Physician Fee Schedule Final Rule: Understanding 4 Key Topics Call

Moderated by: Nicole Cooney
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Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® Event. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Nicole Cooney. Thank you. You may begin.

Announcements & Introduction

Nicole Cooney: Hello everyone. I'm Nicole Cooney from the Provider Communications Group here at CMS. And I'll be your moderator today. I'd like to welcome you to this Medicare Learning Network call on the Physician Fee Schedule Final Rule: Understanding Four Key Topics.

Today's call will cover four topics from the calendar year 2021 Physician Fee Schedule Final Rule, including extending telehealth and licensing flexibilities beyond the public health emergency, updating evaluation and management coding guidance, updating the quality payment program and merit-based incentive payment system value pathways, and updating opioid use disorder and substance use disorder provisions.

Before we get started, you received a link to the slide presentation in your confirmation e-mail. The presentation is available at the following URL, go.cms.gov/mln-events. Again, that's go.cms.gov/mln-events.

This call is open to everyone. If you are a member of the press, you are welcome to listen. But please don't ask questions during the Q&A session. Instead, send your inquiries to press@cms.hhs.gov.

I have several experts on the line with me today. And at this time, I'd like to turn the call over to Emily Yoder, Sarah Leipnik, and Christiane LaBonte from our Center for Medicare to get us started on our first topic.

Presentation

Emily Yoder: Hi everyone. My name is Emily Yoder, and I will be covering Medicare payments for Medicare telehealth and virtual supervision. So, I'm going to start on slide seven. Section 1834(m) of the Social Security Act specifies the circumstances under which Medicare may pay for telehealth. Medicare telehealth services are services ordinarily furnished in person and are subject to geographic, site of service, practitioner, and technological restrictions.

In response to the public health emergency for COVID-19, CMS is able to waive a number of these restrictions, as well as adopt regulatory changes to expand access to Medicare telehealth broadly. While outside of the PHE, the statutory restrictions would require an Act of Congress to modify.

The following is a summary of the regulatory flexibilities that we are adopting on a permanent or temporary basis. So, slide eight and nine provide an overview of services we're adding to the telehealth list on either a permanent or a temporary basis.

So, for CY 2021, we are finalizing the addition of a number of services to the Medicare telehealth list permanently on a Category I basis. These include lower-level established patient home and/or domiciliary

visits, assessment and care planning for patients with cognitive impairment, group psychotherapy, and two add-on codes associated with our office/outpatient E&M policies.

Additionally, we are finalizing the creation of a third temporary category of criteria for adding services to the Medicare telehealth list. This category, which we're calling Category III, describes services added to the Medicare telehealth list during the PHE that will remain on the list through the calendar year in which the PHE adds – ends, excuse me.

Services added to the Medicare telehealth list on the temporary basis include all levels of ED visits, certain therapy services, higher level of established patient home and/or domiciliary visits, certain psychological testing services, nursing facility discharge day management, and a range of critical care services.

I'm now on slide 10. In response to stakeholders who have stated that the once-every-30-day frequency limitation for subsequent nursing facility that's furnished to be a Medicare telehealth provide unnecessary burden and limits access to care for Medicare beneficiaries in that setting, we propose to revise the frequency limitation from one telehealth visit every 30 days to one telehealth visit every three days.

However, based on information from commenters about perhaps creating a disincentive for in-person care, and after consideration of how patients in the nursing facility setting in general tend to have longer lengths of stay when compared to patients in the inpatient setting, we are finalizing a revised frequency limitation for subsequent nursing facility telehealth visit of one visit of telehealth every 14 days.

We also clarified that like these 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.

On this slide, you can see we're also finalizing a couple of clarifications for remote patient monitoring.

I also just want to briefly talk about audio-only services. So, during the public health emergency, we've established separate payment for audio-only telephone E&M services. So, while we did not propose to continue to recognize these codes for payment under the PFS outside of the COVID-19 PHE, we did note that the need for audio-only interactions could remain as beneficiaries continue to try to avoid sources of potential infection such as the doctor's office.

We saw comments on whether CMS should develop coding and payment for a service similar to the virtual check-in. Based on support from commenters, we are establishing payments on an interim final basis for a new HCPCS G-code describing 11 to 20 minutes of medical discussion that is used to determine whether an in-person visit is necessary. And then finally, on slide 11, with regards to direct supervision, during 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 communications technology.

We are finalizing the continuation of this policy up through the year in which the PHE ends, or December 31st, 2021 whichever is the later date. And this will give us time to continue to evaluate whether this policy should be adopted permanently.

Now I will hand it over to Sarah.

Scope of Practice Final Policies

Sarah Leipnik: Thank you, Emily.

My name is Sarah Leipnik. And I'm going to discuss the policies regarding professional scope of practice and related issues. So, I'm on slide 12.

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

And we are adding certified registered nurse anesthetists to this list. And these practitioners must maintain the required statutory relationships under Medicare with supervising or collaborating physicians.

Moving on to slide 13. Pharmacists providing services incident to the physician services. CMS is reiterating the clarification that pharmacists may fall within the regulatory definition of ancillary personnel under our incident to regulation.

And as such, pharmacists may provide services, incident to the services and under the appropriate level of supervision of the billing physician or non-physician practitioner if payment for such services is not made under the Medicare Part D benefit.

And physicians may not report these services using the higher-level E&M visits, Levels 2 through 5. As those visits must provide – be provided directly and cannot be provided incident to the billing clinician's professional services.

Now on slide 14, with therapy assistants furnishing maintenance therapy. In the CY 2021, PFS final rule has finalized the Part B policy for maintenance therapy services that was adopted on an interim basis for the PHE in the May 1st, 2020 COVID-19 IFC.

And this finalized policy allows physical therapists and occupational therapists, so PTs and OTs, to delegate the furnishing of maintenance therapy services clinically appropriate to a physical therapy assistant or an occupational therapy assistant. And this Part B policy allows the PTs and OTs to use the same discretion to delegate maintenance therapy services to the PTA and OTA that they utilized for rehabilitative services.

And lastly, for a medical record documentation, in the CY 2020 PFS final rule, CMS finalized broad modifications to the medical record documentation requirement for physicians and non-physician practitioners.

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

And we're also clarifying that therapy students and students from other disciplines working under a physician or practitioner who bills directly for their professional services to the Medicare program may document and record so long as it's reviewed and verified, signed and dated by the billing physician, practitioner, or a therapist. And I'm now going to pass it over to Christiane.

Teaching Physicians and Residents Final Policies

Christiane LaBonte: Thanks Sarah. Good afternoon or good morning everyone. My name is Christiane LaBonte. Thanks for being here today. And for all that you're doing for our beneficiaries and in particular during this difficult year. I'll be walking through our final rule provisions related to payment for the services of teaching physicians and residents. And this is all on slide 15 if you're following along.

Starting with some background, back in March and May through two interim final rules, we implemented policies that permitted physicians fee schedule payment when the teaching physician was virtually present to the resident, including when the president was furnishing Medicare telehealth services, and we 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 since then is if the teaching physician can be present through audio only. We took care of that because the law requires that the teaching physician render what is called sufficient personal and identifiable physician services to the patient. We've interpreted the legal requirement to mean both audio and video for the teaching physician to bill separately on the Physician Fee Schedule.

We implemented all of these policies for the duration of the public health emergency to ensure that beneficiaries could still access necessary services, reduce exposure risk to COVID-19 both for beneficiaries and for practitioners, and to maintain workforce capacity, in particular in those teaching settings. And then we saw comments on these provisions in the physician fee schedule proposed rule this past summer.

In this slide again, slide 15, describes what we put in place through this final rule that we just issued. And I'm going to start with the bottom of the slide, if you look at bullet number three.

So, these policies that we implemented back in March and May that I just want a few moments describing, these policies will remain in place through the duration of the public health emergency whenever it ends.

And now I'm going to go back to the top of the slide and walk you through the other provisions.

We are also making some of these provisions permanent under certain circumstances. As described in this first bullet, 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 the teaching setting that are outside of the metropolitan statistical area. And I know that's a mouthful, but we mean rural areas, rural setting.

And in these settings, we are establishing the following policies that will be in place after the public health emergency ends.

So first, under bullet A, and this is similar to our policy during the public health emergency. Teaching physicians may use interactive, real-time audio and video communications technology to interact with the

resident through virtual means in order to meet that statutory requirement that I was talking about earlier that they'd be present for the 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.

And in order to ensure that the teaching physician is meeting that legal requirement to be present to bill that physician fee schedule, we expect the medical record to clearly document how the teaching physician was present to the resident during the service

And next, in bullet B, this is similar again to our policy during the public health emergency. Teaching physicians involving residents and providing primary care at primary care centers may provide necessary direction management and review for the resident services using interactive, real-time audio and video communications technology.

Residents furnishing services at the centers may furnish an expanded set of service to beneficiaries, including communication technology-based services and inter-professional consults.

And for all of these points, and 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 during endoscope and anesthesia services.

We have written extensively that we have remained concerned about the ability for the teaching physician to be present during these services, and also concerned about potential safety issues for beneficiaries. So that's why we have excluded these sorts of procedures from these virtual supervision policies.

And finally, for our resident moonlighting policies. Back in March, we had expanded our resident moonlighting rules. And that we allowed Physician Fee Schedule payment in the inpatient setting of a hospital in which residents had their training program, providing that these services were outside of the scope of the approved residency training program and separately identifiable.

The idea was similar to the other policies that we've put in place, which is to expand what residents could do to further help teaching settings with surge capacity for COVID-19. And like the other policies, we saw comments on this policy in the proposed rule.

And for the final rule, and this is covered under bullet two, we see that this policy will remain in place – sorry. We see that this policy will remain in place for the duration of the public health emergency. And we are also making this policy permanent and for all residency training sites in both rural and non-rural settings. So that 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 where the inpatient setting of a hospital in which they have their training program, a medical record must show that the resident furnished identifiable physician services that meets all of the conditions that are outlined in the regulation. That concludes teaching physicians and residents. So now I'll turn it over to Ann Marshall.

Office/Outpatient E/M Visits Final Policies

Ann Marshall: Thanks Christiane. Hi. This is Ann Marshall from the Division of Practitioner Services. And I'll be going over our finalized policies regarding office/outpatient E&M visits.

As you may know last year, we finalized coding and payment policies to the office/outpatient E&M visits code sets, services that account for approximately 20 percent of charges under the Physician Fee Schedule.

These changes go into effect on January 1st. And they were made to reduce administrative burden and update these code sets to better reflect the current practice of medicine.

We largely aligned our policies with changes that were made by the AMA CPT editorial panel. And that included redefining the codes in a way that relies on time or medical decision-making to select visit level with performance of history and exam, as medically appropriate; the deletion of a Level 1 new patient code; and a new prolonged service code specific to office/outpatient E&M visits.

We also adopted increased evaluation for this code set, which was recommended by the AMA RUC. And we finalized a Medicare-specific add-on code to account for office/outpatient visit complexity, especially primary care, and longitudinal specialty care.

Finally, we adopted the AMA's revised medical decision-making guidelines for selecting visit level. And these are available along with other information on the AMA's website. And we provided a link to that here at the bottom of slide 17.

So, moving on to slide 18 to talk about the policies in this year's rule. We made several refinements that will also be effective January 1st.

And the first item was, we clarified our reporting time for prolonged office/outpatient services. In order to avoid double counting time and clarify required time, we finalized a G-code, G2212, instead of the CPT codes for reporting prolonged office visits.

We continued our decision not to allow reporting of prolonged time on a day other than the office visit. Because currently, there are no CPT codes to uniquely identify at this time such that we would know the total time spent when multiple visits take place. We remained open to potentially changing the codes specific to prolonged office service in the future years if code revisions might resolve these issues.

Second, we slightly revised the times that are used to set payment rates for several of the base codes. And we know that these are not the times to report the services that are separate and included in the code descriptors. And this more of a technical change around the times will reflect implementing a total time that is the sum of the component times for pre, intra, and post service.

Third, this year, we finalized increases to the evaluation of the following code sets that include, rely upon, or analogous to the office/outpatient E&M visits, commensurate with the increases that will be coming to the office visits.

This includes end-stage renal disease monthly capitation payment services; transitional care management services; the maternity services packages' cognitive impairment assessment and care planning; the initial preventive physical exam and the initial and subsequent annual wellness visits; emergency department visits in order to avoid a rank order anomaly; therapy evaluations, meaning physical and speech language pathology, and the other therapies; and psychiatric diagnostic evaluations and psychotherapy services.

And finally, based on public comment, we continue to clarify the definition of that add-on codes for all visit complexity. We also refined our utilization assumptions for this code, estimating that it will be reported with approximately 90 percent of the relevant office/outpatient E&M visits, or roughly 75 percent of all office/outpatient visits instead of the 100 percent relevant visits that we assumed in the proposed rule.

And I think I'll be turning it over to the next section, where we'll be reviewing the Quality Payment Program policies. Thank you.

Quality Payment Program Final Policies

Brittany LaCouture: Hi. This is Brittany LaCouture.

I'm going to be reviewing the Quality Payment Program updates beginning with the MIPS value pathways which were a proposal that was finalized in the 2020 rule. However, no MIPS value pathways were introduced or finalized for the 2021 performance period. And the earliest date for MVP implementation is now set for the 2022 QPP performance period.

This year we did finalize additional MVP guiding principles, MVP development criteria, and a process for MVP candidate submission.

We also finalized the APM performance pathway or the APP, which is intended to be a streamlined MIPS reporting pathway, akin to an MVP but specifically designed for APM participants. It includes a fixed group of measures for each performance category intended to reduce reporting burden for eligible clinicians who are already participants in APM.

It would allow for MIPS reporting through this pathway at the individual, group, or APM entity level. And it includes the reweighting of the cost performance category to 0 percent. An automatic score of 100 percent for the improvement activities performance category, in light of the requirements of participation in APMs meeting many of improvement activities requirements.

And for quality, which will be weighted at 50 percent, we are proposing – we proposed six quality measures for scoring. But, in light of feedback that we have received from stakeholders, we are also going to be incorporating the use of the CMS web interface for ACOs for the 2021 calendar year only.

And just a note that Medicare Shared Savings Program ACOs are required to submit quality measures via the APP for purposes of Shared Savings Program participation.

I'm going to turn it over now my colleague, Molly MacHarris, to talk more about the rest of the MIPS rules for 2021.

Molly MacHarris: Thanks Brittany. OK. I'm now on slide 21. So, to go over some of other updates that we've made through the MIPS program for the 2021 performance year. So, first diving into the four performance categories.

For the quality and cost performance category, for all participants that are not part of an APM, their quality and cost weights will be 40 points and 20 points, respectively. Also, for quality, we did not finalize the sunsetting or ending of the CMS web interface, after a lot of stakeholder input. And instead, were provided a one-year extension to sunsetting the CMS web interface in calendar year 2022. So, the web interface will still be available next year but beginning with the 2022 performance period that reporting option will no longer be available.

Additionally, for the quality performance category, we continued our implementation of the meaningful measures framework by making updates to our quality measure set, including adding two new administrative claims measures, removing 11 measures, and second to the updates to other measures, as well as specialty sets resulting in MIPS measure inventory of slightly over 200 measures available for clinicians to choose from.

Additionally, for the cost performance category, the updates there were to add our codes for certain telehealth services to episode-based cost measures and our total per capita cost and Medicare spending for beneficiary measures. Also, again, as Brittany noted on the prior slide, all APM entities will have cost reweighted to zero percent.

Moving on to the next slide. For improvement activities, not too many updates here. We did make some updates to our inventory where we added one new improvement activity, the improvement activity that we initially included as part of one of our COVID-19 interim final rule. We continue that for this year moving into 2021. We removed an obsolete improvement activity. And also introduced new opportunities to get improvement activities into the program.

And then for the last performance category, promoting interoperability, which deals with the usage of certified EHR technology, we continue to retain the query of PDMP measure as optional, and increase it from 5 to 10 bonus points.

We changed 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.

We also did finalize our new optional HIE bi-directional measure. And reweighting for this category will continue to be available moving into calendar year 2021.

Moving on to the next slide, slide 23 for our performance category weights. So, I've touched on this prior, as well as Brittany has, but just to go over them again.

Looking at our middle column, for our calendar year 2021 program, as I've noted, for all participants that are not part of an APM, for quality, it will count for 40 points, cost for 20 points, and improvement activities and promoting interoperability at 15 and 25 points, respectively.

And I do want to note that for next year, by calendar year 2022, by law, we must have quality and cost set at 30 points, respectively.

And then lastly, as Brittany noted for next year for APM entities under MIPS, quality will count for 50 points, cost is not being scored, improvement activity accounts for 20 points, and promoting interoperability for 30.

Moving to slide 24 for our updates to the payment threshold. We did not finalize – or we did not finalize our proposed performance threshold. And instead, retained our previously finalized performance threshold at 60 points for next year. We also do still have our exceptional bonus threshold at 85 points. And we do still have funds available for that for this upcoming 2021 year.

I also want to flag that we have reached our maximum amount of payment that we can distribute subject to a scaling factor to maintain budget neutrality. So, from 2020 forward, the total amount of payment we can distribute is up to 9 percent subject to that scaling factor.

Additionally, for 2021, we've finalized some updates to our scoring hierarchy. This accounts for instances where clinician may have more than one final score available to them. For example, if they are part of an APM, and also, they submit data to us individually, what we would do in that circumstance is, first, we would utilize the virtual group final score, as that is required by law. And then we would use the highest available final score from whatever else is available regardless if it comes from an APM, a group, or an individual.

Last piece I'd like to flag here, is that for 2022, that will be the last year that we will have additional monies available for our exceptional performer bonus. That is also the year when by law we must set the performance threshold at a mean or median base separate of prior performance period. Currently, we estimate that value to be 74 points. So, I want to flag that for folks' awareness ahead of time.

And then moving on to the next slide, slide 25, some flexibilities that we have issued for the COVID-19 public health emergency that are applicable for calendar year 2020, this year, is we have doubled the complex patient bonus from up to five points to up to 10 points. This is based off of a calculation of clinician profile of dual-eligible patients and their HCC risk score. We also for this year, calendar year 2020, have allowed APM entities to submit an application to reweight MIPS performance categories as a result of extreme and uncontrollable circumstances.

And lastly, for third party intermediaries for our policies we finalized for next year, for calendar year 2021, we have allowed QCDRs and qualified registries to support our MVPs once they begin being implemented.

And we also finalized the number of policies, including adopting data validation and corrective action plan requirements, and additional approval criteria, to really ensure that the data we received from our third-party intermediaries is at the highest standard.

From here, I'm going to turn it back over to Brittany. Brittany?

Brittany LaCouture: Thanks Molly. So, on the Advanced APM side of QPP for the 2021 performance year, we have two changes.

First, we finalized the policy to tweak our methodology for calculating whether an Advanced APM such as the payment process, the QP threshold. In situations where a Medicare meets the requirements to be considered attribution-eligible or included in the denominator, for more than one APM entity, but APM attribution rules preclude the beneficiary from actually being attributed for a numerator for more than one APM entity, clinicians may find that their QP threshold score doesn't actually, represent perfectly their efforts in continuing to the APM entity.

Therefore, beginning with the 2021 performance year, and scenarios like what was just described, we will remove from the attribution eligible population, or the denominator, any beneficiaries who are precluded by the rules of the APM from being attributed to the APM entity.

We also finalized the policy to allow targeted review of QP determinations. In very limited situations where an eligible clinician or APM entity believes in good faith that CMS has made a clerical error in inadvertently omitting an eligible clinician from the APM entity's participation list on one or more snapshot fee. I am now going to turn it over to my colleague to discuss the Medicare Shared Savings Program updates for calendar year 2021.

Nicole Cooney: Hi Brittany. This is Nicole. I'm not sure that we have anyone else on the line to cover those slides.

Brittany LaCouture: OK. Then I guess I will do it.

So, for the Medicare Shared Savings Program, for the 2020 performance year, in light of the COVID PHE, we have finalized the policy to waive the CAHPS for ACOs reporting requirement for purposes of the Shared Savings Program. And we will provide full credit to ACOs for the patient experience of care survey measures.

Beginning in 2021, ACOs participating in the Shared Savings Program are required to report quality data via the APP with the addition of CMS web interface flexibility for the 2021 performance year only. So usually CMS web interface was reintroduced, as Molly discussed earlier, in light of comments received during rulemaking.

The Medicare Shared Savings Program had also finalized to modify the phase-in of the increase of the level of quality performance that is required for ACOs to meet those Shared Savings Program quality performance standards in order to share in their maximum savings rate, or to avoid owing maximum losses, as applicable. The Shared Savings Program policies are enforcing compliance with the quality performance standards and will retain the pay-for-reporting year for new ACOs.

And that brings us to the end of Shared Savings Program update. And I'll give it back to Molly for more MIPS updates.

Molly MacHarris: Yes. Thank you, Brittany. So, I'm now on slide 28. The last update I just wanted to provide is for the current year, for calendar year 2020. We have issued an extension to our extreme and uncontrollable circumstances application. Previously, that deadline was December 31st. Now clinicians' group, virtual groups, and APM entities have until February 1st to file an application for reweighting of their MIPS performance category due to the COVID-19 public health emergency.

Again, we strongly encourage all our impacted stakeholders that if they need this flexibility to please file their reweighting application no later than the current deadline of December 1st, 2021.

I also wanted to note that, as we talked about earlier, APM entities may submit an application to reweight their MIPS performance categories as a result of the extreme and uncontrollable circumstances.

To go to filling out the application, there are the links on the slide here.

And I do want to explain our note here about the promoting interoperability performance category. What we mean here is that the only extension that we are offering until February 1st is for clinicians who need reweighting of their performance categories due to the COVID-19 public health emergency. And you can do that for any or all performance categories, including promoting interoperability.

This note here is reflecting that there are additional reweighting flexibilities under the promoting interoperability performance category. For example, if you are a small practice, you can request to have promoting interoperability reweighted. Or if you have certain vendor or certification issues, you can request to have that promoting interoperability performance category reweighted.

That is what we're saying. All of those must be filed by December 31st.

And that covers everything we have for the quality payment program. And now I'll turn it over to Lindsey Baldwin. Lindsey?

Opioid Use Disorder/Substance Use Disorder Provisions

Lindsey Baldwin: Great. Thanks Molly.

Yes. This is Lindsey Baldwin in the Center for Medicare. And I will go over provisions related to opioid use disorder and substance use disorder.

So, expanding access to treatment for opioid use disorder is one of CMS's key areas of focus in addressing the opioid epidemic. Today we'll cover provisions related to opioid treatment programs or OTPs, as well as bundled payments for substance use disorders under the Physician Fee Schedule.

So, moving on to slide 31 to give an overview of the OTP benefit as established last year. So, Section 2005 of the SUPPORT Act established a new Medicare Part B benefit for opioid use disorder treatment services furnished by OTPs. And as finalized in the CY 2020 PFS 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 FDA-approved opioid-agonist and antagonist MAT medications, including methadone, buprenorphine, and naltrexone, the dispensing and administration of MAT medications, as applicable, substance use counselling, individual and group therapies, toxicology testing, intake activities, and periodic assessments.

So, moving on to slide 32, for CY 2021, we finalized our proposal to extend the definition of OUD treatment services to include opioid-antagonist medication, specifically naloxone, that are FDA-approved under Section 505 of the Federal Food, Drug, and Cosmetic Act for the emergency treatment of opioid overdose, and overdose education provided in conjunction with opioid-antagonist medication.

We finalized a new add-on code to cover the cost of providing patients with nasal naloxone. That code is HCPCS code G2215. And priced this code based upon the methodology set forth in Section 1847A of the Social Security Act, except that the payment amount is based on ASP plus zero.

Since the auto-injector naloxone is no longer available in the marketplace, we instead finalized a second new add-on code which is HCPCS code G2216 to cover the cost of providing patients with injectable naloxone. And this code is contractor priced for CY 2021.

We finalized the frequency limit on the codes describing naloxone. However, we are 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 is medically reasonable and necessary.

Additionally, we finalized our proposals to allow periodic assessments to be furnished via two-way interactive audio and video communication technology.

OK. Now moving on to slide 33, I'll go over substance use disorder policies under the Physician Fee Schedule.

So, 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're finalizing our proposal to expand these bundled payments to be inclusive of all substance use disorders.

And moving on to slide 34, we additionally finalized a new G-code, which is HCPCS code G2213 for the initiation of MAT to be billed with E&M visit codes used in the emergency department setting. And that could include payment for assessment, referral to ongoing care, follow-up after treatment begins, and arranging access to supportive services.

And with that, I will pass it back to Nicole to open up the question-and-answer session. Thanks.

Question & Answer Session

Nicole Cooney: Thanks Lindsey.

We are now ready to take your questions, as Lindsey said. And as a reminder, this event is being recorded and transcribed.

In an effort to get to as many questions as possible, we're asking each caller to limit themselves to one question.

And please be mindful of the time that you take asking your question. We have many folks on the line with us today. So, I'll be monitoring the time and moving on when needed to ensure that we hear from as many callers as possible.
OK. Blaire, we're ready for our first caller.

Operator: To ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question to assure clarity. Once your line is open, state your name and organization.

Please note your line will remain open during the time you're asking your question. So, anything you say, or any background noise, will be heard in the conference.

If you have more than one question, press star-one to get back in the queue. And we will address additional questions as time permits.

Please hold while we compile the Q&A roster. Please hold while we compile the Q&A roster.

The first question comes from the line of Dale Gibson.

Dale Gibson: Yes. Thank you. This is Dale Gibson. I have a question. When and how can a facility like a hospital or a clinic bill for these types of services? Is it for the equipment? Or I'm assuming the visits are billed by a practitioner?

Nicole Cooney: This is Nicole. Just to clarify, are you speaking about telehealth services?

Dale Gibson: Yes.

Emily Yoder: OK. Hi. This is Emily. So right now, outside of the public health emergency, there's not really a mechanism by which hospitals can bill for telehealth services specifically. Telehealth services are sort of, by definition, professional claim.

So – and right now, during the PHE to the hospital without walls initiative, hospitals can bill for services where a beneficiary is at home and the practitioner is in the hospital, and the services for initiating communication technology they can bill for that. But that's not strictly – that's not really considered as Medicare telehealth service.

Hospitals are eligible originating sites. So, to the extent that a beneficiary is in a hospital when they received a distant site telehealth service, then the hospital could bill for the originating site facility fee which is billed – which is a flat rate that you bill with a G-code.

Nicole Cooney: Thank you for your question.

Operator: Our next question comes from the line of Amy Maverick.

Amy Maverick: Yes. My question is in regards to the section under medical record documentation on page 14 of the slide presentation. So, if a hospital-employed MP or a non-hospital employed physician, they see the same patient, under the medical record documentation update, is it OK for the physician to just review and verify the hospital-employed MP documentation and not with the acceptance?

Sarah Leipnik: Hi. This is Sarah. So, for this, is that they can review and verify documentation entered for their own services that are paid for under the physician fee schedule. So, it would have to be signed and verified by the provider who's billing the service.

Does that answer?

Amy Maverick: Yes. So just to clarify. So, the physician, they did the full service. And so, the hospital-employed MP, just the hospital-employed MPs are documenting for it. So, then the physician could review and verify and bill it under the physician name. Correct?

Sarah Leipnik: If there is a physician or practitioner who is furnishing and billing directly for their professional service, they would have to be the one to review and verify, sign and date the documentation.

Amy Maverick: So basically, they both saw the patient. But instead of the physician doing all the documentation, can they just review and verify the MP if they saw the patient together?

Sarah Leipnik: Whoever is billing, the billing physician practitioner would have to review and verify on that. I'm not sure if I'm understanding your question perhaps. Ann, I don't know if you have anything else to add.

Amy Maverick: Yes. No. We're sorting clarification to the – it kind of contradicts the shared visit guidelines of what's required there. So that's what we were wanting to make sure. Because under shared visit, they have to be employed by the same group. And this is just basically saying they can review and verify anyone's documentation as long as they were there with the service.

Ann Marshall: Hey, this is Ann Marshall. If I can just jump in, it might be best if we have you submit that question just so we can review it and make sure that we understand it.

Amy Maverick: OK. And we have – we submitted it to…

Ann Marshall: I think I understand Sarah's response. But it might be helpful what shared is – as you know, it's a separate thing.

Amy Maverick: Yes. Yes. And that's why we are going back and forth on, cause we knew the guidelines for split shared. But then this, we're like – it's basically saying they could review and verify the documentation of another professional if we did the service with them.

Ann Marshall: Yes. If you could just submit the question, then we'll take a close look at it and make sure that we understand exactly the role that you're referring to. That would be super helpful.

Nicole, do participants have the information or should we give them an e-mail?

Nicole Cooney: You can submit your question to mlneventsteam@cms.hhs.gov. Thank you.

Operator: Our next question will come from the line of Amber Kroger.

Amber Kroger: Good afternoon.

This is a question regarding telehealth services. Currently, during the PHE, the geographical restriction has been lifted or waived. And I've heard conflicting things and I didn't see it in the final rule. Is that waiving of the restrictions continuing through the end of the calendar year in which the PHE ends? Or will that – those restrictions resume once the PHE ends?

Emily Yoder: Hi. This is Emily. So those restrictions will resume at the termination of the public health emergency. Because the geographic restrictions are actually statutory – and we were only able to waive them using 1135 waivers that were authorized by Congress. Congress would need to step in either to extend the waiver of the geographic restrictions outside of the PHE or to sort of amend that portion of that statute in general.

Amber Kroger: OK. Perfect. Because there are consultants that are doing webinars on the final rule that says that it extends through the end of the calendar year. So, we wanted to verify. Thank you so much.

Emily Yoder: No problem. Thank you.

Operator: Our next question will come from the line of Steven Dish.

Steven Dish: Hi. Thanks for taking my question. I want to circle back to slide 24 with Molly, just talking about the hierarchy of score assignments from MIPS. Will there be – excuse me – a facility-based scoring like there was in 2020? And would that override an individual score if the facility-based score was higher?

Molly MacHarris: Sure. This is Molly. So yes, we do still have facility-based scoring for calendar year 2020, as well as next year, 2021. And the facility-based scoring – so we assess that at both an individual and a group level. So, if for any one individual clinician or per group, if they have multiple final scores, what we're saying here is that we would select from all of the available final scores the highest one.

So, if they have a final score associated with facility measurement, and then based off with individual reporting, whichever one is higher is the score that they would receive. I hope that helps.

Steven Dish: OK.

Molly MacHarris: Thank you.

Steven Dish: Great. Thank you very much.

Operator: The next question comes from the line of Robin Shipping.

Robin Shipping: Hi. Hello. Can you provide – this is – my question is related to evaluation management services. Can you provide clarification that for time-based billing, if a physician and a nurse – say a nurse practitioner saw the patient together – or not together but at various times of that encounter – can both their times be counted toward that patient total time. Or is it just the billing provider?

Ann Marshall: Thanks for that question. We have been silent on that issue to date. And it's something that we may take through rulemaking next year to just sort of dot that "i". I think that the CPT has language. But I will just check with your local Medicare claims carrier in the meantime.

Robin Shipping: OK. Thank you.

Operator: Our next question comes from the line of Dory Mills.

Dory Mills: Hello. Yes. I'm going back to slide 18 actually, the second bullet about the E&M final policies, where it says you've revised the times used for rate setting for this code set. We are just going to make sure we understand the times required for codes 99202 through 215 are the ones that are listed in the CPT book or the AMA CPT – or the same as the AMA CPT guidelines.

Ann Marshall: Hi. This is Ann. Yes, they are. They are. The times that we're talking about revising here, there's a second set of time that a lot of folks just aren't aware of. Because unless you're really into the nitty-gritty of how the payment for services is set, you just wouldn't care about it. But there are physician service times and they're divided and then there's three parts. Sometimes there's a pre and an intra and a post. But it's referring to sort of backseat set-up time that is just used to set the RVUs for the codes.

Dory Mills: Thank you so much.

Ann Marshall: So, the ones that you used – yes. For prolonged services, you want to use the times that are in the G-code because that's where we are right now. There's a difference with CPT.

Dory Mills: We have the minimum and maximum and the range. So, we were clear on that. But we were in a call yesterday. And yes, they're giving out incorrect information. So that was very concerning. Thank you very much.

Ann Marshall: Sure.

Operator: Our next question comes from the line of Norman Brooks.

Norman Brooks: Good afternoon. And thanks for the great presentation. I'm with Lee-Brooks Consultants. Would you be able to provide the work practice expense and malpractice RVUs for the new HCPCS G-2211?

Ann Marshall: Hi. This is Ann. Emily or Christiane, do you know off the top of your head if there's a table in the rule that includes all three. Or will they need to go into the rate setting file?

Christiane LaBonte: I think – this is Christiane. I think all of that information would be available in Addendum B, which is available on the Physician Fee Schedule website. I believe that lists all of the RVU values for all of the codes that are in the fee schedule.

Norman Brooks: I did review that. I did not find any information there. But perhaps it will be made available on January 1st?

Ann Marshall: If you can follow up with us with that question, we can confirm that for you.

Norman Brooks: Excellent. Thank you so much. Stay safe.

Ann Marshall: Sure. Thank you.

Operator: Our next question will come from the line of Jeannine Engel.

Jeannine Engel: Hi. Thank you very much. Jeannine Engel from the University of Virginia. I just want to ask a clarifying question about the telephone audio-only codes 99411 to 99443, which is part of the temporary rulemaking during the PHE had been revalued. Will those – that evaluation continue through the end of the public health emergency? Or through the end of the calendar year at the end of – that ends the public health emergency?

Emily Yoder: Hi. This is Emily. That's a great question. So, we are no – we will not be recognizing those codes outside of the public health emergency. So, when the PHE ends, those codes will revert to payment status as bundled. And so, they won't be paid separately under the PFS at either the original recommended rate or the increased rate that we implemented during the public health emergency.

Jeannine Engel: OK. Thank you. And I did see those – the G2252 code which, I guess, we could use now or could revert to using once the public health emergency ends.

Emily Yoder: Yes. That is correct. Yes.

Jeannine Engel: Which is the audio only code.

Emily Yoder: Yes.

Jeannine Engel: And I do have – the Addendum B is available – just for the previous caller. And the G2211 code is there. So, it may just be that he wasn't able to find it, just for your information.

Christiane LaBonte: Thank you Dr. Engel for pointing that out. This is Christiane LaBonte. I was just about to jump in to say exactly that the PE and MP RVUs are available on Addendum B, if you all could just check. Thank you.

Jeannine Engel: Yes. I appreciate your help. Thank you so much.

Operator: Our next question will come from the line of Nancy Hillsbuzz.

Nancy Hillsbuzz: Hi. This is Nancy Hillsbuzz. On slide 18, the first bullet point, to avoid double counting time to finalize HCPCS G2212, I don't really understand what you're trying to avoid. Because I thought the G-codes that are being offered now talk more about the complexities and less about the time. But if you could explain what you mean by double counting time. How would we be double counting time?

I think you're saying that we need to use 99202 through 15 and add G2212 in around 90 percent of the cases. And that that would then make it unnecessary to look at the prolonged services code 99217. Am I getting into the right universe here? Or…

Ann Marshall: Yes. Hi. This is Ann. So, as you were saying, they're the base code, what we call the base codes, which are 9920 – actually 992 – yes, 99202 through 99215. And then there are two add-on codes. There's the – an add-on code for prolonged code – for prolonged services, which is time. You have to meet at least 15 minutes over a certain – over the level five visit.

Nancy Hillsbuzz: That's the 99217?

Ann Marshall: The CPT, the final CPT code was 99417. And then for time on a different day, CPT would have you use 99358 and 99359, which are the old non-face-to-face codes. But instead of those three, we finalized one single G-code, the G2212 for when you meet 15 or more minutes beyond the ceiling of the level five times.

So, each level, including level five has a range of times now, right? So, once you've reached the maximum time for level five, then if you get to 15 minutes beyond that, you can report the add-one code.

And I think CPT's approach to it, was that, once you reached the minimum, the floor time in level five, and you get 15 minutes beyond that, then you can report the level – the prolonged codes. But if you did it that way, then you would be paid for level five times – level five, as well as twice the prolonged time.

So, we put a table in the rule that might help you with that. But the G-codes for complexity is separate. And it's not time-based. So, you would look at your patients and see if they meet the descriptor as well as the additional language that we put in the rule around how we intend that to be used for which types of patients. But that's separate from the prolonged add-on.

Nancy Hillsbuzz: I'm sorry. What is the code for the complexity then? G-what?

Ann Marshall: G2211.

Nancy Hillsbuzz: And we're to use 2212 to report prolonged?

Ann Marshall: Right. So, in terms of time, if you're using time to select visit level, you would look at the times within the levels, what levels, two through five codes. And then the five, whether you've provided an increment of 15 minutes more on top of that. And if so, then you can report the prolonged codes.

You would look separately regardless of time. Even if you use just medical decision-making to decide your visit level, you would look separately at whether you could bill the G2212, the complexity add-on.

So, they're completely separate. The prolonged one is just for when you're looking at time to select your visit level and reporting on the basis of time. The 2212 code could be used in addition to the prolonged or without the prolonged when you're using just MDM, medical decision-making.

Nancy Hillsbuzz: And the best written source or reference for this distinction, is it going to be written out in a larger way than the slides say before the end of the year? Or…

Ann Marshall: Yes. We're working on an MLN article for E&M. And so that may help shed some light. So, keep an eye out for the Medical Learning Network…

Nancy Hillsbuzz: And you'll have that all out by the end of year?

Ann Marshall: I don't know what their schedule is. But I know that they're working on a draft already.

Nancy Hillsbuzz: OK. Thank you.

Operator: The next question will come from the line of Roxanne Barrera.

Roxanne Barrera: Hi. Thanks for taking my question. I just wanted to know if you guys had any updates for non-patient-facing and hospital-based clinician. Somebody previously asked about facility based so I got that answered. But any updates for those type of providers in the hospital setting.

Emily Yoder: This is Emily. Do you mean for telehealth?

Roxanne Barrera: No. I mean, I just don't see them mentioned anywhere, non-patient-facing or hospital based. Right? They're not facility based so I understand that piece, and you guys answered that question. But I see no mention or any updates. Can we assume that they just stay the same as with previous rules?

Molly MacHarris: This is Molly. Is this in reference to the MIPS program? We just want to get clarification which program you are asking for this information on?

Roxanne Barrera: Yes. Yes.

Molly MacHarris: MIPS? OK. OK. Sure.

So, for your question of any updates for non-patient-facing folks or definition of hospital-based, short answer, no, we did not make any updates there. So those definitions that we've had for prior years are still in effect. Hopefully that helps.

Roxanne Barrera: And how they attest is still in effect. Correct?

Molly MacHarris: Yes. Correct.

Roxanne Barrera: OK. Thank you.

Molly MacHarris: Thank you.

The next question is from the line of Laurel Havener.

Laurel Havener: Yes. I specifically had a question about slide nine, telehealth services. So previously home visits, both new and established, were approved through the PHE in Category III. And it looks like Category III has been updated to only include the high-level established patient home visits now. I'm just trying to get clarification as it seems like they were previously included and now maybe not. Can anybody clarify that for me?

Emily Yoder: Sure. This is Emily. So, during the public health emergency, the Category III actually referred to services that will be available temporarily after the PHE has expired. So, during the public health emergency itself, all levels of home visits are in the Medicare Telehealth list with both new and established patients.

So then once the PHE ends, the new patient visits will no longer be on the telehealth list. However, the lower-level established patient visits are being added permanently. And the higher-level established patient home visits are being added temporarily up through the year in which the public health emergency ends.

So, does that help?

Laura Havener: Yes. So basically, the new and established are good through the public health emergency right now?

Emily Yoder: Yes, that's correct.

Laura Havener: OK. Perfect. That's what I need. Thank you so much.

Emily Yoder: Thank you.

Operator: The next question comes from the line of Shan Haver.

Shan Haver: Hi there. Thank you for taking my question. My question is actually about teaching physicians and residents. And I understand, as I look at slide 15 in a second, a lot of the material that I read does confirm that the teaching physician can provide supervision via direct contact or by video/audio visual.

But I also have read that in some of the Q&As – or yea, the COVID frequently asked question document, that as of March 31st that the levels that the resident can provide care, the E&M level under the primary care exception, that those were expanded to all five levels of code.

So, my question is, just to confirm that a resident may do a level four or a level five without the presence of the teaching physician. And that includes without even the physician being there during audiovisual. Am I understanding that correctly?

Christiane LaBonte: You are. This is Christiane LaBonte. So, for the duration of the public health emergency, residents may continue to do level four and five of E&M. And teaching physicians must meet all of the other provisions of that regulation. So, they may meet with the resident before or during or after the encounter. And their presence with the resident could be audio and video.

But teaching – but residents can continue to furnish level four and five in a primary care center without the in-person presence of a teaching physician during that encounter.

Shan Haver: OK. That is so great. That's what I thought. And thank you for that.

And you know, in the same little Q&A that I look at that was updated on December 3rd, also said that those codes for the resident were expanded to include telephone services. But those services are time-based. So, I was just curious about that.

And then the rest of that Q&A does say that if the service is furnished via telehealth that it can be decided, code level, to be decided based on the MDM or time. But it's all talking about residents. That residents have never been allowed to do time.

So, can you clarify for phone calls and select – code selection by time for residents?

Christiane LaBonte: Yeah. What that person is referring to was something that we had put in place, stock in – I said it was the March rule or the May rule. But it refers to when residents are furnishing on an office evaluation/management visit via Medicare telehealth that we had advanced how the rules on level selection, the time or medical decision making for the services specifically.

So, what that means is that for the 99202 through 99215 codes, CPT made changes to allow those codes to be reported through time and medical decision-making as of January 1st, 2021. And we allowed the time or MDM to be used earlier than that in the specific circumstance when the resident was furnishing those E&M visits over Medicare telehealth in its primary care center. So, it's limited to that specific provision.

Shan Haver: OK. And that makes good sense. I understand allowing the MDM more time, kind of moving that rule up earlier than January 1. But it just caught me by surprise that the resident could use a time-based code, or a code based on time when that's never been allowed.

Christiane LaBonte: Yes. I hear that. To a point that Ann was making a little earlier, we have generally stayed silent on – at this point, on some of the time-based billing rules given the new revisions to the E&M codes that we just frankly haven't had time, pun not intended, to resolve some of these really important other additional

issues. So, with respect to documenting time for teaching physicians, stay tuned. Hopefully we'll address and some additional guidance or an additional rulemaking. Thank you for the question.

Operator: The next question will come from the line of Roy Edroso.

Roy Edroso: Hello. I understand that the ACO – sorry – the CAHPS for ACO reporting for 2020 is waived for people who are in Shared Savings ACO and they are reporting CAHPS for ACO. What about non-Shared Savings ACO reporters who are using the APP pathways reporting methods? Is their CAHPS for MIPS waived as well?

Brittany LaCouture: Hi. This is Brittany. So, the Shared Savings Program waiver for CAHPS for ACOs is for the 2020 calendar year or performance year.

Roy Edroso: Right.

Brittany LaCouture: And that APP will become effective in 2021. So, there is no overlap of those two policies. If we're talking about 2020, the – I can't speak directly to the policy with every ACM. But for purposes of MIPS, there is no requirement to report CAHPS. And if you're being scored in MIPS and you don't report it, we will just remove that measure from the denominator.

And then in 2021, if you are eligible for an exception from the quality reporting category for whatever reason, including the PHE, the same thing will happen. Like any measures that aren't reported would be removed. Or the quality performance category will be waived if you're eligible for the exception. And if you're not eligible, then you would still be required to report it.

Roy Edroso: OK. So that will lead (inaudible) that anyone who is reporting CAHPS from this in 2020, if they got a waiver, in uncontrollable circumstances, they would be – they wouldn't have to report it. (inaudible) 2020 don't have to do it because they're waived.

In 2021, those – both CAHPS for MIPS and CAHPS for ACO, reporters have to report it if they're using the APP reporting method.

Brittany LaCouture: The first of what you said was a little bit garbled, unfortunately. But I think you're mostly right. Yes, in 2020 if it's waived, just don't worry about it. There's no way it will negatively affect your score. In 2021, you have to be eligible for an exception. I just want to flag that there is no distinction between CAHPS for MIPS and CAHPS for ACOs beginning in 2021. It's the same measure.

Roy Edroso: Got you. OK. Thank you.

Brittany LaCouture: You're welcome.

Operator: Our next question will come from the line of Christopher Shank.

Christopher Shank: Hi. So, I think my two questions actually were answered. So, I just wanted to do a quick confirmation. My first one is for the G2211 code. I think I heard earlier that CMS is actually going to be getting an MLN document out. Is that correct for further clarification on the use of that CPT code?

Ann Marshall: I know that we are working on an MLN article for the office/outpatient E&M policies broadly. I don't know what exactly it will have on the G2211. It will probably be comprised of information in the rule in the more acceptable format.

Christopher Shank: OK. And is that going to be coming out prior to January? Or should we expect that probably sometime in January?

Ann Marshall: I'm not sure what their schedule is. It's a separate area that works on that. I can check with them and let Nicole, your other MLN folks on the call know. I do know that it's being worked on.

Nicole Cooney: Hi Ann. Yes, this is Nicole. Unfortunately, I don't have an update on the timing for that. I can also check on my end and see if I can get an update before the call concludes.

Christopher Shank: Great. Thank you. My last clarification is around the teaching physician information that was went – that you guys went over. So, to confirm, you guys are finalizing for calendar year 2021 that for teaching physicians utilizing the primary care exception rule, level four and five E&Ms can be utilized and billed under that rule even after the PHE ends. Is that correct?

Christiane LaBonte: This is Christiane LaBonte. That's not correct. They may continue to bill levels –report levels four and five without the presence of a teaching physician during the public health emergency whenever that ends. But after the public health emergency, in general circumstances, we're returning to our status quo policy with the exception of rural areas.

And if a primary care center happens to be in a teaching setting outside of metropolitan statistical area, so an LMD-defined rural setting, then residents would be able to furnish communications-based – technology-based services and interprofessional consults in the primary care exception. But after the – after the end of the public health emergency, levels four and five of an E&M will no longer be included.

Christopher Shank: Great. Thank you so much.

Christiane LaBonte: Sure. Thank you for the question.

Operator: And as a reminder, to withdraw a question or if the question has been answered, you may remove yourself from the queue by pressing the pound key.

Our next question will come from the line of Joy Hanford. Joy, your line is open.

Joy Hanford: I'm sorry. My phone was on mute. I think you've answered my question. But I just want to clarify that in the final rule, it states – I think I had clarification yesterday in the open forum that, we've already talked

about this, that the actual visit times in the CPT book is how you select your levels for 99202 through 99215. That the actual time is for rate setting.

Does that rate setting affect how CMS audits the documentation? I mean does that not going to affect if the provider is billing based on time, that's going to have no effect on an auditor reviewing that chart?

Ann Marshall: Hi. This is Ann. That's correct. The times for rate setting are – they come from, usually, the RUC survey. When the AMA sent out a survey, they look to check what physicians and non-physician practitioners are saying their costs are for providing a given service. They ask them about time, physician time, and say how much time do you spend?

And then sometimes we use the median of that. Sometimes we use the 25th percentile. They gave us the result. And we decide in that time goes into – gets multiplied by labor and other data to decide what the RVU is going to be, their relative value unit. But, in terms of whether or not we pay a code; we go by the descriptor which actually defines the service.

Joy Hanford: OK.

Ann Marshall: And usually, the times are very close and in sync. But in terms of when you bill what you need to be looking at is the time and the descriptor and not the rate setting time.

Joy Hanford: And I have one other question. Hopefully it's quick.

If the telehealth – if the PHE is over on January 21st which it slated to be, not sure if it will be, it might be extended again. Does that mean the services that were identified as telehealth and the waivers that surround telehealth, where they removed the restriction of geographical location, would be no longer in effect?

Emily Yoder: Hi. This is Emily. That is correct. All of the statutory waivers are slated to expire when the PHE is over. And the services like the – and all the other regulatory flexibilities. If they're not something that we have finalized as either permanent, or in the case of the Category III additions, to the telehealth list temporary policy, those will also stop being effective when the PHE expires.

Joy Hanford: OK. Thank you.

Operator: Our next question will come from the line of Jackie Dunn.

Jackie Dunn: Hi. My question is regarding the G2211. And I just want to know, is this going to be additional cost to the patient? Are they going to have copays on this new add-on code? Or is that something we don't have to worry about creating an extra expense?

Ann Marshall: This is Ann. Hi. There will be a copayment for it — associated with it. The only time that we can waive the copayment is when a law gives us explicit instructions to do that, such as for preventive services. So, add-on codes, just like the prolonged service add-ons, they're added on to an evaluation and managed visit – management visit will get the coinsurance applied to it.

Jacky Dunn: OK. Thank you.

Operator: Our next question comes from the line of Jewel Gazelle.

Jewel Gazelle: Hi. Good afternoon. I have a scope of practice question. The rule allows physical therapists and occupational therapists to delegate the furnishing of maintenance therapy services to PTA, PT assistants and occupational therapy assistants.

It says it applies to Policy B. But I'm asking if this applies to only those PTs/OTs that are enrolled in Medicare and done a professional claim. Or can this apply to the PTs and OTs in a hospital setting when they're billing out an institutional claim?

Sarah Leipnik: Hi. This is Sarah. Thank you for your question. Do you mind just e-mailing your question so we can get you the correct or the most accurate information?

Jewel Gazelle: Sure.

Sarah Leipnik: Thank you. Nicole, do you mind just repeating the mailbox?

Jewel Gazelle: Yes. I already have it. The Med Learn Events?

Nicole Cooney: The MLN Events. Yes.

Jewel Gazelle: Right.

Sarah Leipnik: Yes.

Jewel Gazelle: Thank you.

Sarah Leipnik: Thank you.

Jewel Gazelle: You're welcome.

Operator: Our next question will come from the line of Allison Marks.

Allison Marks: Hi. This is Allison Marks from Mannatech. This is a question about the new APP pathway. We're wondering what the mission process looks like for that APP pathway. So, for example, could a mix QRDA-III file be submitted for the three electronic Clinical Quality Measures within that set for APPs? Or would that data, for the two administration claims will also have to be aggregated with that data.

Brittany LaCouture: That's a good question. Thank you for asking it.

Yes. The QRDA files could be submitted, use of a registry for those measures. It's available based on how you're submitting, whether it's at the individual, group or APM entity level. For example, like a small group that still have – would have that option of using a measure of claim for those measures.

So basically anything, any submission type that's available to groups can be used for the APP. And no, the claims measures don't need to be aggregated. Those will be calculated by CMS. And we will calculate the score based on the claims data that we have plus the data they are submitted to us by you.

Allison Marks: OK. Thank you.

Nicole Cooney: Blair, I have time for one final question.

Operator: The last question will come from the line for Carol Yarbrough.

Carol Yarbrough: Hi. Good afternoon. Carol Yarbrough from UCSF Health in San Francisco. When will it still be appropriate to bill 99358 and the add-on code 99359?

Ann Marshall: Thanks for the question. This is Ann. With any of the other E&M visit code sets, like inpatient or there are other ones that it applies to. Just not with the office outpatient visit.

Carol Yarbrough: OK. I'll research that further then. All right. Thank you so much. I appreciate it.

Additional Information

Nicole Cooney: Thanks everyone. This is Nicole. I just wanted to give you an update that I was unable to get in touch with someone that could give us a timeline for that E&M MLN Matters article.

But I would note that if you subscribe to the MLN Connects newsletter, we do announce articles when they are updated or new articles. They are in that newsletter as they come out. So that is the best way to stay on top of those things.

We are including a link today. You will receive an e-mail after this call to evaluate your experience on today's call.

And included in that e-mail, there will be a link to the zip file that includes all the addenda to the Physician Fee Schedule. I know Addendum B was referenced a couple of times. So, we are going to include that direct link in the evaluation e-mail. And hopefully you'll find that helpful.

And there's more information on slide 37 about evaluating your experience on today's call.

And as I mentioned, an audio recording and transcript will be available in about two weeks at go.cms.gov/mln-events.

And again, my name is Nicole Cooney. And I'd like to thank all of our presenters. And also thank you for participating in today's Medicare Learning Network event on the Physician Fee Schedule Final Rule.

Have a great day everyone.

Operator: Thank you for participating in today's conference call. You may now disconnect. Presenters, please hold.