PUBLICATION

Proposed 2021 Physician Fee Schedule to Expand Telehealth and Scope of Services for Nonphysician Practitioners and Pharmacists

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On August 3, 2020, CMS issued proposed rules announcing and soliciting public comments on new policy changes for Medicare payments under the Calendar Year (CY) 2021 Physician Fee Schedule (PFS) and other Medicare Part B issues. CMS' proposed changes include, but are not limited to, permanent and temporary additions to the Medicare telehealth list of services, clarifications concerning the remote physiologic monitoring services codes, expansions to nonphysician practitioners and pharmacists' scope of services, and updates in the Rural Health Clinic and Federally Qualified Health Clinic setting.

Telehealth Updates

CMS proposes to add on a permanent basis eight new services to the Medicare telehealth list on a category 1 basis. Category 1 services are similar to professional consultations, office visits, and office psychiatry services that are currently on the Medicare telehealth services list. Specifically, CMS is adding the following codes to category 1:

- Group Psychotherapy (Common Procedural Technology or CPT code 90853);
- Domiciliary, Rest Home or Custodial Care Services, Established Patient (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 E/Ms (HCPCS code GPC1X);
- Prolonged Services (CPT code 99XXX); and
- Neurobehavioral Status Exam (CPT code 96121).

In addition to the proposed permanent additions to the telehealth services list, CMS proposes a third category of criteria or category 3 criteria for adding services to the Medicare telehealth services list, on a temporary basis. The category 3 list would permit services added to the Medicare telehealth list during the public health emergency (PHE) to remain on the list of telehealth services through the CY when the PHE ends. Specifically, CMS proposed adding the following list of services as category 3 services:

- 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 – 3 (CPT codes 99281-99283);
- Nursing Facilities Discharge Day Management (CPT codes 99315-99316); and
- Psychological and Neuropsychological Testing (CPT codes 96130- 96133).

Note that these proposed changes do not make permanent the temporarily removed geographic and site of service originating site requirements for Medicare telehealth services. CMS has shared that such changes are limited by statute and would require a legislative change.

The agency seeks public comments on services that were added to the Medicare telehealth services list under the declared PHE but were not proposed to be added to the list on a permanent or temporary basis.

CMS also reiterates that telehealth rules are not applicable where the beneficiary and the practitioner are at the same location. CMS clarifies that licensed physical therapists, occupational therapists, speech-language pathologists, clinical social workers, and clinical psychologists can provide brief online assessment and management services, virtual check-ins, and remote evaluation services during the PHE period. CMS proposes to permanently adopt this policy.

In response to stakeholder complaints about the burdensome effects of the 30-day frequency limitation for subsequent telehealth nursing facility visits, CMS proposes to revise the frequency limitation from one visit every 30 days to one visit every three days. CMS seeks comments on whether it should remove frequency limitations altogether.

In its March 31, 2020 COVID-19 interim final rule with comments (IFC), CMS established a different payment for audio-only telephone evaluation and management services. Although the agency does not propose to continue to recognize these codes for payment in the absence of the PHE, it still sees value in having audio-only interactions to continue to avoid potential COVID-19 infections. CMS seeks comments on whether audio-only services should be made permanent or whether the agency should develop coding and payment for a service similar to the virtual check-in but for a longer unit of time.

Remote Physiologic Monitoring (RPM) Services

CMS proposes two changes related to RPM services and clarifies a number of provisions related to these services. Specifically, CMS:

- proposes to allow consent to be obtained at the time that RPM services are furnished;
- proposes to permanently allow auxiliary personnel to provide services listed under CPT codes 99453 and 99454, under a physician's supervision;
- clarifies that an established patient-physician relationship would be required for RPM services after the COVID-19 PHE period;
- clarifies that a medical device supplied to a patient as part of CPT code 99454 must be a medical device as defined by Section 201(h) of the Federal Food, Drug, and Cosmetic Act, and the device must be reliable, valid, and the data must be collected and transmitted rather than self-reported;
- clarifies that after the COVID-19 PHE period, it will maintain its requirements that 16 days of data during each 30-day period must be collected and transmitted to meet the requirements to bill CPT codes 99453 and 99454. However, the agency seeks comment on whether the RPM codes adequately capture the services provided to patients with acute conditions or whether a coding revision is required;
- proposes to clarify that RPM services are considered to be evaluation and management (E/M) services;
- clarifies that only physicians and nonphysician practitioners (NPPs) who are eligible to furnish E/M services may bill RPM services and clarifies that practitioners may provide RPM services to patients with acute and chronic conditions;
- clarifies that an "interactive communication" for CPT codes 99457 and 99458 must occur in real-time and must include synchronous, two-way interactions that can be enhanced with video or other kinds of data and
- seeks comments on whether the current RPM codes adequately describe the full range of clinical scenarios where RPM services may benefit patients.

Scope of Services

CMS proposes to make permanent its COVID-19 PHE policy allowing certain NPPs to supervise diagnostic testing, specifically nurse practitioners, clinical nurse specialists, certified nurse-midwives, and physician assistants. Prior to the COVID-19 PHE, generally, only physicians were permitted to supervise diagnostic tests.

In addition, CMS clarifies that pharmacists fall within the regulatory definition of auxiliary personnel and, therefore, may provide services incident to the professional services of a physician or other NPP just as other clinical staff. We note that the services must be provided under the appropriate level of supervision, of the billing physician or NPP, if payment for the services is not made under Medicare Part D.

Rural Health Clinics (RHCs) and Federally Qualified Health Clinics (FQHCs) Clarifications

CMS proposes to revise 42 C.F.R. § 405.2464 to reflect the current payment methodology finalized in the CY 2020 PFS final rule and to add the two new HCPCS codes for principal care management services furnished in RHCs and FQHCs.

CMS also proposes a rebase and revision of the FQHC market basket to reflect a 2017 base year. The proposed 2017-based FQHC market basket update for CY 2021 is 2.5 percent, the proposed multifactor productivity adjustment for CY 2021 is 0.6 percent and the proposed CY 2021 FQHC payment update is 1.9 percent.

Comments to the proposed rules are due no later than 5:00 p.m. EST on October 5, 2020.

For further information, please contact any member of the Baker Donelson Reimbursement Team.