



mln call

A MEDICARE LEARNING NETWORK® (MLN) EVENT

Physician Fee Schedule Final Rule: Understanding 4 Key Topics

Thursday, December 10, 2020



Acronyms in this Presentation

- **AMA** - American Medical Association
- **APM** - Alternative Payment Models
- **APP** - APM Performance Pathway
- **ACO** - Accountable Care Organization
- **CAHPS** - Consumer Assessment of Healthcare Providers and Systems
- **CMS** - Centers for Medicare & Medicaid Services
- **CPT** - Current Procedural Technology
- **CY** - Calendar Year
- **ED** - Emergency Department
- **E/M** - Evaluation and Management
- **HCPCS** - Healthcare Common Procedure Coding System
- **IFC** - Interim Final Rule with Comment
- **MAT** - Medication Assisted Treatment



Acronyms in this Presentation

- **MLN** - Medicare Learning Network
- **MIPS** - Merit-based Incentive Payment System
- **MVP** - MIPS Value Pathways
- **NPI** - National Provider Identifier
- **NPP** - Non-Physician Practitioner
- **OTP** - Opioid Treatment Program
- **OD** - Opioid Use Disorder
- **PFS** - Physician Fee Schedule
- **PHE** - Public Health Emergency
- **QCDR** - Quality Clinical Data Registry
- **QPP** - Quality Payment Program
- **SAMHSA** - Substance Abuse and Mental Health Services Administration
- **TIN** - Tax Identification Number
- **TPI** - Third Party Intermediary



Agenda

- **Extending Telehealth & Licensing Flexibilities**
- **Evaluation and Management (E/M) Visits and Analogous Services**
- **Quality Payment Program Updates**
- **Opioid Use Disorder/Substance Use Disorder Provisions**



Extending Telehealth & Licensing Flexibilities

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Topics

- Telehealth & Other Virtual Services
- Virtual Supervision
- Scope of Practice & Related Issues
 - Supervision of Diagnostic Tests
 - Pharmacists Providing Incident To Services
 - Maintenance Therapy
 - Medical Record Documentation
 - Teaching Physicians and Residents



Telehealth Overview

- Specified by Section 1834 (m) of the Social Security Act and related regulations, Medicare telehealth services are services ordinarily furnished in person that are instead furnished via a telecommunications system and are subject to geographic, site of service, practitioner, and technological restrictions.
- In response to the public health emergency (PHE) for the COVID 19 pandemic, CMS temporarily waived a number of these restrictions and adopted regulatory changes to expand access to Medicare telehealth
- Before the PHE, only 14,000 patients received a Medicare telehealth service in a week
- During the PHE, over 12.8 million patients received a Medicare telehealth service from mid-March through mid-September.



CY 2021 Medicare Telehealth List

We permanently added these services to the Medicare telehealth services 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 Evaluation and Management (E/M) (HCPCS code G2211)
- Prolonged Office/Outpatient E/M Services (HCPCS code G2212)



CY 2021 Medicare Telehealth List

We added these services as Category 3, temporary additions to the Medicare telehealth services list:

- 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 1-5 (CPT codes 99281-99285)
- Nursing facilities discharge day management (CPT codes 99315-99316)
- Psychological and Neuropsychological Testing (CPT codes 96130-96133; CPT codes 96136-96139)
- Therapy Services, Physical and Occupational Therapy, All levels (CPT codes 97161-97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507)
- Hospital discharge day management (CPT codes 99238-99239)
- Inpatient Neonatal and Pediatric Critical Care, Subsequent (CPT codes 99469, 99472, 99476)
- Continuing Neonatal Intensive Care Services (CPT codes 99478-99480)
- Critical Care Services (CPT codes 99291-99292)
- End-Stage Renal Disease Monthly Capitation Payment codes (CPT codes 90952, 90953, 90956, 90959, 90962)
- Subsequent Observation and Observation Discharge Day Management (CPT codes 99217; CPT codes 99224-99226)



Other Finalized Policies

- Expanding the types of practitioners who may provide communication technology-based services and clarify which practitioners may bill for eVisits
- Amending the frequency limitations on subsequent nursing facility visits
- Allowing auxiliary personnel to provide certain remote monitoring services under a physician's supervision
 - Auxiliary personnel can include contracted employees
- Clarifying the definition of a medical device supplied to a patient as part of a remote monitoring service and that the device must be reliable, valid, and the data must be electronically collected and transmitted rather than self-reported



Virtual Supervision

For the duration of the PHE, to limit infection exposure, we revised the definition of direct supervision to include virtual availability of the supervising physician or practitioner using interactive audio/video real-time communications technology.

We finalized the continuation of this policy through the end of the PHE or December 31, 2021, whichever is later. This will give us time to continue to evaluate whether this policy should be adopted permanently.



Scope of Practice Final Policies

Supervision of Diagnostic tests by Certain Non-physician Practitioners (NPPs)

- We are making permanent our interim final policy during the COVID-19 PHE allowing supervision of diagnostic tests as allowed by state law and scope of practice by:
 - Nurse Practitioners
 - Clinical Nurse Specialists
 - Physician Assistants
 - Certified Nurse-Midwives
 - Also adding Certified Registered Nurse Anesthetists
- The NPPs must maintain any required statutory relationships with supervising or collaborating physicians.



Scope of Practice Final Policies, Cont'd

Pharmacists Providing Services Incident to Physicians' Professional Services

- Reiterated our clarification that pharmacists can be auxiliary personnel under our “incident to” regulations
- Pharmacists may provide services incident to the services, and under the appropriate level of supervision of the billing physician or NPP, if payment for the services is not made under Medicare Part D
- Physicians may not report these services using higher level E/M visits (levels 2 through 5) as those visits must be provided directly and can't be provided incident to the billing clinician's professional services.



Scope of Practice Final Policies, Cont'd

Therapy Assistants Furnishing Maintenance Therapy

- We finalized our policy for the duration of the COVID-19 PHE that allows a physical therapist and occupational therapist the discretion to delegate the performance of maintenance therapy services, as clinically appropriate, to a therapy assistant

Medical Record Documentation

- We clarified that the broad policy principle that allows billing clinicians to review and verify documentation added to the medical record for their services by other members of the medical team also applies to therapists
- We also clarified that therapy students, and students of other disciplines, working under a physician or practitioner who bills directly for their professional services to the Medicare program, may document in the record so long as it is reviewed and verified (signed and dated) by the billing physician, practitioner, or therapist



Teaching Physicians and Residents

1. We finalized the following policies for teaching physicians billing for services they provide involving residents in training sites of a teaching setting that are outside of a metropolitan statistical area (i.e., rural settings).
 - a) Teaching Physician – can meet the requirement to be present for the key portion of the service using audio/video real-time communications technology to interact with the resident, including when involving the resident in providing Medicare telehealth services.
 - b) Primary Care Exception – Teaching physicians at primary care centers can provide the direction, management and review of a resident’s services using audio/video real-time communications technology. These residents may provide an expanded set of services to patients, including communication technology-based services and inter-professional consults.
2. Resident Moonlighting – For both rural and non-rural settings, the services of residents that are not related to their approved GME programs and are provided to inpatients of the training program hospital are separately billable physicians’ services under the PFS.
3. Policies implemented for the PHE will remain in place for the duration of the PHE.



Payment for Office/Outpatient E/M Visits and Analogous Services

Ann Marshall



Payment for Office/Outpatient Evaluation and Management (E/M) Visits and Analogous Services

Last year, we finalized aligning E/M visit coding and documentation policies with changes by the CPT Editorial Panel for office/outpatient E/M visits, beginning January 1, 2021.

- This includes:
 - Code redefinitions that rely on time or medical decision making for selecting visit level, with performance of history and exam as medically appropriate
 - Deletion of level 1 new patient code
 - A new prolonged services code specific to office/outpatient E/M visits
 - Increased valuation to recognize shifts in medical practice and appropriately reflect resources involved in providing these services, particularly primary care to manage chronic disease

We also adopted revised medical decision making guidelines adopted by the CPT Editorial Panel. Additional information about the American Medical Association (AMA) CPT changes are available on the [AMA website](#).



E/M Final Policies

- We clarified the reporting times for prolonged office/outpatient E/M visits. To avoid double-counting time, finalized HCPCS code G2212 to report these services.
- Revised the times used for ratesetting for this code set.
- Revalued the following code sets that include, rely upon, or are analogous to office/outpatient E/M visits in line with the increases to office/outpatient E/M visits:
 - 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
 - Psychiatric Diagnostic Evaluations and Psychotherapy Services
- Based on public comment, we clarified the definition of HCPCS code GPC1X (G2211), previously finalized for office/outpatient E/M visit complexity. We refined our utilization assumptions to 90% of relevant office/outpatient visits.



Quality Payment Program

Molly MacHarris
Brittany LaCouture



Quality Payment Program (QPP) Updates for 2021 Performance Year

Performance Pathways – Final Policy:

- **MIPS Value Pathways (MVPs):** No MVPs were finalized for the 2021 performance period; the earliest MVP implementation will for be the 2022 performance period
 - Finalized MVP guiding principles, MVP development criteria, and a process for candidate submission
- **APM Performance Pathway (APP):** Finalized pathway for MIPS APMs participants that is complementary to MVPs with a fixed set of measures for each performance category:
 - **Quality (50%)** – Measure set consists of 6 measures with CMS Web Interface flexibilities for ACOs; ACOs participating in Medicare Shared Savings Program are required to submit quality measures via the APP
 - **Cost (0%)** – Reweighted to 0% to account for consideration of cost in MIPS APMs
 - **Improvement Activities (20%)** – Score automatically assigned based on MIPS APMs respective requirements; in 2021, all APM participants reporting via the APP will receive a score of 100%
 - **Promoting Interoperability (30%)** – Reported and scored at the individual or group level as required in MIPS



Merit-based Incentive Payment System (MIPS) Updates for 2021 Performance Year

Performance Categories:

Quality:

- Extend availability of CMS Web Interface through the 2021 performance period; the CMS Web Interface will sunset (discontinue) beginning with the 2022 performance period
- Continuing implementation of the Meaningful Measures framework by adding 2 new administrative claims measures, removal of 11 measures and updates to measures and specialty sets

Cost:

- Add codes for certain telehealth services to episode-based cost measures and TPCC and MPSB measures
- All APM Entities will have cost reweighted to 0%



MIPS Updates for 2021 Performance Year

Performance Categories:

Improvement Activities:

- Establish 1 new criterion for nominating new improvement activities
- Allow 2 new pathways for nominating improvement activities
- Modify 2 existing improvement activities, continued COVID-19 improvement activity as outlined in September Interim Final Rule with Comment (IFC)
- Remove 1 obsolete improvement activity

Promoting Interoperability:

- Retain the Query of Prescription Drug Monitoring Program measure as an optional measure and increase its worth from 5 to 10 bonus points
- Change the name of the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure to Support Electronic Referral Loops by Receiving and Reconciling Health Information
- Add optional Health Information Exchange (HIE) bi-directional measure
- Continue reweighting for 2021 performance period



MIPS Updates for 2021 Performance Year

Performance Category Weights:

| Performance Category | 2020 Performance Category Weights | 2021 Performance Category Weights | 2021 Performance Category Weights APM Entities |
|---|-----------------------------------|-----------------------------------|---|
|  Quality | 45% | 40% | 50% |
|  Cost | 15% | 20% | 0% |
|  Improvement Activities | 15% | 15% | 20% |
|  Promoting Interoperability | 25% | 25% | 30% |



MIPS Updates for 2021 Performance Year

Payment Thresholds:

| Performance Year | Performance Threshold | Additional Performance Threshold for Exceptional Performance | Payment Adjustment* |
|------------------|-----------------------|--|---------------------|
| 2017 | 3 points | 70 points | Up to +4% |
| 2018 | 15 points | 70 points | Up to +5% |
| 2019 | 30 points | 75 points | Up to +7% |
| 2020 | 45 points | 85 points | Up to +9% |
| 2021 | 60 points | 85 points | Up to +9% |

2021 Updates: finalized changes to the hierarchy when assigning a final score when a clinician has multiple final scores associated with a single TIN/NPI:

- Virtual group final score
- Highest available final score from APM Entity, APP, group, or individual

*Payment adjustment (and additional adjustment for exceptional performance) is based on comparing final score to performance threshold and additional performance threshold for exceptional performance. To ensure budget neutrality, positive MIPS payment adjustment factors are likely to be increased or decreased by an amount called a “scaling factor.” The amount of the scaling factor depends on the distribution of final scores across all MIPS eligible clinicians.



MIPS Updates for 2021 Performance Year

COVID-19 Flexibilities:

- Double the complex patient bonus to up to 10 bonus points to account for additional complexity in treating patients during the public health emergency (for the 2020 performance period only)
- Allow APM Entities to submit an application to reweight MIPS performance categories as a result of extreme and uncontrollable circumstances beginning with the 2020 performance period

Third-Party Intermediaries (TPI):

- Allow QCDRs and Qualified Registries to support new MVPs once implemented
- Finalized policies include adopting new data validation and corrective action plan requirements, finalizing additional criteria for TPI approval, and updating QCDR measure requirements



Advanced APM Updates for 2021 Performance Year

- Adopted process for limited targeted review of QP determinations in situations where an eligible clinician believes in good faith that a clerical error on the part of CMS omitted them from a participation list on one or more snapshots
- For purposes of QP determinations, beneficiaries who are considered attribution-eligible by more than one APM Entity will be removed from the attribution-eligible population of APM Entities to which they may not actually be attributed as a result of APM overlap rules



Medicare Shared Savings Program Updates for 2021 Performance Year

Medicare Shared Savings Program

- For the 2020 performance period, finalized a policy to waive the CAHPS for ACOs reporting requirement and provide full credit to ACOs for the patient experience of care survey measures
- For performance year 2021, ACOs participating in the Shared Savings Program will be required to report quality data via the APP with CMS Web Interface flexibilities for the 2021 performance year only
- Gradual phase-in of the increase in the level of quality performance that will be required for all ACOs to meet the Shared Savings Program quality performance standard in order to share in their maximum savings rate or avoid owing maximum losses, if applicable
- Strengthen Shared Savings Program policies for enforcing compliance with the quality performance standard and retain pay-for-reporting year for new ACOs



2020 Extreme and Uncontrollable Circumstances Application Deadline Extended

For the 2020 performance period, the **Extreme and Uncontrollable Circumstances policy** allows MIPS eligible clinicians, groups, virtual groups, and APM Entities to submit an application requesting reweighting of MIPS performance categories to 0% due to the current COVID-19 public health emergency

- **New:** APM Entities may submit an application to reweight MIPS performance categories as a result of extreme and uncontrollable circumstances
- The EUC Exception application deadline is extended until **February 1, 2021**
 - **Note:** The deadline for the Promoting Interoperability Hardship Exception application remains December 31, 2020

Learn more about how to [submit an application](#) by visiting the QPP Resource Library and reviewing the zip file of related resources: <https://qpp.cms.gov/about/resource-library>



Opioid Use Disorder/Substance Use Disorder Provisions

Lindsey Baldwin



Overview

Expanding access to treatment for Opioid Use Disorder (OUD) is one of CMS' key areas of focus in addressing the opioid epidemic.

Today we will cover provisions related to the Opioid Treatment Program (OTP) benefit and bundled payments for Substance Use Disorders (SUDs) under the PFS.



OTP Benefit

Section 2005 of the SUPPORT Act established a new Medicare Part B benefit for opioid use disorder (OUD) treatment services furnished by Opioid Treatment Programs (OTPs).

Under the CY 2020 Physician Fee Schedule [final rule](#), CMS pays OTPs through bundled payments for OUD treatment services in an episode of care provided to beneficiaries with Medicare Part B.

Under the OTP benefit, Medicare covers:

- U.S. Food and Drug Administration-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications
- Dispensing and administration of MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments



CY 2021 OTP Policies Finalized

- 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 under section 505 of the Federal Food, Drug, and Cosmetic Act for emergency treatment of opioid overdose, and overdose education provided in conjunction with opioid antagonist medication.
 - The proposed creation of a new add-on code to cover the cost of providing patients with nasal naloxone (HCPCS code G2215) and pricing this code based upon the methodology set forth in section 1847A of the Act, except that the payment amount shall be average sales price (ASP) + 0. Since auto-injector naloxone is no longer available in the marketplace, CMS instead finalized a second new add-on code (HCPCS code G2216) to cover the cost of providing patients with injectable naloxone and is contractor pricing this code for CY 2021.
 - The proposal to apply a frequency limit on the codes describing naloxone, but allowing exceptions in the case where the beneficiary overdoses and uses the supply of naloxone given to them by the OTP, to the extent that the additional supply of naloxone is medically reasonable and necessary.
- The proposal to allow periodic assessments to be furnished via two-way interactive audio-video communication technology, as clinically appropriate, and in compliance with all applicable requirements.



Bundled Payments under the PFS for Substance Use Disorders

- In the CY 2020 PFS final rule, we finalized the creation of new coding and payment describing a bundled episode of care for office-based treatment of OUD.
- For CY 2021, we finalized our proposal to expand these bundled payments to be inclusive of all SUDs.



Initiation of MAT in the Emergency Department (ED)

- We finalized one add-on G-code (HCPCS code G2213) for initiation of MAT to be billed with E/M visit codes used in the ED setting that includes:
 - Payment for assessment
 - Referral to ongoing care
 - Follow-up after treatment begins
 - Arranging access to supportive services



Q&A Session



Resources

- [E/M Webpage](#)
- [Quality Payment Program Website](#)
- [OTP Webpage](#)
- [SUPPORT for Patients and Communities Act](#)
- [CMS Roadmap: Fighting the Opioid Crisis](#)



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