CMS second interim final rule released April 30, 2020 (rules apply beginning March 1, 2020)

https://www.cms.gov/files/document/covid-final-ifc.pdf (pages will be referenced in the summary below)

Enos Medical Coding has been busy helping our clients and colleagues stay on top of the constant changes coming from Washington DC during the COVID-19 Pandemic. While the best source of information is CMS, please take the time to verify this information by checking your State regulations (Department of Health, Insurance Commissioner) and each payer you contract with, in order to ensure maximum reimbursement and minimal claims denials.

Telephone-only calls will be paid at a higher rate (page 122)

CMS previously announced that Medicare would pay for certain services conducted by audio-only telephone between beneficiaries and their doctors and other clinicians. Now, CMS is broadening that list to include many behavioral health and patient education services. CMS is also increasing payments for these telephone visits to match payments for similar office and outpatient visits. This would increase payments for these services from a range of $14-$41 to about $46-$110. The payments are retroactive to March 1, 2020.

Since some Medicare beneficiaries don't have access to interactive audio-video technology that is required for Medicare telehealth services, or choose not to use it even if offered by their practitioner, CMS is waiving the video requirement for certain telephone evaluation and management services, and adding them to the list of Medicare telehealth services. As a result, Medicare beneficiaries will be able to use an audio-only telephone to get these services.

Many questions have been raised about billing for "telephone only" calls for physicians. There is good news in the April 30th update, CMS will pay the phone call codes, 99441-99443, at the 99212-99214 payment rate. Note, report the phone codes for "telephone only" and the E/M codes for telephone and video. CMS is now adding this as a telehealth service, so use Place of Service (POS) code 11 and add modifier -95 to the 99441-99443. Remember, this is for physicians and Qualified health care providers (QHPs) . CMS will also pay for non-physician telephone calls reported with 98966-98966.(page 125)

Here are the rates, cross-walked from the E/M code rates:

CPT EM / Phone	2020 wRVU	National non-facility payment	National facility payment
99211	0.18	$23.43	$9.37
99212 / 99441	0.48	$46.13	$26.31
99213 / 99442	0.97	$76.04	$52.26
99214 / 99443	1.50	$110.28	$80.37
99215	2.11	$148.12	$113.53
98966	0.25	$14.44	$13.35
98967	0.50	$28.15	$26.71
98968	0.75	$41.14	$39.70

Prolonged Services with Telephone calls (page 123)

Non-Face-to-face prolonged service codes, 99358–99359 can be billed with telephone services (99443 and 98968 would be reported for the first 30 minutes). 99358–99359 are also allowed for telehealth visits.

Please remember that CPT Code 99358 is for the first hour of non-face-to-face services and may be billed before or after direct patient care. CPT 99359 is an add-on code, only billable in conjunction with 99358. In the case of these codes, a provider must spend 31 minutes or more before billing code 99358 and 76 minutes or more before adding code 99359. (Added 4/29/2020)

Times for E/M service codes 99201-99215 (page 136)

Office/Outpatient E/M level selection for services when furnished via telehealth, can now be based on MDM or time, with the defines as all of the time associated with the E/M on the day of the encounter; and the documentation requirements regarding history and/or physical exam in the medical record are removed (for coding purposes). For 2020 CMS is maintaining the current definition of MDM (do not use the 2021 grid). Typical times associated with the office/outpatient E/M's

CPT New	Typical Time	CPT Established	Typical Time
99201	17	99211	7
99202	22	99212	16
99203	29	99213	23
99204	45	99214	40
99205	67	99215	55

Choosing the correct E/M category and code (page 19)

CMS expects physicians and other practitioners to use the E/M code that best describes the nature of the care they are providing, regardless of the physical location or status of the patient. Under ordinary circumstances, we would expect the kind of E/M code reported to generally align with the physical location or status of the patient. In the context of the PHE, we recognize that the relationship among the setting of care, patient status, and kind of E/M code reported may depend on the needs of local communities and the capacity of local health care institutions. Consequently, we are reiterating that practitioners should report the E/M code that best describes the nature of the care they are providing.

Hospital-based clinics can bill an originating fee (page 55)

Hospitals may bill as the originating site for telehealth services furnished by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is located at home. Use G0436 as the code for the facility fee when the patient is at home.

CMS is allowing hospitals, billing for physician services in their hospital-based clinics, to bill an originating fee. Provider based departments (PBD) of a hospital use place of service 19 or 22, outpatient department, on or off campus. When submitting a bill, the charge is split between the professional fee and a facility fee. Up until now, the hospital could not bill a facility fee for telehealth services. There is a

statute in the law that prohibited CMS from paying a facility fee to an originating site (home, in this case). But, CMS is considering "home" to be part of the outpatient department of the hospital, while allowing telemedicine during the PHE. The rule says…

"…when telehealth services are furnished by a physician or practitioner who ordinarily practices in the hospital outpatient department (HOPD) to a patient who is located at home or other applicable temporary expansion location that has been made provider based to the hospital, we believe it would appropriate to permit the hospital to bill and be paid the originating site facility fee amount for those telehealth services, just as they would have ordinarily done outside of the COVID-19 PHE."

Advance practice providers can order, furnish diagnostic tests (page 19)

Advanced practice providers may order, furnish and supervise diagnostic tests, directly and incident to their own service (within their state scope of practice).

"The interim changes will ensure that these practitioners may order, furnish directly, and supervise the performance of diagnostic tests, subject to applicable state law, during the PHE."

Physical Therapy and Occupational Therapy (page 34)

CMS is allowing physical and occupational therapists to delegate maintenance therapy services to physical and occupational therapy assistants in outpatient settings. This frees up physical and occupational therapists to perform other important services and improve beneficiary access.

For the duration of the COVID-19 emergency, CMS is waiving limitations on the types of clinical practitioners that can furnish Medicare telehealth services. Prior to this change, only doctors, nurse practitioners, physician assistants, and certain others could deliver telehealth services. Now, other practitioners are able to provide telehealth services, including physical therapists, occupational therapists, and speech language pathologists.

Hospitals may bill for services furnished remotely by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is at home when the home is serving as a temporary provider based department of the hospital. Examples of such services include counseling and educational service as well as therapy services. This change expands the types of healthcare providers that can provide using telehealth technology.

Adding Services to the list of Medicare Telehealth Services (Page 15-41)

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

On April 30, 2020 there were 45 additional codes added to the list of approved telehealth codes.

Group Psychotherapy:

- CPT code 90853 (Group psychotherapy (other than of a multiple-family group))

End-Stage Renal Disease (ESRD) Services:

● 90952 (End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month)CMS-1744-IFC 33
● 90953 (End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month)
● 90959 (End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month)
● 90962 (End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month)

Psychological and Neuropsychological Testing:

● 96130 (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)
● 96131 (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))
● 96132 (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)
● 96133 (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; each additional hour (List separately in addition to code for primary procedure))
● 96136 (Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes)
● 96137 (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))
● 96138 (Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes)
● 96139 (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)

Therapy Services

- 97161 (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.)
- 97162 (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.)
- 97163 (Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.)
- 97164 (Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a 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.)
- 97165 (Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family.)
- 97166 (Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate

analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate CMS-1744-IFC 38
modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family.)
● 97167 (Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family.)
● 97168 (Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.)
● 97110 (Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility)
● 97112 (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)
● 97116 (Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing))
● 97535 (Self-care/home management training (eg, 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)
● 97750 (Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes)
● 97755 (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)
● 97760 (Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes))
● 97761 (Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes)
● 92521 (Evaluation of speech fluency (eg, stuttering, cluttering))

- 92522 (Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria))
- 92523 (Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language))
- 92524 (Behavioral and qualitative analysis of voice and resonance)
- 92507 (Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual)

Radiation Treatment Management Services

The code used to report radiation treatment management services includes several components, including reviewing the radiation dose and various treatment parameters, as well as weekly face-to-face visits with the patient to assess the patient's response to treatment and manage any symptoms the patient may be experiencing.

- CPT code 77427 (Radiation treatment management, 5 treatments)

Required "Hands-on" Visits for ESRD Monthly Capitation Payments (Page 45)

Codes for End-Stage Renal disease related services monthly, based on age and number of face-to-face visits reported with codes 9095190970 will not be reviewed to consider whether those visits were furnished in person, without the use of telehealth.

Communication Technology-Based Services (CTBS) (page 50)

Services furnished via telecommunications technology (that are not Medicare telehealth services) are reported with **G2010** (Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment), and HCPCS code **G2012** (Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion).

We finalized these codes as part of the set of codes that is only reportable by the physicians and practitioners who can furnish evaluation and management (E/M) services. We stated that we believed this was appropriate since the service describes a check-in directly with the billing practitioner to assess whether an office visit is needed. However, we did note that similar check-ins provided by nurses and other clinical staff can be important aspects of coordinated patient care.

During the PHE for the COVID-10 pandemic, these services can be reported to both new and established patients. Consent must be obtained at the same time that a service is furnished.

Online Digital Evaluation and Management Service, allowed for New or Established Patients (page 53)

CMS finalized separate payment for CPT codes 99421 (Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes), 99422 (Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes), and 99423 (Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes).

CMS also finalized separate payment for HCPCS codes G2061 (Qualified nonphysician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes), G2062 (Qualified nonphysician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11–20 minutes), and G2063 (Qualified nonphysician qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes) (84 FR 62796).

Practitioners: Additionally, in the CY 2020 PFS final rule (84 FR 62796), we stated that HCPCS codes G2061-G2063, specific to practitioners who do not report E/M codes, may describe services outside the scope of current Medicare benefit categories and as such, may not be eligible for Medicare payment. CMS received a number of questions regarding which benefit categories HCPCS codes G2061-G2063 fall under. In response to these requests, we are clarifying here that there are several types of practitioners who could bill for these service. For example, the services described by these codes could be furnished as licensed clinical social worker services, clinical psychologist services, physical therapist services, occupational therapist services, or speech language pathologist services, so practitioners that report services in those benefit categories could also report these online assessment and management services.

To facilitate billing of these services by therapists, we are designating CPT codes 98966-98968 as CTBS “sometimes therapy” services that would require the private practice occupational therapist, physical therapist, and speech-language pathologist to include the corresponding GO, GP, or GN therapy modifier on claims for these services (Page 125)

Physicians at Teaching Hospitals (Page 101)

To increase the capacity of teaching settings to respond to the PHE for the COVID-19 pandemic as more practitioners are increasingly being asked to assist with the COVID-19 response, on an interim basis, for the duration of the PHE for the COVID-19 pandemic, CMS is amending the teaching physician regulations to allow that as a general rule under § 415.172, the requirement for the presence of a teaching physician can be met, at a minimum, through direct supervision by interactive telecommunications technology, as described in section II.E. of this IFC. In other words, the teaching physician must provide supervision either with physical presence or be present through interactive telecommunications technology during the key portion of the service.

Specifically, when use of such real-time, audio and video telecommunications technology allows for the teaching physician to interact with the resident through virtual means, their ability to furnish assistance and direction could be met without requiring the teaching physician's physical presence for the key portion of the service.

Medicare may make payment under the PFS for teaching physician services when a resident furnishes telehealth services to beneficiaries under direct supervision of the teaching physician which is provided by interactive telecommunications technology. Additionally, on an interim basis, for the duration of the PHE for the COVID-19 pandemic, Medicare may make payment under the PFS for services billed under the primary care exception by the teaching physician when a resident furnishes telehealth services to beneficiaries under the direct supervision of the teaching physician by interactive telecommunications technology. We also seek comment on our belief that direct supervision by interactive telecommunications technology is appropriate in the context of this PHE, as well as whether and how it balances risks that might be introduced for beneficiaries with reducing exposure risk and the increased spread of the disease, in the context of this PHE.

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