"There are far better things ahead than any we leave behind." -- C.S. Lewis

Client Memo December 2020

NEWS Update

Key Changes on Deck for 2021

On December 1, 2020, CMS issued its annual Physician Fee Schedule final rule that includes updates on policy changes for Medicare payments under the Physician Fee Schedule and other Medicare Part B issues.

The entire 2165 page document can be viewed by going to: https://www.cms.gov/files/document/12120-pfs-final-rule.pdf

Provisions covered by the final rule include, but are not limited, to the following items.

CY 2021 PFS Rate setting and Conversion Factor

The final 2021 PFS conversion factor is $32.41, a decrease of $3.68 from the 2020 PFS conversion factor of $36.09.

Medicare Telehealth and Other Services Involving Communications Technology

For 2021, CMS added the following list of services to the Medicare telehealth list on a Category 1 basis. Category 1 services are similar to services already on the telehealth list:

- 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 E/M codes (HCPCS code G2211)
- Prolonged Services (HCPCS code G2212)

Category 3 describes services added to the Medicare telehealth list during the COVID-19 public health emergency that will remain on the list through the calendar year in which the PHE ends or December 31, 2021.

CMS added additional services to the Medicare telehealth list on a Category 3 basis such as:

- Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT codes 99336-99337)
- Home Visits, (CPT codes 99349-99350)
- Nursing facilities discharge (CPT codes 99315-99316)
- Psychological and Neuropsychological Testing (CPT codes 96130-96133; CPT codes 96136-96139)
- Therapy, Physical and Occupational Therapy (CPT codes 97161-97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507)
- Hospital discharge (CPT codes 99238-99239)
- Critical Care Services (CPT codes 99291-99292)
- Subsequent Observation and Observation Discharge (CPT codes 99217; CPT codes 99224-99226)

Remote Physiologic Monitoring Services

CMS clarified its payment policies related to the RPM services described by CPT codes 99453, 99454, 99091, 99457, and 99458, some of which are listed below:

- at the end of the COVID-19 PHE, there must be an established patient-physician relationship for RPM services to be furnished;
- auxiliary personnel may provide services described by CPT codes 99453 and 99454 incident to the billing practitioner's services and under their supervision;
- at the end of the COVID-19 PHE, 16 days of data each 30 days must be collected and transmitted to bill CPT codes 99453 and 99454.
- only physicians and NPPs who are eligible to furnish E/M services may bill RPM services.

Direct Supervision by Interactive Telecommunications Technology

For the duration of the COVID-19 PHE, direct supervision may be provided using real-time, interactive audio and video technology through the end of the calendar year in which the PHE ends or December 31, 2021.

Payment for Office/Outpatient E/M Visits

For 2021, CMS will be largely aligning 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.

CMS is also clarifying the definition of HCPCS add-on code **G2211** (formerly referred to as GPC1X), previously finalized for office/outpatient E/M visit **complexity**.

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) is being finalized to clarify the times for which prolonged office/outpatient E/M visits can be reported.

Updates to Quality Payment Program

CMS is limiting the number of significant changes to the Quality Payment Program in 2021, continuing a gradual implementation timeline for the MIPS Value Pathways (MVPs), and introducing the Alternative Payment Model (APM) Performance Pathway.

Due to COVID-19, the proposal for initial MVPs is delayed until at least the 2022 performance year. In addition, CMS will continue to support clinicians on the front lines by providing burden relief via extreme and uncontrollable circumstances policy exceptions for 2019, 2020 and 2021.

Some of the provisions finalized for the MIPS 2021 performance period are mentioned below:

- incorporate 2 new administrative claims outcome quality measures, address substantive changes to 112 existing MIPS quality measures, and remove measures from specific specialty sets;
- include services provided via telehealth in quality and cost measures;
- update two Promoting Interoperability measures and continue reweighting the Promoting Interoperability performance category;
- add a new Promoting Interoperability performance category: Health Information Exchange (HIE) bi-directional exchange measure using CEHRT;
- proposal for an exception to the 20-case minimum for all administrative claims-based measures;
- increase the maximum number of points available for the complex patient bonus for one year due to the increase in patient complexity resulting from the PHE for COVID-19.
- modify the proposal to remove 11 instead of 14 quality measures from the MIPS program;
- retain the previously finalized performance threshold at 60 points for 2021.

For a complete list of provisions, please refer to the 2021 Quality Payment Program Final Rule fact sheet located on the QPP website: https://qpp.cms.gov

Medicare Coverage for Opioid Use Disorder Treatment (OUD) Services

CMS is finalizing the proposal to extend the definition of OUD treatment services to include opioid antagonist medications, specifically naloxone, that are approved by Food and Drug Administration for emergency treatment of opioid overdose, as well as overdose education.

Section 2002 of the Support Act

Section 2002 of the SUPPORT Act required the Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV) to include screening for potential substance use disorders (SUDs) and a review of any current opioid prescriptions.

Section 2003 of the Support Act

Section 2003 of the SUPPORT Act requires that, effective January 1, 2021, the prescribing of a Schedule II, III, IV, or V controlled substance under Medicare Part D be done electronically.

2021 E/M Office Visit Revisions – Staff, AMA

On November 1, 2019, CMS finalized a historic provision in the 2020 Medicare Physician Fee Schedule Final Rule. This provision includes revisions to E/M office visit codes 99201-99215 and to documentation standards that directly address the continuing problem of administrative burden for physicians in nearly every specialty, from across the country.

With these landmark changes, as approved by the CPT Editorial Panel, documentation for E/M office visits will now be centered around how physicians think and take care of patients and not on mandatory standards that encouraged copy/paste and checking boxes.

The AMA's proposal to reduce administrative burden achieves a shared goal with CMS. These revisions work in lock step with the already established administrative burden relief initiatives established by CMS for 2019:

- Elimination of the requirement to document medical necessity of furnishing visits in the home rather than office.

- Elimination of the requirements for clinicians to re-record elements of the history and physical exam when there is evidence that the information has been reviewed and updated.
- Physicians must only document that they reviewed and verified information regarding the chief complaint and history that is already recorded by ancillary staff or the patient.

Summary of Revisions

1. **Eliminate history and physical as elements for code selection**: While the physician's work in capturing the patient's pertinent history and performing a relevant physical exam contributes to both the time and medical decision making, these elements alone should not determine the appropriate code level.

2. **Allow physicians to choose whether their documentation is based on Medical Decision Making (MDM) or Total Time:**
   - MDM: The Panel did not change the three current MDM subcomponents, but did provide extensive edits to the elements for code selection and revised/created numerous clarifying definitions in the E/M guidelines.
   - Time: The definition of time is minimum time, not typical time, and represents total physician/qualified health care professional (QHP) time on the date of service.

   - **Modifications to the criteria for MDM:** The Panel used the current CMS Table of Risk as a foundation for designing the revised required elements for MDM:
     - Removed ambiguous terms (e.g. "mild");
     - defined previously ambiguous concepts (e.g. "acute or chronic illness with systemic symptoms");
     - defined important terms, such as "Independent historian;"
     - re-defined the data element to move away from simply adding up tasks to focusing on tasks that affect the management of the patient.

3. **Deletion of CPT code 99201:** The Panel agreed to eliminate 99201 as 99201 and 99202 are both straightforward MDM and only differentiated by history and exam elements.

4. **Creation of a shorter prolonged services code:** The Panel created a shorter prolonged services code that would capture physician/QHP time in 15-minute increments. This code would only be reported with 99205 and 99215 and be used when time was the primary basis for code selection.

The AMA has set up an "Implementing E/M" site to help with the transition. This site contains free educational modules and step-by-step details to help you understand these new guidelines. The site is located at: https://www.ama-assn.org/practice-management/cpt/implementing-cpt-evaluation-and-management-em-revisions

2021 E/M Changes FAQs

Vinita Magoon, DO, JD, MBA, provides some answers to common questions about the E/M changes coming January 1st in the November 6, 2020, issue of the *FPM Journal.*

Here are some answers to common questions asked about the E/M changes.

Do these E/M changes apply to any other outpatient services? No, these changes only apply to outpatient E/M office visits (CPT codes 99202-99215). All other outpatient services, including consultations and emergency visits, will continue to use the same key elements for leveling visits.

Do these E/M changes apply to inpatient services? No, at this time they only apply to outpatient E/M office visits The previous E/M guidelines will continue to apply to inpatient services.

Since history and physical exam are no longer required to level the visit, should I still document these elements? Yes. Although history and physical exam are no longer required to level the visit, they are still important components in establishing medical necessity, supporting medical decision making, and providing high-quality care.

If I am leveling the visit based on total time, do I still need to document an assessment and plan? Yes, an A/P should always be documented for each visit. The A/P may provide additional information that will allow your visit to be leveled if the time statement does not have enough information.

If you document both MDM and total time, you can level the visit based on whichever is more advantageous, but you still must present documentation. Documentation of an A/P is also important in establishing medical necessity and maintaining continuity of care.

If I am leveling the visit based on total time and have also provided additional time-based services (e.g., advance care planning, tobacco cessation counseling,

etc.) how do I document time for those services? Make sure to document time separately for each of those services in order to bill for them separately. The time for each service must be carved out of the total time.
If a patient presents for a Medicare Annual Wellness Visit (AWV) and follow-up for chronic conditions, what are the documentation requirements for the E/M? If you've met the requirements for outpatient office E/M, an office visit can be billed based on MDM in addition to the Medicare AWV. However, if you use total time to level the E/M visit, along with an AWV, you will need to carve out the total time for the office visit specifically in the note.

If I order a test during one visit and review the same test during the next visit, can I count this as a data point for both visits? No, you can only get one point for this lab, so the order and review of results is part of the data ordered/reviewed during the first visit.

COVID-19 Codes for Pfizer, Moderna Vaccines

The AMA updated its CPT code set to reflect the expected future availability of COVID-19 vaccines. The new codes apply to the experimental vaccine being developed by Pfizer Inc, in collaboration with a smaller German firm Bio NTech, and to the similar product expected from US biotech Moderna Inc, writes Kerry Dooley Young, in her November 12, 2020, article for *Medscape Medical News*.

Additional vaccine-specific CPT codes will be introduced as more vaccine candidates approach FDA review. According to the AMA, these vaccine-specific CPT codes can go into effect only after the FDA grants a clearance.

The newly created Category I CPT codes for the vaccine products are:

- 91300; COVID-19 vaccine, Pfizer/BioNTech
- 91301; COVID-19 vaccine, Moderna

These two administrative codes would apply to both the Pfizer-BioNTech and Moderna vaccines:

- 0001A; Immunization administration, first dose.
- 0002A; Immunization administration, second dose.

-- shutterstock

Medicare Reimbursement Rate for COVID-19 Vaccine Released – CMS.gov

As of November 12, 2020, Medicare payment rates for COVID-19 vaccines requiring a series of 2 or more doses will be $16.94 for the administration of the initial dose and $28.39 for the administration of the final dose in the series. For single-dose vaccines, the COVID-19 vaccine administration rate will be $28.39.

These rates recognize the costs involved in administering the vaccine, including the additional resources involved with required public health reporting, conducting important outreach and patient education, and spending additional time with patients answering any questions they may have about the vaccine. These rates will also be geographically adjusted.

When COVID-19 vaccine doses are provided by the government without charge, only bill for the vaccine administration. Don't include the vaccine codes on the claim when the vaccines are free.

Home Health Final Rule

About $150 million less will make it into home health than proposed, writes Rebecca Johnson in the November 6, 2020, issue of *AAPC.com*.

The scores of comments on the Home Health final rule for 2021 fell mostly on deaf ears. CMS has changed almost nothing from the 2021 proposed rule, she adds.

What HHAs wanted: Home health agencies (HHAs) and their representatives urged CMS to eliminate the 4.36 percent behavioral adjustment cut it implemented in 2020, based on assumptions about how providers would react to the Patient-Driven Groupings Model (PDGM).

What HHAs got: As stated in the 2021 HH PPS proposed rule, CMS believed it would be premature to propose any changes to the CY 2021 payment rate based on the data available at the time of CY 2021 rulemaking and in light of the ongoing COVID–19 PHE.

Further, CMS has ratcheted down the inflation payment update for agencies, bringing the rate of increase for next year down from the proposed 2.6 percent to 1.9 percent.

CMS calculates the 2021 increase with a 2.0 percent Home Health Prospective Payment System update percentage ($410 million increase) — down from 2.7 percent in the proposed rule — and a 0.1 percent decrease due to the

rural add-on phase-out ($20 million decrease), which is the same as proposed. Both the proposed and final update percentages include a 0.4 percent multifactor productivity (MFP) adjustment required by law.
The end result is an additional $390 million in home health payments next year, compared to the proposed $540 million increase, CMS estimates.

The 30-day PDGM period base payment rate will be $1,901,12 — up from $1,864.03 this year. That compares to the proposed rate of $1,911.87.

In a message to members, NAHC President William Dombi says, "We are disappointed that CMS put off consideration of dropping the behavioral adjustment to payment rates based on its view that it needs a full year of data before it can act."

Final 2021 Per-Visit Payment Amounts*

Discipline	2021 Final Per-Visit Payment
Home Health Aide	$69.11
Medical Social Services	$244.64
Occupational Therapy	$167.98
Physical Therapy	$166.83
Skilled Nursing	$152.63
Speech Language Pathology	$181.34

* Rates are 2 percent lower for agencies that do not submit required quality data.

Public Health Emergency Still Scheduled to End January 20, 2021

The public health emergency will probably be extended another 90 days, but official word has not yet been released.

End Dates by Payers for Relaxed Telehealth Visit Rules

Insurance Plan	Proposed End Date
Aetna	12/31/2020
BCBS No Dakota	until end of COVID-19 emergency
BCBS So Dakota	until further notice
BCBS Oklahoma	until end of COVID-19 emergency
BCBS Federal Plan	until end of COVID-19 emergency
Cigna	12/31/2020 ++
GEHA	until further notice
Humana	until end of COVID-19 emergency
Medicare	until end of COVID-19 emergency
Tricare	until end of COVID-19 emergency
UnitedHealthcare	12/31/2020 ***

++ Cigna's virtual care policy goes into effect Jan. 1, 2021

*** Starting Jan. 1, 2021, UnitedHealthcare will cover all in network telehealth services as outlined in current CMS guidelines and additional codes as outlined in UHC's telehealth reimbursement policy

UHC Telehealth Reimbursement Policy for 2021 – *United Healthcare Bulletin*, November 2020

For **commercial plans**, effective with dates of service on and after Jan. 1, 2021, UnitedHealthcare will modify its Telehealth and Telemedicine Policy as follows:

- Eligible telehealth services will only be considered for reimbursement under this policy when reported with POS 02 (Telehealth Services).
- UnitedHealthcare will consider the member's home as an originating site for eligible services.
- Various codes will be eligible for consideration under the policy including codes listed in the current policy, as well as similar types of services rendered using interactive audio and video technology.
- Certain physical, occupational and speech therapy (PT/OT/ST) telehealth services using interactive audio and video technology will be considered for reimbursement when rendered by qualified health care professionals.

Some **Medicare Advantage plans** will allow certain CMS-eligible telehealth services when billed for members at home.

For **UnitedHealthcare Community Plans**, UHC will continue to follow state regulations and guidelines regarding telehealth services and reimbursement.

Cigna introduces Virtual Care Services

Beginning January 1, 2021, Cigna will implement a new Virtual Care Reimbursement Policy to ensure continued coverage of virtual care services for patients and providers. Cigna's interim COVID-19 virtual care guidelines remain in place until December 31, 2020. If it is necessary to extend that interim coverage without change based on an extended public health emergency period, Cigna's new permanent Virtual Care Reimbursement policy may be implemented at a later date.

MIPS Updates

Extreme & Uncontrollable Circumstances Exception Application Deadline Extended

To further support clinicians during the COVID-19 public health emergency, CMS is extending the 2020 MIPS Extreme and Uncontrollable Circumstances Exception application deadline to **February 1, 2021**.

The deadline for the Promoting Interoperability Hardship Exception application will remain December 31, 2020.

For the 2020 performance year, CMS will be using the Extreme and Uncontrollable Circumstances policy to allow MIPS eligible clinicians, groups, and virtual groups to submit an application requesting reweighting of one or more MIPS performance categories to 0% due to the current COVID-19 public health emergency.

If you have an approved application, you can still receive scores for the Quality, Improvement Activities and Promoting Interoperability performance categories if you submit data. If the Cost performance category is included in your approved application, you will not be scored on cost measures even if other data are submitted.

CMS has finalized that APM Entities may submit an application to reweight MIPS performance categories as a result of extreme and uncontrollable circumstances, such as the public health emergency resulting from the COVID-19 pandemic, by February 1, 2021.

MIPS Promoting Interoperability Hardship Exceptions

MIPS eligible clinicians, groups, and virtual groups may qualify for a re-weighting of the Promoting Interoperability performance category to 0% if they:

- Are a small practice;
- Have decertified EHR technology;
- Have insufficient Internet connectivity;
- Face extreme and uncontrollable circumstances such as disaster, practice closure, severe financial distress, or vendor issues; **or**
- Lack control over the availability of CEHRT.

Note: providers already exempt from reporting Promoting Interoperability data do NOT need to apply. Providers are exempt if they are identified on the QPP Participation Status Tool as:

- Ambulatory Surgical Center (ASC),
- Hospital-based, or;
- Non-patient facing

For more information on the two applications, please go to the Quality Payment Program website:

CMS would like to remind clinicians of important upcoming MIPS dates and deadlines:

- **December 31** – 2020 Promoting Interoperability Hardship Exception Application period closes**.**
- **December 31** – 2021 virtual group election period closes.
- **January 4, 2021** – 2020 MIPS performance year data submission window opens.
- **February 1, 2021** – 2020 Extreme and Uncontrollable Circumstances Application period closes.
- **March 1, 2021** – Deadline for CMS to receive 2020 claims for the Quality performance category. Claims must be received by CMS within 60 days of the end of the performance period.
- **March 31, 2021** – 2020 MIPS performance year data submission window closes.

MEDICARE NEWS

2021 Medicare Part B Premiums Remain Steady

CMS announced the standard monthly premium for Medicare Part B enrollees will be $148.50 in 2021, an increase of $3.90 from $144.60 in 2020. CMS also announced that the annual deductible for Medicare Part B beneficiaries is $203 in 2021, an increase of $5 from $198 in 2020.

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