rule Policy; Regulatory Revisions in Response to the Public Health Emergency (PHE) for COVID-19; and Finalization of Certain Provisions from the March 31st, May 8th and September 2nd Interim Final Rules in Response to the PHE for COVID-19," unpublished final rule, December 1, 2020, https://go.cms.gov/3qicQuK.
2 Nina Youngstrom, "OIG: Providers Should Prepare for New CMS Telehealth 'Guardrails' and a 'Cleanup on Back End,'" *Report on Medicare Compliance* 29, no. 39 (November 2, 2020), https://bit.ly/3p4aTBu.