

Finalized CY 2020 Physician Fee Schedule

The Center for Medicare and Medicaid Services (CMS) has finalized their CY 2020 proposed revisions related to the Physicians Fee Schedule (PFS). For items related to telehealth, CMS has decided to finalize their proposal to add three new codes for a bundled episode of care for treatment of opioid use disorder to the list of services that are eligible for telehealth reimbursement. Additionally, CMS has finalized a bundled payment structure for opioid use disorder (OUD) treatment by opioid treatment programs (OTPs), and would allow the counseling and therapy (face-to-face) components to be delivered via live interactive video. CMS has also taken steps to further refine the codes for transitional care management (TCM) and chronic care management (CCM), and create new codes for principal care management (PCM) services for patients that have only one serious chronic condition. Each of these elements is discussed in detail below.

ADDITION OF MEDICARE TELEHEALTH SERVICES

CMS has an established process for adding codes to the list of Medicare telehealth services eligible for reimbursement. The process includes assigning qualifying requests to either one of two categories. Category 1 is reserved for services that are similar to services already approved on the Medicare telehealth list such as professional consultations, office visits and office psychiatry services. Category 2 (which entails a more extensive qualification process) is for services that are not similar to current telehealth services on the Medicare list, but pose a significant benefit for the patient. For the CY 2020 proposed PFS, CMS did not receive any requests from the public to add new codes. Instead, CMS is adding three newly created codes for office-based treatment for OUD:

- **HCPSC code G2086:** Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month.
- **HCPSC code G2087:** Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month.
- **HCPSC code G2088:** Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (List separately in addition to code for primary procedure).

CMS has accepted these codes under Category 1 because the face-to-face psychotherapy services included in the codes are sufficiently similar to services already on the Medicare telehealth list. They feel that these new codes will complement the policies finalized in the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (SUPPORT Act) which provides an exemption from the telehealth geographic requirement and allows services to be delivered in the home for patients with substance use disorder (SUD) or co-occurring mental health conditions.

CMS will be accepting new codes for consideration for the CY 2021 PFS until Feb. 10, 2020.

OPIOID USE DISORDER TREATMENT SERVICES BY OPIOID TREATMENT PROGRAMS

The SUPPORT Act established a Part B benefit category for OUD treatment services by an OTP beginning Jan. 1, 2020. It also provides for coverage of OUD treatment services and establishes a bundled payment for OTPs certified by SAMHSA for OUD treatment services during an episode of care. To comply with the Act, CMS has finalized a duration of an episode of care that includes a one-week (7 day) period and the bundle of care which a patient receives during that period includes one substance use counseling session, one individual therapy session, one group therapy session and one toxicology test. If the patient received 51% or more of those services, then they can bill the full weekly bundle. If they received less, then the OTP could bill a partial episode of care. There will be no limits on the maximum number of weeks allowed.

CMS is also establishing separate payment methodologies for the drug and non-drug component of the bundled payment. The non-drug component would include counseling, therapy and toxicology testing during weeks where medication is not administered. CMS considers OUD treatment services to include services furnished through communication technology, and are finalizing their proposal to allow OTPs to furnish substance use counseling, individual therapy, and group therapy via two-way interactive audio-video communication technology, as clinically appropriate, in order to increase access to care for beneficiaries. These services could be delivered to patients when they are located their home. CMS acknowledges that OTPs are not eligible providers under Medicare's telehealth restrictions, but state that because they are not considered to be services provided by a physician or other practitioner, the statutory telehealth requirements of 1834(m) does not apply to OTPs. Likewise, because OTP services are not PFS services, OTPs are not authorized to bill the facility fee. They note that the counseling or therapy services furnished via communication technology as part of OUD treatment services furnished by an OTP must not be separately billed because these services would already be paid through the bundled payment made to the OTP. In response to commenters who suggested other medical services be included in the bundle via telecommunications, CMS notes that Substance Abuse and Mental Health Services Administration

(SAMHSA) and the Drug Enforcement Administration (DEA) have regulations related to OUD services furnished via telecommunications which they would need to further consider before any future rulemaking.

CCHP ANALYSIS

If the statutory telehealth requirements in 1834(m) do not apply for OTPs delivering services through audio-video communication technology, it is unclear why there would be a limitation on store-and-forward technology being used for the same purpose. Additionally, it raises the question of if OTPs are exempt from the requirements of 1834(m) because they are not a physician or other eligible practitioner, would other providers not currently on the telehealth list, such as FQHCs and RHCs be able to deliver services via audio-video communication technology, using the same reasoning, without being subject to the requirements of 1834(m)?

BUNDLED PAYMENT FOR SUBSTANCE USE DISORDER

CMS is establishing bundled payment for treatment of OUD, including management, care coordination, psychotherapy, and counseling activities. This would not include payment for the medication itself in medication assisted treatment (MAT). These bundled codes would be a monthly reported code, with a code for the initial month (G2086) for intake activities and development of a treatment plan, as well as assessment, therapy and counseling, a code for subsequent months (G2087) and finally, an add on code (G2088) when needed. These are the codes discussed earlier that CMS finalized adding to the list of telehealth eligible codes for reimbursement.

CMS notes that some components of the codes involve care coordination which are typically furnished using telecommunications technology and do not require in-person contact and are therefore not considered telehealth. The care coordination components on their own do not necessitate being on the telehealth list, but because they are combined with the face-to-face elements of the code, they are included for this bundled payment.

In accordance with the SUPPORT Act, which created an exception from the Medicare geographic and facility requirement for SUD treatment or co-occurring mental health disorders, CMS is allowing these services to be delivered at any telehealth originating site, including the patient's home without regard for the geographic requirement. Because certain required services (psychotherapy) are included in the OUD bundled payment codes, they would qualify and could be furnished more broadly under the exceptions in the SUPPORT Act.

CMS has finalized their decision not to add a new G code for OUD treatment for RHCs and FQHCs, since they can already bill using G0511 and G0512.

CARE MANAGEMENT SERVICES

CMS is taking steps to further refine the codes for transitional care management (TCM) and chronic care management (CCM). They have also created new codes for principal care management (PCM) services for patients that have only one serious condition.

Transitional Care Management (TCM)

CMS has finalized their proposal to allow for concurrent billing with TCM services in the following code families:

- Prolonged services without direct patient contact
- Home and outpatient international normalized ration monitoring services
- End stage renal disease services
- Interpretation of physiological data (RPM)
- Chronic care management
- Complex chronic care management services
- Care plan oversight services.

See the full text for list of specific codes.

Chronic Care Management (CCM)

CMS had proposed to adopt two new G codes with new increments of clinical staff time instead of the existing single CPT code (99490), and two additional G codes to be used to establish and revise a comprehensive care plan. However, in response to commenters concerns that the temporary G codes replacing most of the CCM code set would create administrative burden, CMS has chosen to only finalize one code (G2058 – the add-on code for additional clinical staff time), because it addresses the need for a code to bill for additional time increments for non-complex CCM. G2058 could be reported a maximum of two times within a given service period for a given beneficiary.

Principal Care Management (PCM)

CMS has finalized their proposal to establish separate coding and payment for principal care management (PCM) services, which describes care management services for one serious chronic condition (as opposed to the multiple chronic conditions covered by CCM). A qualifying condition would be expected to last between 3 months and a year or until death, may have led to a recent hospitalization and/or place the patient at significant risk of death, acute exacerbation, decompensation or functional decline. The services would include coordination of medical and/or psychosocial care related to the single complex chronic condition, provided by a physician or clinical staff under the direction of a physician or other qualified health professional.

Due to the similarity between the description of the PCM and CCM services, both of which involve non-

face-to-face care management services, the full CCM scope of service requirements would apply to PCM, including documenting the patient's verbal consent in the medical record. PCM could not be billed by the same practitioner for the same patient concurrent with certain other care management services, such as CCM, behavioral health integration services and monthly capitated ESRD payments.

New Principle Care Management Codes:

- **HCPCS code G2064** - Comprehensive care management services for a single high-risk disease, e.g., Principal Care Management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements: One complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities.
- **HCPCS code G2065** - Comprehensive care management for a single high-risk disease services, e.g. Principal Care Management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities.

CMS expressed concerns that this separate coding could result in a patient with multiple chronic conditions having their care managed by multiple practitioners, each only billing for PCM, which could potentially result in fragmented patient care, overlaps in services, and duplicative services. They are finalizing a requirement that ongoing communication and care coordination between all practitioners furnishing care to the beneficiary must be documented by the practitioner billing for PCM in the patient's medical record.

CHRONIC CARE REMOTE PHYSIOLOGIC MONITORING SERVICES

One of the codes established in Sept. 2018 CPT Editorial Board for remote physiologic monitoring was 99457. Effective for CY 2020, the code has been revised, still with 99457 as the base code that describes the first 20 minutes of treatment management services, but then allows for use of an add on code, for subsequent 20 minute intervals (99458). The codes now only require that these services be delivered with general supervision of auxiliary personnel by a physician or other qualified healthcare professional, as opposed to direct supervision, as previously required.

CMS also clarified that RPM services are not separately billable for FQHCs and RHCs because it is included in the RHC All-Inclusive Rate (AIR) or FQHC Prospective Payment System (PPS) payment.

CONSENT FOR COMMUNICATION TECHNOLOGY-BASED SERVICES

In the CY 2019 PFS, CMS finalized payment for a number of communication technology-based services, including brief virtual check in services and interprofessional consultation. Currently consent is required for each service delivered through communication technology-based services, in part to ensure that patients are aware of any fee sharing they may be responsible for. However, based on feedback CMS received that obtaining consent for each and every one of these services is burdensome, they have revised this policy for CY 2020 to only require consent once a year for technology-based services.

ONLINE DIGITAL EVALUATION SERVICE (E-VISIT)

CMS is finalizing their proposal to create new G-codes that describe the performance of an online “assessment” rather than an “evaluation” so that qualified non-physician health care professionals that fall outside the category of a practitioner able to bill for “evaluation codes”, may bill for those services.

The new codes are as follows:

- **G2061** - Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes.
- **G2062** - Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes.
- **G2063** - Qualified non-physician qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes.

These codes would be valued at a lower rate than when the service is furnished by a physician because the work is likely less, due to the acuity of the patient.

ORIGINATING SITE FACILITY FEE

For CY 2020 the payment amount for HCPCS code Q3014 (the telehealth originating site facility fee) will be 80% of the lesser of the actual charge or \$26.56.

OTHER REFERENCES TO TELEHEALTH

- **Calculations Under the Merit-based Incentive Payment System (MIPS)** – CMS finalized changes to the way scoring is calculated in certain categories involving telehealth, including the area of promoting interoperability, adult major depressive disorders, heart failure, coronary artery disease, tobacco use, and alcohol and drug dependence treatment.
- **Remote Interrogation Device Evaluation** – A new code (G2066) is proposed for remote interrogation device evaluation to describe services previously covered under CPT code 93299, which is being deleted for CY 2020.
- **Long-Term EEG Monitoring** – CMS finalized the revised valuation for some of these services, while others were not finalized. See page 738 of the manual for further information.

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