Medicare Physician Fee Schedule Final Rule

November 17, 2021
**OVERVIEW**

**Telehealth**
- Category 3
- Interim telehealth
- Consolidated Appropriations Act
- Audio-only
- Extended CTBS

**Therapy Services**
- Therapy assistant payment
- 10% de minimis standard

**RHC/FQHCs**
- Hospice attending providers
- Transitional care management
- Chronic care management
- Mental health visit

**Evaluation and Management Services**
- Split/shared
- Teaching physicians
- Primary care exception
- Physician assistant services

**Colorectal Cancer Screening**
- Closing the gap on patient financial responsibility

**Supervision**
- Addresses virtual presence during PHE wind-down
Telehealth
Telehealth

No new category 1 or category 2 services will be added. The distinction between category 3 and interim services is critical to end of coverage dates.

Categories 1 and 2
1: Services that are similar to professional consultations, office visits, and office psychiatry services; similar to those already on list
2: Services that are not similar to those on the current Medicare telehealth services list

Interim Telehealth Services
- Not all services added as telehealth were added as category 3 telehealth
- 106 codes’ coverage as telehealth will end when PHE ends
- Medicare sought comment on whether to add as category 3

Category 3
- Adds telehealth services temporarily following the end of the PHE
- Added during the PHE
- Likely clinical benefit
- Insufficient evidence to add permanently as category 1 or 2
- Added 93797, 93798, G0422, G0423
- Coverage will extend through 12/31/2023
<table>
<thead>
<tr>
<th>Service Type</th>
<th>HPCS</th>
<th>Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urodynamics</td>
<td>51741</td>
<td>Complex uroflowmetry (e.g., calibrated electronic equipment)</td>
</tr>
<tr>
<td>Biofeedback</td>
<td>90901</td>
<td>Biofeedback training by any modality</td>
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<tr>
<td></td>
<td>90912</td>
<td>Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient</td>
</tr>
<tr>
<td></td>
<td>90913</td>
<td>Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>Neurological &amp; Psychological Testing</td>
<td>96130</td>
<td>Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour</td>
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<tr>
<td></td>
<td>96131</td>
<td>Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)</td>
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<tr>
<td></td>
<td>96132</td>
<td>Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour</td>
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<tr>
<td></td>
<td>96136</td>
<td>Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes</td>
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<tr>
<td></td>
<td>96137</td>
<td>Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)</td>
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<tr>
<td></td>
<td>96138</td>
<td>Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes</td>
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<tr>
<td></td>
<td>96139</td>
<td>Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>Therapy Procedures</td>
<td>97110</td>
<td>Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility</td>
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<tr>
<td></td>
<td>97112</td>
<td>Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities</td>
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<tr>
<td></td>
<td>97116</td>
<td>Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)</td>
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<td>97150</td>
<td>Therapeutic procedure(s), group (2 or more individuals)</td>
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<tr>
<td>Physical Therapy Evaluations</td>
<td>97161</td>
<td>Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.</td>
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<tr>
<td></td>
<td>97162</td>
<td>Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>Service Type</td>
<td>HCPCS</td>
<td>Long Descriptor</td>
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<tr>
<td>Therapy</td>
<td>97530</td>
<td>Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes</td>
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<tr>
<td>Therapy Procedures</td>
<td>97535</td>
<td>Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes</td>
</tr>
<tr>
<td>Personal Care</td>
<td>97537</td>
<td>Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes</td>
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<tr>
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<td>97542</td>
<td>Wheelchair management (e.g., assessment, fitting, training), each 15 minutes</td>
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<tr>
<td>Tests and Measurements</td>
<td>97750</td>
<td>Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes</td>
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<td></td>
<td>97755</td>
<td>Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes</td>
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<tr>
<td></td>
<td>97763</td>
<td>Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes</td>
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<tr>
<td>Personal Care</td>
<td>98960</td>
<td>Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient</td>
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<tr>
<td></td>
<td>98961</td>
<td>Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients</td>
</tr>
<tr>
<td></td>
<td>98962</td>
<td>Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients</td>
</tr>
<tr>
<td>Evaluative and Therapeutic</td>
<td>92607</td>
<td>Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour</td>
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<tr>
<td>Services</td>
<td>92608</td>
<td>Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td></td>
<td>92609</td>
<td>Therapeutic services for the use of speech-generating device, including programming and modification</td>
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</tbody>
</table>
When the PHE ends, CMS’s waiver authority to permit audio-only services as telehealth ends

**AUDIO-ONLY SERVICES**

Medicare is permanently expanding coverage for audio-only services to certain mental health visits
Telehealth for Mental Health Conditions

Final Rules:

- Who can provide in-person visits? Statute said “the provider” but Medicare billing policy that same subspecialty, same group practice = same provider
- Periodic visit frequency. “Further, the exceptions process will allow for situations where an in-person annual visit is not needed.”
  - “For example, situations in which the risks and burdens associated with an in-person service may outweigh the benefit could include, but are not limited to instances when an in-person service is likely to cause disruption in service delivery or has the potential to worsen the patient’s condition(s).”
  - There is no exception to the initial in-person visit requirement
- No claim indicator to distinguish between SUPPORT Act SUD telehealth
- Clarification on “home” POS: “our definition of home, both in general and for this purpose, can including temporary lodging, such as hotels and homeless shelters.” “Where the patient, for privacy or other personal reasons, chooses to travel a short distance from the exact home location during a telehealth service, the service is still considered to be furnished ‘in the home of an individual’.
- Also adds rural emergency hospital, a new provider type, as eligible originating site effective 1/1/2023
Audio-Only Services

Medicare proposes to extend coverage of audio-only visits for certain mental health services. Originating site, distant site professional definitions are decided by Congress under the SSA. “Telecommunications technology” is defined by HHS.

**Conditions**
- Diagnosis, evaluation, or treatment of mental health disorders including SUD
- Established patients
- Originating site is the patient’s home

**Final Rule**
- Documentation requirements: Why audio only
- Level of service limits
- Exclusions if psychotherapy add-on is used
- Exclusions if crisis code is reported

**Other Restrictions**
- Patient is unable to, does not want to use, or does not have access to two-way, audio/video technology
- Provider must have capacity for audio-visual, two-way real-time communication
- Modifier to identify audio-only service and certify compliance
The originating site fee for telehealth began at $20 and is adjusted each year.

ORIGINATING SITE FEES

The originating site fee for CY 2022 is $27.59.
When the PHE ends, CMS’s waiver authority to permit audio-only services as telehealth ends.
Split/Shared Visits

Mechanism to report services under physician’s name when shared between physician and NPP

- IOM
- Good Guidance Regulations
- DHHS Petition for Removal; Rulemaking Required

Conditions

Established patients
Physician performs "substantive" portion

Manual Provisions Removed

DHHS Petition Jan. 19, 2021
CMS Response
Transmittal 10742cp
Removal Effective May 9, 2021
Impact on Medical Review
Split/Shared Visits

Proposed regulatory definition and several changes to previous manual provisions that would apply to split/shared visits in a facility setting.

Changes

- New and established patients
- Initial and subsequent visits
- SNF/NF setting permitted
- Allowed for critical care
- Substantive portion > 50% of time
  
  "We believe the commenters overestimate the administrative burden of tracking and attributing time, given the advent of EHRs and new E/M visit coding structures."

  2022 Transition year
- Prolonged services could be split/shared

Proposed Definition

An E/M visit in the facility setting that is performed in part by both a physician and an NPP who are in the same group, in accordance with applicable laws and regulations.

Substantive Portion

2022 transition year definition (except time-based codes):

- 1 of 3 key components; or
- > 50% time

Components: Billing provider must perform 1 in its entirety

Physical exam: If used, billing practitioner’s exam must meet level of exam for level of service billed

Other Provisions

Level of service based on MDM or time

Only distinct time counts towards level

ED visit activities? No different list at this time

Does not required both providers to have face-to-face

Modifier required
**Critical Care**

Proposed adopting CPT rules, including definition and bundled services, with certain exceptions

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**Changes**

- Allow as concurrent care regardless of group affiliation
- All providers in the same group, same day, same patient combine time to determine 99291, 99292 units
- 99291 once per day, per patient, per group
- Provider reporting more than 50% of time bills
- Bundled into post-op for 10–90-day procedures (new modifier required to identify that critical care is unrelated to the procedure)

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**Other Provisions**

- Start/stop times not required
- Sufficiently document to allow reviewer to determine role each professional played
- When services span midnight, use the rule for IV hydration
- No other E/M visit for the same patient, same day as critical care by provider in same specialty and group → Critical care allowed with other E/M provided "that the [other] E/M service was provided prior to the critical care service at a time when the patient did not require critical care"
Supervision
Medicare sought comment on whether to extend and/or make supervision rules permanent

- Whether to allow only for a subset of services
- Whether modifier would be needed

**Final Rule: Taking comments under consideration; no decision yet**
Remote Therapeutic Monitoring
Remote Therapeutic Monitoring

- Intended for providers who can’t report RPM
- Assigned to medicine category
- Assigned as “sometimes therapy”
- Must be provided under direct supervision unless performed directly by physicians, NPPs, or therapists
- RTM = 20 minute intervals
- Consider PTA/OTA “de minimum” policy based on 15-minute therapy codes
Available Through Heartland Telehealth Resource Center for Technical Assistance
Richelle Marting, JD, MHSA, RHIA, CPC, CEMC, CPMA, CPC-I

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