CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 4468	**Date: November 27, 2019**
	Change Request 11560

SUBJECT: Summary of Policies in the Calendar Year (CY) 2020 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List

I. SUMMARY OF CHANGES: This Change Request (CR) provides a summary of the policies in the CY 2020 Medicare Physician Fee Schedule (MPFS) Final Rule and announces the Telehealth Originating Site Facility Fee payment amount. The attached recurring update notification applies to publication 100-04, chapter 12, section 190.5, chapter 13, section 20.2.4, and chapter 18, section 240.

EFFECTIVE DATE: January 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 6, 2020

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Recurring Update Notification

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 4468	Date: November 27, 2019	Change Request: 11560

SUBJECT: Summary of Policies in the Calendar Year (CY) 2020 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List

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I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to provide a summary of the policies in the CY 2020 Medicare Physician Fee Schedule (MPFS). Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary to establish by regulation a fee schedule of payment amounts for physicians' services for the subsequent year. The Centers for Medicare & Medicaid Services (CMS) final rule that updates payment policies and Medicare payment rates for services furnished by physicians and Nonphysician Practitioners (NPPs) that are paid under the MPFS in CY 2020 went on display on November 1, 2019. The final rule also addresses public comments on Medicare payment policies proposed earlier this year.

B. Policy: This Change Request provides a summary of the payment polices under the MPFS and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in CY 2020.

Regulation number CMS-1715-F, Medicare Program: Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2020, went on display November 1, 2019. This Change Request provides a summary of the payment polices under the MPFS and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in CY 2020.

Medicare Telehealth Services

For CY 2020, CMS is finalizing our proposals to add the following codes to the list of telehealth services:

- Healthcare Common Procedure Coding System (HCPCS) codes G2086, G2087, and G2088 (bundled episode of care for treatment of opioid disorders)

Telehealth origination site facility fee payment amount update

Section 1834(m)(2)(B) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the Medicare Economic Index (MEI) as defined in section 1842(i)(3) of the Act. The MEI increase for 2020 is 1.9%. Therefore, for CY 2020, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or $26.65. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.)

For more information regarding Telehealth Services contact Lindsey Baldwin 410-786-1694

Medical Record Documentation

CMS is finalizing for CY 2020 a proposal to reduce burden by implementing a broadened general principle beyond teaching physicians, that allows all physicians, Physician Assistants (PAs), Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Certified Nurse-Midwives (CNMs) and, Certified Registered Nurse Anesthetists (CRNAs), each of whom are recognized as Advanced Practice Registered Nurses (APRNs), to review and verify (sign/date) documentation in medical records without having to re-document notes already included in the medical record. This principle applies across the spectrum for all Medicare-covered professional services furnished by each of these professionals that are paid under the Medicare Part B Physician Fee Schedule. Also, in addition to physicians, residents, nurses, and medical students, this provision includes PA and APRN students or other members of the medical teams, as those individuals who are allowed to make notes in a patent's medical record that are reviewed and verified by physicians, PA's and APRNs.

For more information regarding Medical Record Documentation, contact Regina Walker-Wren 410-786-9160

Scope of Practice

CMS is finalizing for CY 2020 the "Physician Supervision for Physician Assistant (PA) Services" proposal implementing our reinterpretation of Medicare law that requires physician supervision for the professional services of PAs. Accordingly, Federal regulations at 42 CFR 410.74 (a)(2) require that a PA must furnish their professional services in accordance with State law and State scope of practice rules for PAs in the State in which the services are furnished to the extent that those rules describe the required relationship between physicians and PAs, including its collaborative nature, describe a form of supervision for Medicare's purposes. For States with no explicit State law and guidance regarding physician supervisions of PAs, physician supervision is a process with one or more physicians to supervise the delivery of their healthcare services. Such physician supervision is evidenced by documenting the PA's scope of practice and indicating the working relationships the PA has with the supervising physicians when furnishing professional services, with any required documentation of PA supervision maintained at the practice level, instead of in the medical record for each patient.

For more information regarding Scope of Practice, contact Regina Walker-Wren 410-786-9160

Chronic Care Management (CCM) Services

For non-complex CCM, we are creating a Medicare-specific add-on code G2058 to Current Procedural Terminology (CPT) code 99490 that may be used to report increments of 21-40 and, if applicable 41-60 minutes of clinical staff time of non-complex CCM services. This add-on code to CPT code 99490 can be reported a maximum of twice per service period. When G2058 is reported, CPT code 99490 will represent the first 20 minutes of non-complex CCM services, with G2058 reporting additional 20-minute increments of service time (maximum of 60 minutes total).

G2058: Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure). (Do not report G2058 for care management services of less than 20 minutes additional to the first 20 minutes of chronic care management services during a calendar month). (Use G2058 in conjunction with 99490). (Do not report 99490, G2058 in the same calendar month as 99487, 99489, 99491).

CCM Typical Care Plan Revision

For all CCM, we are finalizing revised language for the typical care plan that will apply for Medicare payment purposes. The new language reads: The comprehensive care plan for all health issues typically

includes, but is not limited to, the following elements:

● Problem list

● Expected outcome and prognosis

● Measurable treatment goals

● Cognitive and functional assessment

● Symptom management

● Planned interventions

● Medical management

● Environmental evaluation

● Caregiver assessment

● Interaction and coordination with outside resources and practitioners and providers

● Requirements for periodic review

● When applicable, "revision of the care plan”

For complex CCM (CPT codes 99487, 99489)

We are providing that the care planning service element may be met when the care plan is established, implemented, revised or monitored (rather than established or substantially revised).

For Transitional Care Management (TCM) (CPT 99495 and 99496)

We are increasing payment by adopting the Relative Value Scale (RVS) Update Committee (RUC) recommended increases in valuation. We are also providing that 14 HCPCS codes currently not reportable during the same service period as TCM may be concurrently reported when medically necessary and not duplicative of other services. The codes are listed in table in the final rule.

For more information regarding Care Management Services, contact Ann Marshall 410-786-3059, Christiane LaBonte 410-786-7237, Liane Grayson 410-786-6583, or Emily Yoder 410-786-1084

Therapy

In the CY 2019 PFS final rule, in accordance with amendments to the Medicare law, we established modifiers to identify therapy services that are furnished in whole or in part by Physical Therapy (PT) and Cccupational Therapy (OT) assistants, and set a *de minimis* 10 percent standard for when these modifiers will apply to specific services. We also established that the statutory reduced payment rate for therapy assistant services, effective beginning for services furnished in CY 2022, does not apply to services furnished by critical access hospitals because they are not paid for therapy services at PFS rates.

Beginning January 1, 2020, these modifiers are required by statute to be reported on claims. After consideration of public comments, we finalized that the assistant modifiers do not apply when a therapist and therapist assistant furnish services together, and, that in addition to untimed codes, we are allowing, for billing purposes, the application of the modifier to each 15-minute timed unit of such timed codes, instead of

all the time units for that service on a given day.

For more information regarding Therapy, contact Pam West 410-786-2302

Opioid Use Disorder Treatment Furnished by Opioid Treatment Programs (OTPs)

Section 2005 of the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act established a new Medicare Part B benefit for Opioid Use Disorder (OUD) treatment services, including medications for Medication-Assisted Treatment (MAT), furnished by Opioid Treatment Programs (OTPs). To meet this statutory requirement, CMS is finalizing:

- The definition of OUD treatment services which includes:
- Food and Drug Administration (FDA)-approved opioid agonist and antagonist treatment medications,
- The dispensing and administering of such medications (if applicable),
- Substance use disorder counseling,
- Individual and group therapy,
- Toxicology testing,
- Intake activities, and
- Periodic assessments
    - The Substance Abuse and Mental Health Services Administration (SAMHSA) certification is required as part of the enrollment policy and process for OTPs. OTPs that received SAMHSA certification prior to October 24, 2018 will be deemed "moderate risk" while OTPs that received SAMHSA certification on or after October 24, 2018 will remain in the "high risk" screening level.
    - CMS is finalizing bundled payment rates for OTPs based on the medication administered and the intensity of services in order to account for differences in beneficiaries' clinical needs. CMS finalized the period of an episode of care as one week in duration. The proposal to establish partial episodes was not finalized, based on public comment.
    - For the drug component of the OTP bundle, CMS finalized a payment of Average Sales Price (ASP)+0 percent, when ASP data are available. CMS also finalized an increased payment rate for the non-drug bundle payment rate and add-on codes for intact, periodic assessments and take-home dosing. For methadone, we will use TRICARE pricing when ASP is not reported. For oral buprenorphine, we are finalizing using National Average Drug Acquisition Cost pricing when ASP data are not reported; payment rates will be adjusted by geographic locality and adjustment on a yearly basis.
    - A policy to allow counseling and therapy services described in the bundled payments, to be furnished via two-way interactive audio-video communication technology as clinically appropriate; and
    - Zero beneficiary copayment for as long as there is a public health emergency to address the opioid crisis.

CMS is implementing this benefit beginning January 1, 2020, as required by the SUPPORT Act.

*Please see CR11353 for more information.

For more information regarding Opioid Use Disorder Treatment furnished by Opioid Treatment Programs, contact Lindsey Baldwin 410-786-1694 or Terry Simananda 410-786-8144

Coding and Payment for Evaluation and Management, Observation and Provision of Self-Administered Esketamine Interim Final Rule

We are finalizing the creation of two new HCPCS codes, G2082 and G2083, effective January 1, 2020 on an interim final basis. This will allow for payment under the PFS for use of esketamine in services to patients

with treatment-resistant depression during CY 2020.

For more information regarding esketamine, contact Terry Simananda 410-786-8144

Insertion, Removal, and Removal and Insertion of Implantable Interstitial Glucose Sensor System (Category III CPT codes 0446T, 0447T, and 0448T)

Category III CPT codes 0446T, 0447T, and 0448T describe services related to the insertion and removal of an implantable interstitial glucose sensor system, which are currently contractor priced, and will remain contractor priced in CY 2020. Given the immediate needs of Medicare beneficiaries with diabetes, including some who could benefit from the use of innovative technologies, we are seeking information from stakeholders to ensure proper payment for this important physician's service by establishing national payment rates in future rulemaking for the insertion, removal, and removal and insertion of implantable interstitial glucose sensor system**.**

For more information regarding implantable interstitial glucose sensor, contact Terry Simananda 410-786-8144

Long-Term EEG Monitoring Codes

CMS is finalizing for CY 2020 CPT codes 95700-95716 as contractor-priced. The rates are established by regional Medicare Administrative Contractors (MACs) in their respective jurisdictions.

For more information regarding long-term EEG monitoring codes, contact Michael Soracoe 410-786-6312.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11560.1	Contractors shall be aware of the policies published in the Medicare Physician Fee Schedule Final Rule (Regulation number CMS-1715-F, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2020), which are summarized with this change request and apply those policies as appropriate.	X	X	X						
11560.2	Effective for dates of service January 1, 2020 and after, Medicare contractors shall continue to pay for the Medicare telehealth originating site facility fee as 80 percent of, the lesser of the actual charge or $26.65, as described by HCPCS code Q3014 "Telehealth facility fee."	X	X	X						

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11560.3	Contractors shall use the list of telehealth services found on the CMS website at http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html.	X	X							
11560.4	Contractors shall continue to use the codes identified in CR 9250 for the CT modifier reduction.		X							
11560.5	Contractors shall use the prolonged preventive services G0513 and G0514 as an add-on to the covered preventive services located on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Medicare-PFS-Preventive-Services.html.		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
11560.6	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X	X	X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Kathleen Kersell, 410 786-2033 or Kathleen.Kersell@cms.hhs.gov , Julie Adams, 410-786-8932 or julie.adams@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0