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CMS Issues Second Round of Policy Changes in Response to COVID-19

Interim Final Rule Summary

On April 30, 2020, the Centers for Medicare & Medicaid Services (CMS) issued the *Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program*, interim final rule with comment period (IFC). The IFC includes key policy changes designed to give physicians and other health care providers needed flexibilities so they may continue to provide care during the COVID-19 public health emergency (PHE). ASTRO is pleased that the IFC addresses key telehealth issues that are of importance to radiation oncology, including:

- Increased Reimbursement for Telephone Evaluation and Management (E/M) Services (99441-99443);
- Additional Guidance on the Selection of E/M Level;
- Subregulatory Process for Updating the Medicare Telehealth List; and
- Hospital Services Accompanying a Professional Service Furnished Via Telehealth

Increased Reimbursement for Telephone Evaluation and Management (E/M) Services (99441-99443)

In the March 30th COVID-19 interim final rule (IFR), CMS established payment for services conducted by audio-only telephone between Medicare beneficiaries and their physicians (CPT codes 99441-99443 *Telephone Evaluation and Management Services*) to reduce exposure risks during the COVID-19 PHE, recognizing that audio-only communication between the physician and the patient could be clinically appropriate during the PHE. The Agency further established that these services would be paid based on RUC-recommended values discussed in the CY 2008 Physician Fee Schedule (PFS) final rule of 0.25 for CPT code 99441, 0.50 for CPT code 99442, and 0.75 for CPT code 99443.

In the April 30th IFC, CMS is increasing payments for these telephone visits to match payments for similar office and outpatient visits. Stakeholder feedback in response to the March 30th IFR indicated that the use of audio-only services is more prevalent than CMS had previously considered, especially because many Medicare beneficiaries are not utilizing video-enabled communication technology from their homes.

CMS is finalizing new RVUs for the telephone E/M services based on crosswalks to the most analogous office/outpatient E/M codes. Specifically, CMS is crosswalking CPT codes 99212, 99213, and 99214 to CPT codes 99441, 99442, and 99443 respectively. This results in a work RVU of 0.48 for CPT code 99441, 0.97 for CPT code 99442, and 1.50 for CPT code 99443. The adjusted payment amounts range from $46-$110, a sizable increase from the $14-$41 rates established using the CY 2008 values.

The payments are retroactive to March 1, 2020. The Agency does not anticipate that the increases in payment rates will result in higher aggregate Medicare expenditures as long as the telephone E/M visits fully substitute for in-person or telehealth E/M visits that otherwise would have occurred during the PHE.

Additional Guidance on the Selection of E/M Level

The provisions of the March 30th COVID-19 IFR revised the Agency's policy that specified parameters involving the office/outpatient E/M level selection criteria for office/outpatient E/M services furnished via telehealth. The policy indicated that E/M level selection can be based on medical decision making (MDM) or time, with time defined as all time associated with E/M on the day of the patient encounter. In addition, CMS removed requirements regarding documentation of history and/or physical exam in the medical record. At the time of the IFR, CMS finalized that the current typical times associated with the office/outpatient E/M visits should be met for purposes of level selection, causing confusion among physicians because those typical times listed by CMS did not align with the typical times included in the office/outpatient E/M code descriptors.

In the April 30th IFC, CMS is clarifying the typical times for E/M level selection and updating its policy. CMS is finalizing that the times listed in the code descriptors are the most appropriate for the purpose of E/M level selection. This policy only applies to office/outpatient visits furnished via Medicare telehealth during the COVID-19 public health emergency.

Note: Please see ASTRO's COVID-19 Coding Guidance for a list of E/M codes and their typical times

Subregulatory Process for Updating the Medicare Telehealth List

In the March 30th COVID-19 IFR, CMS added a number of services to the Medicare telehealth list on an interim basis for the duration of the PHE. In the April 30th IFC, CMS is modifying the method for adding or deleting services from the Medicare telehealth services list to expedite the process during the PHE outside the customary notice and comment rulemaking. CMS states that although the vast majority of services have already been added to the Medicare telehealth list for purposes of the PHE for the COVID-19 pandemic, it is possible that more services may be identified that would be appropriate additions to the telehealth list, taking into consideration infection control, patient safety, and other public health concerns resulting from the COVID-19 PHE. CMS will use a subregulatory process and post new services to the Agency's web listing of telehealth services when the agency receives a request to add (or identifies through internal review) a service that can be furnished in full, as described by the relevant code, by a distant site practitioner to a beneficiary in a manner that is similar to the in-person service, to modify the services included on the Medicare telehealth list. These additional services would remain on the list only during the PHE.

Hospital Services Accompanying a Professional Service Furnished Via Telehealth

According to guidance issued by CMS in the March 30th COVID-19 IFR, when a physician who ordinarily practices in an Hospital Outpatient Department (HOPD) furnishes a telehealth service to a patient who is located at home, they would submit a professional claim with the place of service code indicating the services were furnished in a HOPD and using the CPT telehealth modifier 95. Medicare pays the physician under the Physician Fee Schedule at the "facility" rate as if the service were furnished in the HOPD. The March 31st IFR did not provide any guidance regarding whether the hospital should submit claims associated with the service under this scenario.

In the April 30th IFC, CMS acknowledges that hospitals still provide some administrative and clinical support for services that are provided via telehealth. During the COVID-19 PHE, when telehealth services are furnished by a physician who ordinarily practices in the HOPD to a patient who is located at home or other applicable temporary expansion location that has been made provider based to the hospital, CMS will permit the hospital to bill and be paid the originating site facility fee amount for those telehealth services. Additionally, hospitals may bill the facility fee if the physician is at a distant site and the patient is located in the HOPD. CMS requires documentation in the medical record of the reason for the visit and the necessity of the visit.

Additional information about the COVID-19 Interim Final Rule can be found at the following links:

The Interim Final Rule and waivers can be found at:

https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf

CMS Fact Sheet:

https://www.cms.gov/newsroom/press-releases/trump-administration-issues-second-round-sweeping-changes-support-us-healthcare-system-during-covid

Physician-specific Fact Sheet:

https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf