Centers for Medicare & Medicaid Services
Physicians, Nurses & Allied Health Open Door Forum
Moderator: Jill Darling
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2:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time, all participants are in listen-only mode until the question-and-answer session of today's conference. At that time you may press star 1 on your phone, to ask a question. I would like to inform all parties that today's conference is being recorded. If you have any objections you may disconnect at this time. I would now like to turn the conference over to your host, Jill Darling. Thank you. You may begin.

Jill Darling: Great. Thank you, (Danielle). Good morning and good afternoon everyone. I'm Jill Darling in the CMS Office of Communications. And welcome to today's Physicians, Nurses and Allied Health Open Door Forum. Before we get into today's agenda, I have one brief announcement. This open door forum is open to everyone, but if you are a member of the press you may listen in but please refrain from asking questions during the Q&A portion of the call. If you have any inquiries, please contact CMS at Press@CMS.HHS.gov. And also, we'd like to thank you for your patience as we are waiting for more folks to join us. So now I will hand the call off to Gift Tee.

Gift Tee: Thanks, Jill. And good afternoon and good morning if you're on the West Coast. I appreciate your patience as we get this open door forum rolling. And also appreciate your patience overall, given that 2021 PFS final rule was just released only last week. Definitely appreciate your patience there. And all of the information you've provided CMS from a stakeholder perspective as the agency does its part to deal with the COVID-19 pandemic.

As you're aware, there's been lots of work here at the agency, to release a lot of different policies that are described in a number of interim final rules that I'm sure you've all had the opportunity to read. And now you're poring through 1300 pages of the CY 2021 PFS. So with that, I'll turn it over to the team who will be talking about a number of our policy discussions in the rule.

And I believe our first item is telehealth and other services involving communication technologies. So I will turn you over to Patrick Sartini.

Patrick Sartini: Thanks, Gift. So for CY 2021, we are finalizing the addition of a number of services to the Medicare telehealth list on a category one basis. These include lower level established patients, home and/or domiciliary visits and assessment and care planning for patients with cognitive impairments, group psychotherapy and two - as well as two add-on codes associated with our office and outpatient E/M policies.

In addition to that, we are finalizing the creation of a third temporary category of criteria for adding services to the list of Medicare telehealth services. This category 3 describes services added to the telehealth list during the public health emergency for the COVID-19 pandemic that will remain on the list through the calendar year in which the public health emergency ends.

Services added to the Medicare telehealth list on a category 3 basis include all levels of emergency department visits, certain therapy services, higher level established patient home and domiciliary visits, certain psychological testing services, nursing facility discharge day management, as well as a range of critical care services.

In addition to that, in response to stakeholders who have stated that the once every 30 day frequency limitation for subsequent nursing facility visits

furnished via Medicare telehealth, provides unnecessary burden and limits access to care for Medicare beneficiaries in the setting. Therefore, we propose to revise this frequency limitation from one visit every 30 days to one visit every three days.

Based on information provided by commenters about creating a disincentive for in-person care and after additional consideration of how patients in the non-facility setting in general, tend to have longer stays - lengths of stay when compared to patients in the inpatient setting. We are finalizing a frequency limitation for subsequent nursing facility telehealth visits of one visit every 14 rather than 30 days.

We also clarified that licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists and speech language pathologists, can furnish the brief online assessment and management services as well as virtual check-in and remote evaluation services.

In the March 31, 2020 COVID-19 interim final rule with comments, we established separate payment for audio-only telephone E/M services. While we didn't propose to continue recognizing these codes for payment under the PFS, in the absence of the COVID-19 public health emergency, we did note the need for audio-only interactions could remain as beneficiaries continue to try to avoid potential sources of infection, such as a doctor's office.

Therefore, for this rule, we saw - for 2021, we saw a comment on whether CMS should develop coding and payment for a service similar to the virtual check-in. Based on support we received from commenters, we are establishing payment on interim final basis, for a new HCPCS G Code which describes 11 to 20 minutes of medical discussion, to determine the necessity of an in-person visit.

Finally, with regard to direct supervision, for the duration of the public health emergency, we adopted a policy revising the definition of direct supervision, to include virtual presence of the supervising physician or practitioner, using interactive audio/video real time communication technology.

We are finalizing continuation of this policy through the year in which the public health emergency ends, or December 31, 2021, whichever comes later. We believe this will give us time to continue to evaluate whether this policy should be adopted permanently. And with that, I would like to hand it off to Christiane LaBonte.

Christiane LaBonte: Thanks, Patrick. Good afternoon or good morning, everyone. As Gift noted earlier, thanks for being here today and thank you for all that you're doing for our beneficiaries, and especially during this particular year. As Patrick noted, my name is Christiane LaBonte and I'll be walking through the final rule provisions related to evaluation and management or office visit services and then payment for services of teaching physicians and residents.

I'll start with the office visits. The changes to office and outpatient visit coding and documentation that we finalized in the CY 2020 Physician Fee Schedule rulemaking cycle and as laid out by the CPT Editorial Panel will be implemented this coming January 2021. And with respect to proposals that we made this year, for 2021, we are finalizing in four areas.

The first, we're finalizing our proposal to revise the times used for rate setting for the office visit code set. This is only a technical detail that has to do with how CMS sets prices and not how practitioners report time. Practitioners will use the CPT code descriptors when using time to select the level of an office visit.

Second, we are finalizing separate payment for a new HCPCS code G2212 which describes prolonged office visits, to be used in place of CPT code 99417 which was formerly referred to as CPT code 99XXX. And this is to clarify the times for which prolonged office visits can be reported.

In the proposed rule we stated that we were concerned about potential for double counting time because CPT code 99417 could be reported when time exceeded the minimum time on a level 5 visit, by 15 minutes when time is used for level selection.

For the final rule, we stated that we will use a G code, G2212, to resolve this concern about double counting time. So when time is used for level selection and the maximum time on a level 5 visit is exceeded by 15 minutes, practitioners will report G2212 for Medicare instead of CPT code 99417.

Third, we had made a number of proposals to value code sets that include, rely upon, or are analogous to office visits commensurate with the increases in values we finalized for the office visit codes. We're finalizing values for these code families and they are as follows.

End stage renal disease monthly capitation payment services, transitional care management services, maternity services, cognitive impairment assessment and care planning, initial preventive physical examination and initial and subsequent annual wellness visits, emergency department visits, therapy evaluations, and psychiatric diagnostic evaluations and psychotherapy services.

And last, but not least, we solicited comment on the definition and utilization assumptions for HCPCS add-on code G2211, formerly referred to as GPC1X

that we finalized in the CY 2020 rule for office and outpatient visit complexity. And in the final rule for 2021, you'll find more language about how we've intended this code to be used.

And with respect to utilization assumptions, in the proposed rule we assumed that this could be reported with 100% of office visits by specialties that rely on the office visit codes to report the majority of their services. And because we think it may take some time for practitioners to be reporting HCPCS add-on code G2211, for 2021 we are assuming that it will be reported with 90% of office visits by specialties that rely on these visits to report the majority of their services. So we reduced the utilization assumptions a little bit to get practitioners a bit of additional time to begin reporting this code.

I'm going to switch topics now to teaching physicians and residents. Back in March and May, through two interim final rules for COVID-19, we had implemented policies that permitted physician fee schedule payment when the teaching physician was virtually present to the resident, including when the resident was furnishing Medicare telehealth services. And we had permitted physician fee schedule payment for an expanded array of services under the primary care exception.

One question that we've received a few times is the teaching physician can be present through audio only. Because the law requires that the teaching physician render sufficient personal and identifiable physician services to the patient, we've interpreted this legal requirement to mean both audio and video for the teaching physician to be able to bill separately on the physician fee schedule.

And we've implemented these policies for the duration of the public health emergency, to help ensure that beneficiaries could still access necessary

services, reduce exposure risk to COVID-19 for both beneficiaries and practitioners and to maintain workforce capacity in teaching settings. We then sought comment on these provisions in the proposed rule this past summer.

For the final rule these policies will remain in place through the duration of the public health emergency whenever it ends. And we are also making some of these policies permanent under certain circumstances. The virtual supervision and primary care exception policies that are in place for the public health emergency will be our ongoing policy for residency training sites of a teaching setting that are outside of the metropolitan statistical area. I know that's a mouthful, but we mean rural areas.

In these settings we are establishing the following policies that will be in place even after the public health emergency ends. So first, similar to our policy during the public health emergency, teaching physicians may use interactive real time audio/video communication technology to interact with the resident through virtual means, in order to meet that statutory requirement that I mentioned earlier, that they be present for a key portion of the service, including when the teaching physician is involving the resident in furnishing Medicare telehealth services.

And again, we've interpreted that statutory requirement to mean both audio and video. Second, in order to ensure that the teaching physician is meeting the legal requirement to be present, we expect the medical record to clearly document how the teaching physician was present to the resident during the service.

And third, similar to our policies during the public health emergency, teaching physicians involving residents and providing care at primary care centers, may

provide necessary direction, management and review for our resident services, using interactive real time audio and video communications technology. Residents furnishing services at these primary care centers can furnish an expanded set of services to beneficiaries including communication technology based services and interprofessional consults.

Fourth, as in during the public health emergency, these flexibilities do not apply in the case of surgical, high risk interventional, or other complex procedures, services performed through an endoscope and anesthesia services. We remain concerned about the risk that services like that we offer and the ability for the teaching physician to be present to the resident through these services.

And finally, for our resident moonlighting policies, back in March we had extended our resident moonlighting rules in that we allowed physician fee schedule payment in the inpatient setting of the hospital in which residents had their training programs, providing that the services were outside the scope of the approved residency training program and separately identifiable.

The idea was similar to our teaching physician policies, was to expand what practitioners could do to further help teaching settings with surge capacity from COVID-19. And in the proposed rule we also sought comment on this policy.

For the final rule we stated that this policy will remain in place for the duration of the public health emergency. And we are also making this policy permanent for all residency training sites. So we're not limiting it to our rural areas. This will be national policy.

And then finally, to prevent potential duplication of payment with the inpatient prospective payment system for graduate medical education, and regardless of whether the resident services are performed in the outpatient department, the emergency department, or the inpatient setting of a hospital in which they have their training program, the medical records must show that the resident furnished identifiable physician services that meets all of the conditions that are outlined in the regulation.

So that concludes teaching physicians and residents. And now I'll turn it over to Sarah Leipnik. Thanks.

Sarah Leipnik: Thanks Christiane. Good afternoon and good morning. My name is Sarah Leipnik and I'm going to now discuss the policies regarding professional scope of practice and related issues. First is supervision of diagnostic tests by certain non-physician practices, NPPs.

CMS finalized our proposal to make permanent following the COVID-19 PHE, the same policy that was finalized under the May 1, 2020 COVID-19 IFC, for the duration of the COVID-19 PHE, to allow nurse practitioners, clinical nurse specialists, physician assistants and certified nurse midwives, to supervise the performance of diagnostic tests within their scope of practice and state law.

We are adding certified registered nurse anesthetists to this list. These practitioners must maintain the required statutory relationships under Medicare with supervising or collaborating physicians. Second is pharmacists providing services incident to physician services.

And CMS is reiterating the clarification provided in the May 1, 2020 COVID-19 IFC, that pharmacists may fall within the regulatory definition of auxiliary

personnel under our Incident to regulations. As such, pharmacists may provide services incident to the services and under the appropriate level of supervision of the billing physician or a non-physician practitioner if payment for the services is not met under the Medicare Part D benefit.

This includes providing the services incident to the services of the billing physician and non-physician practitioner, and in accordance with the pharmacist state scope of practice and applicable state law.

Third is therapy assistants, furnishing maintenance therapy. In the CY 2021 PFS final rule, CMS finalized the Part B policy for maintenance therapy services that was adopted on an interim basis for the public health emergency in the May 1, 2020 COVID-19 IFC.

This finalized policy allows the physical therapist and occupational therapist to delegate the furnishing of maintenance therapy services as clinically appropriate to a physical therapy assistant, or an occupational therapy assistant.

And this Part B policy allows PTs and OTs to use the same discretion to delegate maintenance therapy services to PTAs and OTAs, the physical therapy assistants and occupational therapy assistants, that they utilize for rehabilitative services.

And lastly, medical record documentation. Last year, in the CY 2020 PFS final rule CMS finalized broad modifications to the Medicare medical record documentation requirements for physicians and certain non-physician practitioners.

And in this year, CY 2021 PFS final rule, we're clarifying that physicians and non-physician practitioners including therapists, can review and verify documentation entered into the medical record by members of the medical team, for their own services that are paid for under the PFS.

We are also clarifying that therapy students and students of other disciplines, working under a physician or a practitioner who furnishes and bills directly for their professional services to the Medicare program, may document in the record, so long as the documentation is reviewed and verified, signed and dated by the billing physician practitioner or therapist.

I'm now going to discuss valuation of services for vaccine administration. For immunization services, in the CY 2021 PFS final rule we finalized the policy to maintain the CY 2019 payment for CPT codes 90460, 90461, 90471, 90472, 90473, and 90474. And HCPCS codes G0008, G0009, and G0010, in consideration of payment stability for stakeholders, public health concerns and the importance of these services for Medicare beneficiaries.

I'm now going to turn it over to Terry Simananda, Terry.

Terry Simananda: Thank you, Sarah. I'm Terry Simananda and I will be discussing Medicare coverage for opioid use disorder treatment services furnished by OTP. In the calendar year 2021 PFS final rule, CMS finalized the proposal to extend the definition of OUD treatment services to include opioid antagonist medications, specifically naloxone, that are approved by FDA under Section 505 of the Federal Food, Drug, and Cosmetic Act, for emergency treatment of opioid overdose as well as overdose education.

CMS also finalized the proposed creation of a new add-on code to cover the cost of providing patients with nasal naloxone, and pricing this code based

upon the methodologies set forth in Section 1847(a) of the Social Security Act except that the payment amount shall be AFP plus zero.

Since auto-injected naloxone is no longer available in the marketplace, CMS instead finalized a second new add-on code to cover the cost of providing patients with infectible naloxone and is contractor pricing this code for calendar year 2021.

CMS finalized the proposal to apply the frequency limit on the code describing naloxone but allowing an exception in the case where the beneficiary overdoses and uses the supply of naloxone given to them by the OTP, to the extent that additional supplied naloxone is medically reasonable and necessary. Additionally, CMS finalized our proposals to allow periodic assessments to be furnished via two-way interactive audio/video communication technology.

Now I would like to turn it over to JoAnna Baldwin. JoAnna?

JoAnna Baldwin: Hi, thank you. And thank you everyone, for joining us today, to get the rundown of the physician fee schedules for CY 2021. So as background, in Section 2002 of the Support Act, the Congress required that specific elements be included in the initial preventive physical examination and the annual wellness visit.

So the elements that we have finalized as proposed, to become part of those two Medicare wellness visits, includes the review of any current opioid prescription. Now specifically, that entails the review of potential risk factors to the individual, for opioid use disorder, and evaluation of the individual's severity of pain and current treatment plan, the provision of information on non-opioid treatment options, and a referral to a specialist as appropriate.

The second element that was finalized as proposed, and is now included in both of these wellness visits, is a screening for potential substance use disorders and a referral to treatment as appropriate. So we ended up finalizing these as proposed. There was no change between the rules. And they are now part of the initial preventive physical exam or IPPE, and the annual wellness visit, the AWV.

To bring some of this discussion full circle, as was mentioned earlier by Christiane, both of these visits because they are crosswalked to evaluation and management service codes, the evaluation for each of these wellness visits, has increased as of January 1 for - as the outcome of the physician fee schedule final rule.

Jill, back to you. I think I'm the last one on the agenda.

Jill Darling: Yes. Thank you, JoAnna and thank you to all of our speakers today. (Danielle), will you please open the lines for Q&A?

Coordinator: Thank you. We will now begin the question and answer session. If you would like to ask a question, please press star 1, unmute your phone, and record your name clearly when prompted. Your name is required so we can introduce your question.

If you need to cancel your question for any reason, you can dial star 2. Again, if you'd like to ask a question, please press star 1. It'll take just a moment for those to queue through. Please standby. All right. Our first question today comes from (Amy). Go ahead. Your line is now open.

(Amy): Hi there. Thank you for taking my question today. My - I'm seeking clarification on the required documentation by a physician, a teaching physician when working with students, in our case it's medical students, but students of any sort. In the final rule it says as long as they review and verify. And then in parentheses it does say that they basically sign and date it.

Is that all that is required by the teaching physician is just that they sign and date the student documentation? Or do they need to do an attestation similar to what is required for working with residents?

Gift Tee: Sarah, I'll take this one if that's okay. So I think we were just clarifying that for purposes of billing Medicare. That the…

Sarah Leipnik: Correct.

Gift Tee: …billing professional physician, right, would be reviewing, signing and verifying the information that was included in the medical record by students, other members of the medical staff. I think that's separate from the attestation that you mentioned. I'm not as familiar with that. So I don't know if they are in conflict.

But I think our clarification holds up for purposes of billing Medicare. That's what would be required.

(Amy): Simply a date and a signature for billing Medicare?

Gift Tee: Yes. Verifying, signing…

(Amy): Thank you.

Gift Tee: …and dating.

(Amy): Thank you. Thank you.

Gift Tee: Sure.

Coordinator: Our next question comes from (Kim Carr). Go ahead, (Kim). Your line is open.

(Kim Carr): Hi. Thank you. I have a question similar to the previous caller, regarding billing Medicare for actually therapy students. If the inclusion in the medical record by the therapy student is to be signed and dated by the billing therapist, we just wanted to clarify that this is for any therapy documentation that would normally be entered into the medical record.

And then a follow on question would be are the students signing those entries themselves and then it being co-signed by the billing therapist or, after they have reviewed it, or is the student creating the record but the billing therapist is the only one signing it?

Sarah Leipnik: Thank you. Oh…

Gift Tee: Go ahead, Sarah.

Sarah Leipnik: …go ahead.

Gift Tee: Go ahead.

Sarah Leipnik: You can go ahead.

Gift Tee: So I think the same principle applies, right, where the therapy student is entering information to the medical record. Again, they're not the ones billing. We're really relying on the billing therapist, practitioner, physician, to verify and sign off on the information that's been included in the medical record, given that it's subject to medical review, to the extent that that is necessary.

But for purposes of billing Medicare, we expect that that billing practitioner is signing off on that information. And then your second question, I'm blanking, so if you wouldn't mind just repeating, just a bit of it.

(Kim Carr): Yes. I just wanted to know as far as like how it actually is going to happen, so the student is providing the information in the record but are they actually signing as a student and then being - and then having the billing therapist cosign behind them? Or are they just creating the record that the therapist that's billing signs by themselves?

Gift Tee: You know, I think we leave that up to the workflow that, you know, the practice, institution, whatever, may have established. We're just looking for ultimately, the billing practitioner. So, you know, if the student is just entering the information, creating the record versus signing off on what they created, that's not what we're looking for, versus the billing practitioner that would be submitting that claim or billing Medicare, having verified and signed off on the documentation.

(Kim Carr): Okay. Thank you.

Gene Freund: Hey, this is Gene Freund. Gift, would it not be the case that - I hope I'm not adding confusion to this. But would it not be the case if a student practitioner of some kind who needs to be supervised by the billing provider, is the one

who clearly filled out the record, they would have to document the presence and participation of the teaching clinician or the teaching - someone would - I mean let me rephrase it.

The medical record would need to clearly state the participation and verification by the practicing clinician. That might be one for Christiane to…

Gift Tee: Yes. Please Christiane, if you can offer thoughts here that would be great.

Christiane LaBonte: So I think the best way to say this is that as far as teaching physician presence goes, we would expect a full documentation in the medical record to state how the teaching physician was present during the particular encounter. So if the teaching physician was virtually present through let's say an office visit, we would expect the record to be able to - we would expect that information to be found in the record.

But going back to some points that Gift was stating a little while ago, I think agency policy generally has been that doesn't matter to us who on the medical team is doing the documentation, but that at the end of the day the billing practitioner whether that's a teaching physician or someone else, does need to be able to verify all the information that is in the medical record and to sign off and date on all of that.

So it doesn't necessarily matter to us who actually is making the notations in the medical record. Just as long as the billing practitioner is overseeing that process and can sign off on it. And specifically, if the teaching physician is virtually present, that there is a documentation in the medical record that reflects that as well.

I hope that's helpful.

(Kim Carr): Yes. Thank you.

Coordinator: Our next question comes from (Dale Gibson). Go ahead. Your line is open.

(Dale Gibson): Thank you. This is a - okay, this is my opinion. There's a lot of confusing information, you know, especially about the - all these changes. You know, there's been numerous changes over the past several months. Is there some place where we can access some of these information in a simple form, so that we can understand and, you know, start providing the service or whatever? Does that make any sense?

Gift Tee: Yes. We appreciate that there's certainly a lot of content that we've put out last week and preceding months. Is there specific like range of services or policies that you need a little bit more clarification on?

(Dale Gibson): Yes. Basically all of it. I mean it, you know, a lot of facilities are trying to start using this and, you know, it just - to me it just seems - keep changing. And, you know, I'd like somewhere some type of clear explanation of what is available and how it's to be done and who can bill it. I mean I don't know about anybody else, but I'm very confused.

Gift Tee: Okay. I think what would be helpful Gene, Jill, if you wouldn't mind just stating that email box. I think there is a lot no doubt, but a bit more specificity would be helpful for us to point you to information that's out there that may be more consumable.

Jill Darling: Sure. You can email Partnership@CMS.HHS.gov.

Gene Freund: The other advice - this is Gene Freund again, I might add is that if you've got coders that you're working with they will be familiar with the CPT manual which contains most of what is in there as far as CPT coding. And that's the AMA that owns that. So go to them for CPT coding with the - I won't add anymore.

And also look for MLN Matters articles about this. But it's, you know, our medical - Medicare Learning Network. Those will be coming out and those - as they come out that can help clarify things. And again, don't hesitate to send us a specific question that can also help us figure out what needs to be shared.

And correct me if anything I said was off, CM folks.

(Dale Gibson): All right, thank you.

Gift Tee: Yes. Thanks, Gene.

Coordinator: Our next question…

Jill Darling: We'll take our next question, please.

Coordinator: Our next question comes from (Arlene). Go ahead. Your line is now open.

(Arlene): Hi. Thank you. I'm inquiring about the screening for potential opioid use disorder that's part of the IPP and annual wellness visit. So I guess I'm just wondering, if somebody is not taking opioids, if you can see that in the annual wellness visit, do we still, you know, have to screen them? And when you say screen, do we have to have a specific, you know, a tool that we use to screen?

I'm just looking - does it have to be for everybody even if they're not on opioids? And what are we looking at that this documentation needs to show us?

JoAnna Baldwin Thank you for your question. So we will be having some - unfortunately the final rule went out a bit late this year. And we missed some of our opportunities for the routine updates of the annual wellness visit and initial preventive physical exam educational materials.

So we are in process of updating those now and we will - and, you know, thank you for your question here on the phone today, because as we work on those we will try to include language that answers that question. If you have that question I'm sure many others do as well.

And we will try to make that more specific. What I can say is that for these two wellness visits the general guidance that has been given over the past years and that hasn't changed today, is that you would have to demonstrate in the record, that each of the services were furnished.

And if they weren't furnished then, you know, that would just need to be documented too. So it would need to touch upon that each one of these requirements as part of each of these visits, has been touched upon during the visit. Or if it hasn't, why?

To answer your question about screening tools, Medicare has not required that a tool be used to satisfy the screening requirement. So again, that leaves - we left that purposely to the discretion of the practitioner to do what is appropriate for their particular patient.

There is more a discussion on that in the preamble of the physician fee schedule. Off the top of my head I don't have a page number for you out of the hundreds of pages that were published. But I do believe - but the upcoming educational materials should be able to make these things more clear to practitioners and to stakeholders.

So for that, thank you for your questions, so we can ensure that those things are touched upon as those materials go out.

(Arlene): Thank you.

Coordinator: Our next question comes from (Hyatt). Your line is now open.

(Hyatt): Thank you. I do have two questions. The first one is about the behavioral health 99441 through 99443. And the question is since COVID I know that that - those services are now available to audio only, or can be done through audio only. So the question I have is can those be billed using the E/M codes 99213 through 99215 based on time?

I see that in the final rule they've changed the - or updated the RBUs for that. And have crosswalked these codes to the E/M codes. And so can you use E/M codes in lieu of the 99441 through 99443 on that? Second question…

Emily Yoder: Hi. This is Emily. If I could just…

(Hyatt): Hi.

Emily Yoder: …take your questions one at a time that would be…

(Hyatt): Oh, yes. Yes.

Emily Yoder: …best for me. Thank you.

(Hyatt): Go ahead. I'm sorry Emily. Go ahead.

Emily Yoder: No. No. No worries. So right now the policy is that we do pay separately during the public health emergency for the 99441 through 99443 which are audio only phone evaluation and management services.

(Hyatt): Right. Right.

Emily Yoder: Now it is true that you can now choose a level for the office outpatient E/M visits based on time. However, those codes still in terms of when they're furnished via telehealth, they are not able to furnished via audio only communication technology. And so you would need to continue to use the 99441 through 99443 in instances where you're using audio only communication technology.

(Hyatt): So based on what the rule says, when you see it cross walking what does that really mean? What is it that you're trying to convey? Is that just for - I guess I'm not understanding why you would publish that, that you're cross walking it. Can you explain that?

Emily Yoder: So - yes, so generally speaking, when we talk about cross walking, it has to do with how the service is valued. And so I think what you're pointing out is that we did say that during the public health emergency, we would pay for the audio only E/M at the same payment rate as we would pay for the established patient level two through four office visit.

So that was sort of what we mean when we say crosswalk. We're just saying oh, well the valuation won't be the same.

(Hyatt): So you cannot use the 99212 through 99214 in lieu of the 99441 through 443?

Emily Yoder: That is correct. That is correct.

(Hyatt): Okay. Okay. The next one is a simple one. So we have prenatal visits that since COVID we've had patients come in and not come in - not come in really, and do prenatal antepartum visits through telehealth. My question is we have two codes for telehealth for antepartum rather, the 59425 and 26 based on the number of visits. Can telehealth visits be used as the number of visits?

Emily Yoder: Yes. So I think you're referring to - these are codes that have a certain number of office visits that are kind of built into the structure of the code. Yes. So those absolutely can be done using telehealth.

(Hyatt): Okay. Just for the 59425 it's 426, so I know that they have a lot of patients who exceed that and they can go into the next set of codes, the 59426 if it's greater than 7. So you're saying that if any of those antepartum visits go beyond that I can go into the next set of codes?

Emily Yoder: Yes. So these are - because these visits are not actually reported separately, we have no way to even know whether or not, even under normal circumstances, they're furnished like in person or if they're furnished remotely.

So I would definitely - so while there are certain aspects of these codes that will require, I do believe that right now they're not on the telehealth system. I

mean that would be because you believe that there's still some components that have to be in person. But those follow up visits that are built into the code, can absolutely be done as telehealth.

(Hyatt): Perfect. Thank you very much. And thank you for having these sessions. They're great.

Coordinator: Our next question comes from (Jennifer). Go ahead. Your line is now open.

(Jennifer): Hi. Thank you very much. I appreciate it. My only question actually is a little bit different. I'm hoping you can at least answer it to clarify it for us though. The review of a prior external note from each unique source.

So if an individual healthcare system who belongs to a network can access the EMR from other members of that same network, are they considered external organizations? Because we both are actually using - well actually we're different networks, but we're both using the same like EMR record because they both can access the EPIC.

Would this be considered external notes or would it be considered internal notes?

Gift Tee: I'll take a stab at this.

(Jennifer): Okay.

Gift Tee: But you may want to submit your question to our mailbox. So same organization, just different clinics or different locations?

(Jennifer): Well it would actually be - the system - we belong to the in network and other members of in network so they'd be separate from other members of the network with prior auth. So this is what the question reads. Individual healthcare systems who belong to the network, can access the EMR from other members of the network with the patient's authorization.

They are external organizations but the notes can be accessed via EPIC using Care Everywhere. Would these still be considered external notes?

Gift Tee: That's a tricky one. It's got a lot of nuance to it. But ultimately…

(Jennifer): Yes.

Gift Tee: …someone's going to be billing for a service, right, that is furnished…

(Jennifer): Yes.

Gift Tee: …using information in those notes?

(Jennifer): Right.

Gift Tee: Right. So - and let me just go a little further into the scenario. Those other entities are contributing to the care or could be considered members of a medical team that are contributing to the services being furnished to the beneficiary for which the claim would be submitted, or…

(Jennifer): I believe so. Yes. So - and that's why they're both using the same EPIC - they're both using the same notes because they can read each other's notes in the EPIC system. So to me that would seem like it's external organizations

but I'm not sure. That's why I'm asking. So yes, they would both - different entities would be billing different yes.

Gift Tee: Yes. I would go ahead and just submit your question and…

(Jennifer): Okay.

Gift Tee: …give us some time to review and discuss internally.

(Jennifer): Okay. Okay. And should I submit that to the one that she said earlier, the…

Jill Darling: Yes.

Gift Tee: Yes.

Jill Darling: The Partnership.

(Jennifer): The partner - okay, great. Hey, thank you guys very much. I appreciate it.

Jill Darling: Sure.

Coordinator: Our next question comes from (Jenika). Go ahead. Your line is now open.

(Jenika Burke): Yes, thank you. This is (Jenika Burke) from the University of Utah. I have a specific question related to the non-face to face prolonged services for the new outpatient code set. It does indicate that there'll no longer be - CMS will no longer be reimbursing for the 99358 and 359 associated with an outpatient E/M visit.

And I just wanted clarification because we've codes that do require that there's an established previous visit or a new visit occurring for these non-face to face prolonged services. And there's no timeframe. So these, at times, you know, occur 30 days after a visit.

And I just wanted to get a clarification if the E/M services or the non-face to face services related to any outpatient E/M visit that they're no longer payable. These would only be payable in relation to inpatient services.

Ann Marshall: So this is Ann Marshall. I'm on the PFS team. That's correct. The reason we are not paying 99358 and 9 in association with the office visits anymore, which means that there's not a mechanism to report work done on another day, is because there's a new prolonged code for face to face and non-face to face time the day of the visit as you know.

It was a CPT code. We're doing a G code for now. We've been working hard to align with CPT on this. But we're not yet in the same space. And I don't - I think we said in the rule that in concept, we're not opposed to paying for work on a separate day, but we think there should be a unique code that identified time specific to an office outpatient visit.

And the 99358 and 9 code as you're saying, is not. And since it's - can be reported on any other day, when we see that in the claims really have no way of knowing what the base visit was. If the patient had more than one visit, let's say they had an admission and then outpatient follow up, in that month we also see a 99358 in the record, we don't know whether the prolonged time is for the inpatient visit or the outpatient visit.

And especially now that time can be used to select visit level and really drive payment in a new way, we'd like to be able to know for certain how much

time is done for a given visit. So for now we're not using the 99358 and 9. That could change in the future if CPT revises the framework or if we could consider revising our G code. But that's where things stand for right now.

(Jenika Burke): Okay. Thank you. That's helpful. We would appreciate it. Because there are a lot of times when feedback from a provider is where an exorbitant amount of time is spent outside of the data service for which they don't feel like the RBU of time evaluation for pre-service and post-service time are reflective of that. So we appreciate consideration in the future. Thank you very much.

Ann Marshall: Yes. The interesting thing was when the (unintelligible) we surveyed the office outpatient set last year, they found that not a lot of time in the survey responses was reported on another day. So I think in their view that's more an outlier. But that may be more an issue where, you know, practice on the ground is not matching what they're seeing in the survey. It's a good question.

(Jenika Burke): Thank you.

Jill Darling: And (Danielle), we'll take one more question, please.

Coordinator: All right. Our final question comes from (Joy Hanford). Go ahead. Your line is now open.

(Joy Hanford): Hello. I just have a question about the time component for the (E/M) services 99202 through 99215. In the rule, in the final rule on page 210, it was stating that you were going to go with the actual times which are different than what CMS - different than what the AMA has documented in the CPT book, which is a range. Are you - is that a change? Are you following the AMA guidance on the time for these codes?

Christiane LaBonte: Yes. This is Christiane LaBonte. Thanks for the question. So for level selection, we wrote that the level selection continued to use the CPT code descriptor. What the table on page 210, I am scrolling there right now, discusses, is how we use time to calculate a payment rate. So when you're using time for level selection, continue to use what is outlined in the CPT book.

(Joy Hanford): Thank you so much for that clarification.

Christiane LaBonte: Sure thing. You're welcome.

Jill Darling: All right. Well I'll turn it over to Gift or to Gene, for any closing remarks.

Gene Freund: Thanks all for…

Gift Tee: Well, thanks Jill. Go ahead, Gene, please.

Gene Freund: Oh well, I just want to thank everybody for attending and particularly thankful for these folks from our Center for Medicare, who have really worked super hard in a very difficult time period, to get this rule out. I hear them apologizing for how late it was. And as an agency we can, you know, we can offer our apologies for that.

But I want to give this crowd big kudos and I'm grateful that the audience gives them kudos for the work that they've done this year. And that's all I have to add. Thank you very much.

Jill Darling: Great. Thank you. And one more reminder. If you were not able to ask a question today, please feel free to send it into the partnership email at

Partnership@CMS.HHS.gov. And have a wonderful day. And happy holidays everyone.

Coordinator: That concludes today's conference. Thank you for participating. You may disconnect at this time.

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