Centers for Medicare & Medicaid Services

Questions and Answers from Open Door Forum: Physicians

July 15, 2021

1. In reviewing the regulatory impact analysis, American Speech-Language-Hearing Association (ASHA) is not clear whether CMS accounted for the impact of the discontinuation of the 3.75% to 2021 conversion factor. We understand the projected 2022 CF is based on the original 2021 CF without the 3.75 % increase. But we believe it's important for providers to understand the full impact of the change in the conversion factor based on actual 2021 payments using the adjusted CF. Can you comment as to whether the regulatory impact analysis does this?
    - **a.** Yes, we did take into account the 3.75 and the impact table does show that it would not be in effect for quite CY 2022. And we did take that into account when we were calculating the conversion factor.
        - **i.** You're saying it did take into account the 2022 - the proposed 2022 conversion factor takes into account the 3.75
            1. **1.** Yes. The expiration of the 3.75.
2. I had a very similar question to what was previously asked. Does this mean that the specialty impacts included the - or that the specialty impacts on table 123 took into account the 3.75 that was taken away?
    - **a.** Yes, that is correct. Specialty impacts take into account the expiration of the 3.75 for CY 2022.
        - **i.** When you're comparing allowed charges for 2021 versus allowed charges for 2022 the changes in the allowed charges for 2022 include the taking away of the 3.75% as well as changes to the RBUs?
            1. That is correct.
3. The AMA along with many other of the house of medicine specialty societies and state medical societies have submitted extensive comments urging CMS to adopt and immediately pay for the new CPT Code 99072 to account for additional expenses in treating patients during the public health emergency and was surprised not to see a discussion of any of the extensive input that was provided by the AMA and specialty societies committee or, you know, respond to the many letters and sign all letters that were sent in support of that code being paid for. I was just wondering if you could provide a little bit more background in your thinking around that comment solicitation and not responding to support for CPT 99072?
    a. We did discuss a lot of our thoughts around 99072 in previous years rule. And as you point out, you know, definitely some things to consider. The PHE is still ongoing. We've met with a lot of stakeholders that provided us with information but wanted a little bit more context and information specifically from that perspective. We definitely anticipate receiving a lot of information from folks including from the AMA with respect to our comment solicitation.
4. I just wanted to verify for the telehealth for the audio only visits that starting in 2022 this would be allowed only for behavioral health visits or for patients with limitations. Is that correct?

    a. Right now what we are proposing is to use audio only for mental health diagnosis other than substance use disorders or co-occurring mental health disorder. So essentially what we're proposing is just to do regulation implement the CAA what was passed.
        i. I think I was asking giving the reverse so that audio only options for telehealth go away except for certain mental health diagnoses other than substance abuse?
            1. Correct.
5. In the discussion about shared visit it refers to patients who are new patients and patients who are established. And it's the second for critical care visits that there's new and established codes but those don't exist. Is that just an error when that was written up or are there new codes that have been proposed to critical care?
    a. There aren't any new codes it's just the 99291 and two. And I think it was probably just - probably not the best choice of describing the add on code. Would be referring to the base code and then the primary procedure and then the add on code for critical care.
6. We've stumbled on a couple of examples of really significant practice expense jobs that were not figuring out what might have driven them. It might not be useful for me to give a specific example but I'll try. If you're working in real-time as I look at 33285 for example which is a supply heavy code, has one rather expensive input. It goes from 147 RVUs to 119 roughly. And if there's any insight you would have to like some significant change in practice expense methodology is because it seems to be in several places that would be really helpful?
    a. As you continue to pour over the rule you'll see our proposed updates to clinical labor, right, that could impact what the P/E looks like across services that maybe have a different mix, i.e., clinical labor versus supply heavy. But that's just one thought so I guess keep reading and see what you think. And certainly, shoot us an email if that doesn't hold up.