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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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Implementation Date: January 6, 2020

PROVIDER TYPES AFFECTED

This MLN Matters Article is for physicians and other providers who submit claims to Medicare Administrative Contractors (MACs) for services paid under the Medicare Physician Fee Schedule (MPFS) and provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11560 provides a summary of the policies in the CY 2020 MPFS Final Rule, announces the Telehealth Originating Site Facility Fee payment amount and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in CY 2020. Make sure your billing staffs are aware of these updates.

BACKGROUND

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 Non-Physician 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 CMS proposed earlier this year. You can find the final rule at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F.html.

Medicare Telehealth Services

For CY 2020, CMS is finalizing the proposals to add HCPCS codes G2086, G2087, and G2088 (which describe a bundled episode of care for treatment of opioid use disorders) to the list of telehealth services:

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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.)

Medical Record Documentation

CMS is finalizing, for CY 2020, a proposal to reduce burden by implementing a broadened general principle beyond teaching physicians that will allow:

1. All physicians,
2. Physician Assistants (PAs),
3. 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 the record already includes.

This principle applies to all Medicare-covered professional services that each of these professional disciplines furnish, and that are paid under the MPFS.

In addition to physicians, residents, nurses, and medical students, this provision includes PA and APRN students or other members of the medical teams, as individuals who are allowed to make notes in a patient's medical record, and that are reviewed and verified by physicians, PA's and APRNs.

Scope of Practice

For CY 2020, CMS is finalizing the "Physician Supervision for Physician Assistant (PA) Services" proposal, implementing CMS' reinterpretation of Medicare law that requires physician supervision for PAs' professional services.

Accordingly, Federal regulations at 42 CFR 410.74 (a)(2) require that PAs must furnish their professional services in accordance with State law, and State scope of practice rules for PAs that are specific for 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, and 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.

Chronic Care Management (CCM) Services

Non-Complex CCM

For non-complex CCM, Medicare is creating a Medicare-specific add-on code (G2058) to Current Procedural Terminology (CPT) code 99490; that you may use to report increments of 21-40 and, (if applicable) 41-60 minutes of clinical staff time of non-complex CCM services. You can report this add-on code to CPT code 99490 a maximum of twice per service period. When you report G2058, 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). Additional information on G2058 is as follows:

- 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, CMS is 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)

CMS is 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 99495-6)
CMS is increasing payment by adopting the Relative Value Scale (RVS) Update Committee (RUC) recommended increases in valuation. CMS is 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 20 in the final rule.

Therapy
In the CY 2019 MPFS final rule, in accordance with amendments to the Medicare law, CMS established modifiers to identify therapy services that are furnished in whole, or in part, by Physical Therapy (PT) and Occupational Therapy (OT) assistants, and set a *de minimis* 10 percent standard for when these modifiers will apply to specific services. CMS 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 MPFS rates.

Beginning January 1, 2020, these modifiers are required by statute to be reported on claims. After consideration of public comments, CMS finalized that the assistant modifiers do not apply when a therapist and therapist assistant furnish services together, and, that in addition to untimed codes, CMS is 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.

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 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
- 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, CMS will use TRICARE pricing when ASP is not reported. For oral buprenorphine, CMS is finalizing the use of 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
- 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.

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

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.

Long-Term EEG Monitoring Codes
CMS is finalizing for CY 2020 CPT codes 95700-95716 as contractor-priced. The rates are established by regional MACs) in their respective jurisdictions.

Notes:

1. Your MACs will continue to use the codes identified in CR 9250 for the CT modifier reduction. You can find the associated MLN Matters article (MM9250) at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9250.pdf.

2. Your MACs will 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

ADDITIONAL INFORMATION

The official instruction, CR 11560, issued to your MAC regarding this change is available at https://www.cms.gov/files/document/r4468cp.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
December 2, 2019	Initial article released.