hfma
healthcare financial management association

HFMA 2021 Proposed Medicare Physician Fee Schedule Rule
Executive Summary: Non-Quality Payment Program Provisions

Key Financial and Operational Impacts from the proposed 2021 PFS Rule:
The calendar year (CY) 2021 physician fee schedule (PFS) proposed rule will be published on August 17, 2020,in the Federal Register. A detailed summary of the rule will be available here shortly. Below are key changes in the proposed rule.

1) **Conversion Factor**: The proposed CY21 PFS conversion factor is $32.26, a decrease of $3.83 from the CY20 PFS conversion factor of $36.09. This includes the budget neutrality adjustment to account for changes in relative value units (RVUs), as required by law. The CY21 anesthesia conversion factor is $19.9631, down from $22.2016 in CY20.

   The table below shows CMS's estimates of the negative impact of the combined finalized policies on select specialties.

Specialty	Allowed Charges (millions)	Impact of Work RVU Changes	Impact of Practice Expense (PE) RVU Changes	Impact of Malpractice Expense (MP) RVU Changes	Combined Impact
Nurse Anes /Anes Asst	$1,316	-9%	-1%	0%	-11%
Radiology	$5,253	-6%	-5%	0%	-11%
Chiropractor	$759	-7%	-3%	0%	-10%
Cardiac Surgery	$264	-6%	-2%	-1%	-9%
Interventional Radiology	$497	-3%	-5%	0%	-9%
Pathology	$1,257	-6%	-4%	0%	-9%
Physical/Occupational Therapy	$4,946	-5%	-5%	0%	-9%
Anesthesiology	$2,011	-7%	-1%	0%	-8%
Critical Care	$376	-6%	-2%	0%	-8%
Nuclear Medicine	$56	-5%	-3%	0%	-8%
Thoracic Surgery	$350	-5%	-2%	-1%	-8%
Nurse Anes / Anes Asst	$1,316	-9%	-1%	0%	-11%
Radiology	$5,253	-6%	-5%	0%	-11%
Chiropractor	$759	-7%	-3%	0%	-10%
Cardiac Surgery	$264	-6%	-2%	-1%	-9%
Interventional Radiology	$497	-3%	-5%	0%	-9%
Pathology	$1,257	-6%	-4%	0%	-9%
Physical/Occupational Therapy	$4,946	-5%	-5%	0%	-9%
Anesthesiology	$2,011	-7%	-1%	0%	-8%
Critical Care	$376	-6%	-2%	0%	-8%
Nuclear Medicine	$56	-5%	-3%	0%	-8%
Thoracic Surgery	$350	-5%	-2%	-1%	-8%

   The table below shows the estimated positive impact of these changes by select specialty.

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Specialty	Allowed Charges (millions)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Endocrinology	$506	11%	6%	1%	17%
Rheumatology	$546	10%	6%	1%	16%
Hematology/Oncology	$1,702	9%	5%	1%	14%
Family Practice	$5,982	9%	4%	1%	13%
Allergy/Immunology	$246	5%	4%	0%	9%
General Practice	$405	5%	2%	0%	8%
Nurse Practitioner	$5,069	5%	3%	0%	8%
Obstetrics/Gynecology	$633	4%	3%	0%	8%
Physician Assistant	$2,888	5%	3%	0%	8%
Psychiatry	$1,099	4%	3%	0%	8%
Urology	$1,803	4%	4%	0%	8%
Interventional Pain Mgmt	$932	4%	3%	0%	7%
Otolaryngology	$1,264	4%	3%	0%	7%
Nephrology	$2,213	4%	2%	0%	6%

Table 1 in the Appendix provides a complete list of impacts by specialty.

2) **Payment for Office/Outpatient Evaluation and Management (E/M) and Analogous Visits:** As finalized in the CY20 proposed rule, in CY21 CMS aligns its E&M documentation and coding with changes in the CPT Editorial Panel effective for January 1, 2021. The rule proposes to clarify the times for which prolonged E&M visits can be reported and are proposing to revise the times used for rate setting.

Proposed Prolonged Office/Outpatient E/M Visit Reporting – New Patient[1]

CPT Code(s)	Total Time Required for Reporting*
99205	60-74 minutes
99205 x 1 and 99XXX x 1	89-103 minutes
99205 x 1 and 99XXX x 2	104-118 minutes
99205 x 1 and 99XXX x 3 or more for each additional 15 minutes.	119 or more

*Total time is the sum of all time, including prolonged time, spent by the reporting practitioner on the date of service of the visit.

Proposed Prolonged Office/Outpatient E/M Visit Reporting – Established Patient[2]

CPT Code(s)	Total Time Required for Reporting*
99215	40-54 minutes
99215 x 1 and 99XXX x 1	69-83 minutes

[1] Table 22 in the proposed rule
[2] Table 23 in the proposed rule

99215 x 1 and 99XXX x 2	84- 98 minutes
99215 x 1 and 99XXX x 3 or more for each additional 15 minutes.	99 or more

*Total time is the sum of all time, including prolonged time, spent by the reporting practitioner on the date of service of the visit.

The proposed rule also revalues the following code sets that include, rely upon or are analogous to office/outpatient E/M visits commensurate with the increases in values CMS finalized in the CY20 rule for office/outpatient E/M visits for CY21:

- End-stage renal disease (ESRD) monthly capitation payment (MCP) services[3,4]
- Transitional care management (TCM) Services[5]
- Maternity services[6]
- Cognitive impairment assessment and care planning[7]
- Initial preventive physical examination (IPPE) and initial and subsequent annual wellness (AWV) visits[8]
- Emergency department visits[9]
- Therapy evaluations[10]
- Psychiatric diagnostic evaluations and psychotherapy services[11]

3) **Telehealth**: The rule proposes multiple changes related to telehealth. Many of these proposals are designed to make permanent the regulatory waivers CMS provided in response to COVID-19.

   a. *Adds Telehealth Services*: The proposed rule permanently adds the services in Table 2 (below) permanently to the list of covered telehealth services. The services in Table 3 are added on a temporary basis and will remain on the covered telehealth services list through the end of the calendar year in which the public health emergency (PHE) ends. Table 11 in the proposed rule (not included in this summary) lists the telehealth services expanded during the PHE for which CMS is currently not planning to continue coverage as a telehealth service once the PHE expires.

   b. *Telehealth Nursing Facility Visit Frequency*: The proposed rule revises the nursing facility frequency limitation from one visit every 30 days to one visit every three days.

   c. *Licensed Clinical Social Worker, Clinical Psychologist, and Physical Therapist/Occupational Therapist/Speech Language Pathologist Brief Assessment and Management Services:* The rule clarifies that these providers can furnish brief online assessment and management services as well as virtual check-ins and remote evaluation services. CMS proposes to use two new HCPCS G-codes to bill for these services.

[3] Table 18 in the proposed rule
[4] Table 19 in the proposed rule
[5] Ibid
[6] Ibid
[7] Ibid
[8] Ibid
[9] Table 21 in the proposed rule
[10] Ibid
[11] Ibid

d. *Remote Patient Monitoring:* The proposed rule clarifies an array of issues related to remote patient monitoring. Table 4 in the appendix summarizes these clarifications.

e. *Direct Supervision by Interactive Telecommunications Technology:* CMS proposes to allow direct supervision to be provided using real-time, interactive audio and video technology (excluding telephone that does not also include video) through December 31, 2021.

Finally, the proposed rule does not address two key issues related to telehealth.

a. *Geographic Requirement*: The proposed rule does not eliminate the geographic location requirements after the PHE. This requires Congress to pass enabling legislation.

b. *Audio-Only Telephone E&M*: CMS established separate payment for audio-only telephone evaluation and management services in response to COVID-19. The CY21 PFS rule does not propose to continue recognizing these codes for payment under the PFS in the absence of the PHE for the COVID-19.

4) **Scope of Practice Issues:** CMS uses the CY21 proposed rule to expand on and/or clarify questions related to the multiple scope of practices waivers/changes it provided in response to COVID-19.

a. *Supervision of Diagnostic Tests by Certain Nonphysician Practitioners (NPPs)***:** CMS proposes to make permanent, after the expiration of the PHE, the ability of nurse practitioners (NPs), clinical nurse specialists (CNSs), physician assistants (PAs) and certified nurse-midwives (CNMs) to supervise the performance of diagnostic tests, in addition to physicians. If finalized on a permanent basis effective January 1, 2021, NPs, CNSs, PAs and CNMs would be allowed under the Medicare Part B program to supervise the performance of diagnostic tests within their state scope of practice and applicable state law, provided they maintain the required statutory relationships with supervising or collaborating physicians.

b. *Pharmacists Providing Services Incident to Physicians' Services:* The proposed rule reiterates the clarification in the May 1, 2020, COVID-19 interim final rule with comment period (IFC), that pharmacists fall within the regulatory definition of auxiliary personnel under CMS's "incident to" regulations. Therefore, pharmacists may provide services incident to the services, and under the appropriate level of supervision, of the billing physician or NPP, if payment for the services is not made under the Medicare Part D benefit and the services are within the pharmacist's state scope of practice and applicable state law.

c. *Therapy Assistants Furnishing Maintenance Therapy:* CMS proposes to make permanent its Part B policy for maintenance therapy services that were adopted on an interim basis for the PHE in the May 1, 2020, COVID-19 IFC that grants a physical therapist (PT) and occupational therapist (OT) the discretion to delegate the performance of maintenance therapy services, as clinically appropriate, to a therapy assistant – a physical therapist assistant (PTA) or an occupational therapy assistant (OTA).

d. *Medical Record Documentation:* CMS clarifies that physicians and NPPs, including therapists, can review and verify documentation entered into the medical record by members of the medical team for their own services that are paid under the PFS. Therapy students, and students of other disciplines, working under a physician or practitioner who furnishes and bills directly for their professional services to the Medicare program, may document in the record so long as it is reviewed and verified (signed and dated) by the billing physician, practitioner or therapist.

5) **Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Clinics (FQHCs)**: CMS proposes to add two new HCPCS codes, G2064 and G2065, to the general care management HCPCS code, G0511, for principal care management (PCM) services furnished in RHCs and FQHCs beginning January 1, 2021.

   RHCs and FQHCs furnishing PCM services would bill HCPCS code G0511, either alone or with other payable services on an RHC or FQHC claim. The current payment rate for HCPCS code G0511 is the average of the national nonfacility PFS payment rate for the RHC/FQHC care management and general behavioral health codes (CPT codes 99484, 99487, 99490 and 99491). HCPCS G2064 and G2065 would be added to G0511 to calculate a new average for the national nonfacility PFS payment rate. The payment rate for HCPCS code G0511 would be updated annually based on the PFS amounts for these codes.

6) **Rebase and Revise the FQHC Market Basket**: The proposed rule rebases and revises the FQHC market basket to reflect a 2017 base year. The proposed 2017-based FQHC market basket update for CY21 is 2.5%. The proposed multifactor productivity adjustment for CY21 is 0.6%. The proposed CY21 FQHC payment update is 1.9%.

7) **Medicaid Promoting Interoperability Program Requirements for Eligible Professionals (EPs):**
   a. *2021 eCQM (electronic clinical quality measures) Reporting Requirements*: For CY21, CMS proposes to continue requiring that Medicaid EPs report on any six electronic clinical quality measures relevant to the EP's scope of practice, regardless of whether they report via attestation or electronically. This policy of allowing Medicaid EPs to report on any six measures relevant to their scope of practice would generally align with the Merit-based Incentive Payment System (MIPS) data submission requirement for eligible clinicians using the eCQM collection type for the quality performance category.

      Similarly, CMS proposes that for 2021, EPs in the Medicaid Promoting Interoperability Program would be required to report on at least one outcome measure (or, if an outcome measure is not available or relevant, one other high priority measure).

      CMS proposes to use the same three methods for identifying high priority eCQMs for the Medicaid Promoting Interoperability Program for 2021:

      - The same set of measures that are identified as high priority measures for reporting on the quality performance category for eligible clinicians participating in MIPS.
      - All e-specified measures from the previous year's core set of quality measures for Medicaid and the Children's Health Insurance Program, or CHIP (Child Core Set) or the core set of health care quality measures for adults enrolled in Medicaid (Adult Core Set) that are also included on the MIPS list of eCQMs.
      - Each state has the flexibility to identify which of the eCQMs available for reporting in the Medicaid Promoting Interoperability Program are high priority measures for Medicaid EPs in that state, with review and approval by CMS, through the State Medicaid Health IT Plan (SMHP).

      The Medicaid Promoting Interoperability Program 2021 eCQM reporting period is a minimum of any continuous 90-day period within CY21, provided that the end date for this period falls before October 31, 2021, or falls before a state-specific alternative date prior to October 31, 2021 that is specified in the SMHP.

8) **Medicare Shared Savings Program (MSSP):** For 2021 and subsequent years, CMS proposes multiple changes to the Medicare Shared Savings Program.

   a. *Applying the Alternative Payment Model (APM) Performance Pathway (APP) to Shared Savings Program accountable care organizations (ACO)s*: CMS is proposing to revise the MSSP quality performance standard effective for performance year 2021 and subsequent performance years. This proposed revision would align the MSSP quality performance standard with the proposed APP under the Quality Payment Program as participants in the MSSP would be required to report quality for purposes of the MSSP via the APP.

   At a high level, the APP would replace the current MSSP quality measure set. The APP contains a narrower measure set than has previously been used for MSSP quality measurement, six measures (Table 5 in the appendix) versus the current 23 scored measures, and is specifically intended for use in APMs and population health. ACOs would only need to report one set of quality metrics that would satisfy the reporting requirements under both MIPS and the MSSP. Eligible clinicians in MSSP ACOs would continue to receive full credit for the improvement activities performance category in 2021 based on their performance of activities, as they do under current MIPS scoring policy.

   Eligible clinicians participating in the MSSP are not currently assessed on the MIPS cost performance category as these eligible clinicians are already subject to cost and utilization performance assessments as part of the MSSP. Therefore, the cost performance category would continue to be weighted at zero percent. The four categories in the proposed APP framework would be weighted as follows:

   - Quality: 50%
   - PI: 30%
   - IA: 20%
   - Cost: 0%

   The MIPS quality performance category score would be calculated for ACOs based on MIPS benchmarks, which are used for other non-ACO group and individual reporters and reflect the method of data submission (for example, eCQM measures have benchmarks calculated using electronic health record, or EHR, data).

   b. *Revising the MSSP Quality Performance Standard*: CMS proposes that for years beginning on or after January 1, 2021, in order to be eligible to receive shared savings for a performance year, ACOs must achieve an APP quality performance score equivalent to the 40th percentile or above across all MIPS quality performance category scores, excluding entities/providers eligible for facility-based scoring. In addition, CMS proposes that if an ACO does not report any of the three of the measures ACOs are actively required to report and does not field a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, the ACO would not meet the quality performance standard.

   Finally, CMS proposes that for 2021 and subsequent performance years, ACOs must submit quality data via the APP to satisfactorily report on behalf of the eligible clinicians who bill under the tax identification number (TIN) of an ACO participant for purposes of the MIPS quality performance category.

c. *Use of ACO Quality Performance in Determining Shared Savings and Shared Losses*: CMS proposes to modify the methodology for determining shared losses under Track 2 and the ENHANCED track, for performance years beginning on or after January 1, 2021, to account for the proposed revisions to the quality performance standard. If the ACO meets the quality performance standard, as proposed, CMS would determine the shared loss rate as follows:

Step 1: Calculate the quotient of the MIPS quality performance category points earned divided by the total MIPS quality performance category points available.
Step 2: Calculate the product of the quotient described in step 1 and the sharing rate for the relevant track, either 60% for Track 2 or 75% for the ENHANCED track.
Step 3: Calculate the shared loss rate as 1 minus the product determined in step 2.

Consistent with the existing structure of the financial models: under Track 2, the shared loss rate may not exceed 60%, and may not be less than 40%; under the ENHANCED track, the shared loss rate may not exceed 75%, and may not be less than 40%. If the ACO fails to meet the quality performance standard as proposed the shared loss rate would be 60% under Track 2 or 75% under the ENHANCED track.

d. *Revisions to the Definition of Primary Care Services used in Shared Savings Program Beneficiary Assignment*: CMS proposes to revise the definition of primary care services in the MSSP regulations to include the following additions:
   i. Online digital evaluation and management CPT codes 99421, 99422, and 99423
   ii. Assessment of and care planning for patients with cognitive impairment CPT code 99483
   iii. Chronic care management code CPT code 99491
   iv. Non-complex chronic care management HCPCS code G2058 and its proposed replacement CPT code, if finalized through the CY21 PFS rulemaking
   v. Principal care management HCPCS codes G2064 and G2065
   vi. Psychiatric collaborative care model HCPCS code GCOL1, if finalized through the CY21 PFS rulemaking.

The rule also proposes to modify the definition of primary care services for purposes of assignment in the MSSP regulations to exclude advance care planning CPT code 99497 and the add-on code 99498 when billed in an inpatient care setting, for use in determining beneficiary assignment for the performance year starting on January 1, 2021, and subsequent performance years.

CMS proposes to revise the existing exclusion for professional services billed under CPT codes 99304 through 99318 that are furnished in a skilled nursing facility (SNF) to include services reported on an FQHC or RHC claim that includes CPT codes 99304 through 99318, when those services are furnished in a SNF. Operationally, the exclusion would occur when both of the following conditions are met:

- Either a professional service is billed under CPT codes 99304 through 99318, or an FQHC/RHC submits a claim including a qualifier CPT code 99304 through 99318
- A SNF facility claim is in claims files with dates of service that overlap with the date of service for the professional service or FQHC/RHC service

If CMS finalizes any of the proposed changes to the definition of primary care services for purposes of beneficiary assignment, it will adjust the ACO's historical benchmarks to account for these changes for the performance year starting on January 1, 2021, and subsequent performance year.

HFMA Physician Fee Schedule – Non QPP Components
Executive Summary
CY21 Proposed Rule

Appendix: Tables Related to the Proposed Rule

Table 1: 2021 PFS Estimated Impact on Total Allowed Charges by Specialty[12]

	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Allergy/Immunology	$246	5%	4%	0%	9%
Anesthesiology	$2,011	-7%	-1%	0%	-8%
Audiologist	$74	-4%	-2%	0%	-7%
Cardiac Surgery	$264	-6%	-2%	-1%	-9%
Cardiology	$6,849	1%	0%	0%	1%
Chiropractor	$759	-7%	-3%	0%	-10%
Clinical Psychologist	$824	-1%	1%	0%	0%
Clinical Social Worker	$851	-1%	1%	0%	0%
Colon And Rectal Surgery	$168	-4%	-1%	0%	-5%
Critical Care	$376	-6%	-2%	0%	-8%
Dermatology	$3,758	-1%	-1%	0%	-2%
Diagnostic Testing Facility	$813	-1%	-5%	0%	-6%
Emergency Medicine	$3,065	-5%	-1%	0%	-6%
Endocrinology	$506	11%	6%	1%	17%
Family Practice	$5,982	9%	4%	1%	13%
Gastroenterology	$1,749	-3%	-1%	0%	-5%
General Practice	$405	5%	2%	0%	8%
General Surgery	$2,041	-4%	-2%	0%	-7%
Geriatrics	$190	2%	2%	0%	4%
Hand Surgery	$245	-2%	-1%	0%	-3%
Hematology/Oncology	$1,702	9%	5%	1%	14%
Independent Laboratory	$639	-3%	-2%	0%	-5%
Infectious Disease	$653	-4%	-1%	0%	-4%
Internal Medicine	$10,654	2%	2%	0%	4%
Interventional Pain Mgmt	$932	4%	3%	0%	7%
Interventional Radiology	$497	-3%	-5%	0%	-9%
Multispecialty Clinic/Other Phys	$152	-3%	-1%	0%	-4%
Nephrology	$2,213	4%	2%	0%	6%
Neurology	$1,513	3%	2%	0%	6%
Neurosurgery	$806	-4%	-2%	-1%	-7%
Nuclear Medicine	$56	-5%	-3%	0%	-8%

[12] Table 90 in the proposed rule

Nurse Anes / Anes Asst	$1,316	-9%	-1%	0%	-11%
Nurse Practitioner	$5,069	5%	3%	0%	8%
Obstetrics/Gynecology	$633	4%	3%	0%	8%
Ophthalmology	$5,328	-4%	-2%	0%	-6%
Optometry	$1,349	-2%	-2%	0%	-5%
Oral/Maxillofacial Surgery	$78	-2%	-3%	0%	-5%
Orthopedic Surgery	$3,796	-3%	-1%	0%	-5%
Other	$47	-3%	-2%	0%	-5%
Otolaryngology	$1,264	4%	3%	0%	7%
Pathology	$1,257	-6%	-4%	0%	-9%
Pediatrics	$66	4%	2%	0%	6%
Physical Medicine	$1,157	-3%	0%	0%	-3%
Physical/Occupational Therapy	$4,946	-5%	-5%	0%	-9%
Physician Assistant	$2,888	5%	3%	0%	8%
Plastic Surgery	$378	-4%	-3%	0%	-7%
Podiatry	$2,111	-1%	0%	0%	-1%
Portable X-Ray Supplier	$94	-2%	-4%	0%	-6%
Psychiatry	$1,099	4%	3%	0%	8%
Pulmonary Disease	$1,647	0%	0%	0%	1%
Radiation Oncology And Radiation Therapy Centers	$1,803	-3%	-3%	0%	-6%
Radiology	$5,253	-6%	-5%	0%	-11%
Rheumatology	$546	10%	6%	1%	16%
Thoracic Surgery	$350	-5%	-2%	-1%	-8%
Urology	$1,803	4%	4%	0%	8%
Vascular Surgery	$1,287	-2%	-5%	0%	-7%
TOTAL	**$96,557**	**0%**	**0%**	**0%**	**0%**

Table 2: CY21 Proposed Additions to the Medicare Telehealth Services List on a Category 1 Basis[13]

HCPCS Code	Long Descriptor
GPC1X	Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services (Add-on code, list separately in addition to an evaluation and management visit)
90853	Group psychotherapy (other than of a multiple-family group)
96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)
99XXX	Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)
99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (e.g., basic and instrumental activities of daily living), including decision-making capacity; Use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]); Medication reconciliation and review for high-risk medications; Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); Evaluation of safety (e.g., home), including motor vehicle operation; Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (e.g., rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.

[13] Table 8 in the proposed rule

99334	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent with the patient and/or family or caregiver.
99335	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent with the patient and/or family or caregiver.
99347	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99348	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

Table 3: Services Proposed for Temporary Addition to the Medicare Telehealth Services List[14]

Service Type	HCPCS	Long Descriptor
Domiciliary, Rest Home, or Custodial Care services, Established patients	99336	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent with the patient and/or family or caregiver.
	99337	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent with the patient and/or family or caregiver.
Home Visits, Established Patient	99349	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
	99350	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be

[14] Table 10 in the proposed rule

		unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent face-to-face with the patient and/or family.
Emergency Department Visits	99281	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.
	99282	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.
	99283	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate
Nursing facilities discharge day mgmt	99315	Nursing facility discharge day management; 30 minutes or less
	99316	Nursing facility discharge day management; more than 30 minutes
Psychological and Neuro-psychological 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)

Table 4: Proposed Rule Clarifications Related to Remote Patient Monitoring (RPM)

Patient Relationship/ Consent	Following the PHE for the COVID-19 pandemic, an established patient-physician relationship must exist for RPM services to be furnished.
	A permanent policy consent may be obtained at the time that RPM services are furnished.
Who Can Provide/Bill RPM Services	As a permanent policy, auxiliary personnel are allowed to furnish CPT codes 99453 and 99454 services under a physician's supervision. Auxiliary personnel include contracted employees.
	RPM services are considered to be evaluation and management (E/M) services.
	Only physicians and NPPs who are eligible to furnish E/M services may bill RPM services.
Billing Requirements	Practitioners may furnish RPM services to patients with acute conditions as well as patients with chronic conditions.
	The medical device supplied to a patient as part of CPT code 99454 must be a medical device as defined by Section 201(h) of the Federal Food, Drug, and Cosmetic Act, that the device must be reliable and valid, and that the data must be electronically (i.e., automatically) collected and transmitted rather than self-reported.

	After the PHE for COVID-19, CMS will maintain the current requirement that 16 days of data each 30 days must be collected and transmitted to meet the requirements to bill CPT codes 99453 and 99454.
	CPT codes 99457 and 99458 require, an "interactive communication" which is a conversation that occurs in real-time and includes synchronous, two-way interactions that can be enhanced with video or other kinds of data as described by HCPCS code G2012.

Table 5: Measures Included in the Proposed APM Performance Pathway Measure Set[15]

Measure #	Measure Title	Collection Type	Submitter Type	Meaningful Measure Area
Quality ID#: 321	CAHPS for MIPS	CAHPS for MIPS Survey	Third Party Intermediary	Patient's Experience
Quality ID#: 001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control	eCQM/MIPS CQM	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions
Quality ID#: 134	Preventive Care and Screening: Screening for Depression and Follow-up Plan	eCQM/MIPS CQM	APM Entity/Third Party Intermediary	Treatment of Mental Health
Quality ID#:236	Controlling High Blood Pressure	eCQM/MIPS CQM	APM Entity/Third Party Intermediary	Mgt. of Chronic Conditions
Measure # TBD	Hospital-Wide, 30-day, All- Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups	Administrative Claims	N/A	Admissions & Readmissions
Measure # TBD	Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs	Administrative Claims	N/A	Admissions & Readmissions

[15] Table 36 in proposed rule