



On August 3, 2020 the Calendar Year 2021 Medicare Physician Fee Schedule and Quality Payment Program proposed rule was released. The rule proposes changes to Medicare payment policies for 2021. Comments are due October 5, 2020. Below is a summary of health IT-related proposed changes.

Medicare Physician Fee Schedule	
Issue Area	CMS Proposal
Telehealth Services	<ul style="list-style-type: none"> <li>• Proposing to add services listed in <a href="#">Table 8</a> to the Medicare telehealth services list for CY 2021</li> <li>• Proposed Temporary Addition of a Category 3 Basis for Adding to or Deleting Services from the Medicare Telehealth Services List               <ul style="list-style-type: none"> <li>○ In the event the COVID-19 PHE expires before the end of 2021, stakeholders might not have the opportunity to use CMS' current consideration process for telehealth services to request permanent additions to the Medicare telehealth services list prior to those services being removed from the Medicare telehealth services list.</li> <li>○ Proposing to create a third category of criteria for adding services to the Medicare telehealth services list on a temporary basis</li> <li>○ The new category would describe services that would be included on the Medicare telehealth services list on a temporary basis</li> <li>○ Would include in this category the services that were added during the PHE for which there is likely to be clinical benefit when furnished via telehealth, but for which there is not yet sufficient evidence available to consider the services as permanent additions under Category 1 or Category 2 criteria</li> <li>○ CMS considered the following factors for Category 3:                   <ul style="list-style-type: none"> <li>▪ Whether, outside of the circumstances of the PHE, there are increased concerns for patient safety if the service is furnished as a telehealth service.</li> <li>▪ Whether, outside of the circumstances of the PHE, there are concerns about whether the provision of the service via telehealth is likely to jeopardize quality of care.</li> <li>▪ Whether all elements of the service could fully and effectively be performed by a remotely located clinician using two-way, audio/video telecommunications technology</li> </ul> </li> </ul> </li> </ul>

- The proposed list of temporarily added telehealth services under Category 3 is listed in [Table 10](#)
- Seeking public comment on whether specific services should be added on a temporary, Category 3 basis:
  - Initial and final/discharge interactions (CPT codes 99234-99236 and 99238-99239)
  - Higher level emergency department visits (CPT codes 99284-99285)
  - Hospital, Intensive Care Unit, Emergency care, Observation stays (CPT codes CPT 99217-99220; 99221-99226; 99484-99485, 99468-99472, 99475- 99476, and 99477- 99480)
- [Table 11](#) lists Medicare telehealth services that are covered during the COVID-19 PHE, but not proposed to be covered after the PHE ends
- Seeking comment on whether physical therapy, occupational therapy, and speech-language pathology services should be added to the list of Medicare telehealth services even though PTs/OTs/SLTs are not eligible telehealth practitioners under the law
  - Also seeking comment on which specific aspects of these services are appropriate to deliver via telehealth
- Seeking comment on whether the current critical care coding for telehealth services does not fully reflect additional models of critical care delivery, specifically, models of care delivery that utilize a combination of remote monitoring and clinical staff at the location of the beneficiary to allow, when an onsite practitioner is not available, for a practitioner at a distant site to monitor vital signs and direct in-person care as needed
- Also seeking comment on the following concerns:
  - How to distinguish the technical component of the remote monitoring portion of the service from the diagnosis-related group (DRG) payment already being provided to the hospital.
  - How to provide payment only for monitoring and interventions furnished to Medicare beneficiaries when the remote intensivist is monitoring multiple patients, some of which may not be Medicare beneficiaries.
  - How this service intersects with both the critical care consult G codes and the inperson critical care services.
- [Table 12](#) summarizes the list of telehealth services proposed to be added and those not proposed to be made permanent after the PHE ends
- Seeking comment on whether or not initial visits required for SNF residents could be delivered via telehealth after the PHE ends

	<ul style="list-style-type: none"> <li>• Not proposing to modify frequency limitation of subsequent inpatient visits - currently once every 3 days</li> <li>• Proposing to revise the frequency limitation for nursing facility residents from one visit every 30 days to one visit every 3 days</li> <li>• Seeking comment on whether frequency limitations broadly are burdensome and limit access to care when services are only available via telehealth</li> <li>• Proposing to remove from the definition of telehealth the sentence “[t]elephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system”</li> <li>• If audio/video technology is used in furnishing a service when the beneficiary and the practitioner are in the same institutional or office setting, then the practitioner should bill for the service furnished as if it was furnished in person, and the service would not be subject to any of the telehealth requirements under section 1834(m) of the Act</li> </ul>
<p>Communication Technology-Based Services</p>	<ul style="list-style-type: none"> <li>• Proposing to allow billing of HCPCS Codes G2061 through G2063 by licensed clinical social workers, clinical psychologists, PTs, OTs, and SLPs</li> <li>• Also proposing creating two additional HCPCS G codes to allow billing of CTBS by other nonphysician practitioners: <ul style="list-style-type: none"> <li>○ G20X0 (Remote assessment 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 service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment.)</li> <li>○ G20X2 (Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot 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 a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion)</li> <li>○ Proposing to value these new codes identically to HCPCS G2010 and G2012</li> </ul> </li> <li>• To facilitate billing of the CTBS by therapists, CMS is proposing to designate HCPCS codes G20X0, G20X2, G2061, G2062, and G2063 as “sometimes therapy” services</li> <li>• Proposing to replace the eVisit G codes with corresponding CPT codes</li> </ul>

	<ul style="list-style-type: none"> <li>• For all CBTS codes, patient consent to receive these services can be documented by auxiliary staff under general supervision, as well as by the billing practitioner</li> <li>• Retaining the requirement that in instances when the brief communication technology-based service originates from a related E/M service (including one furnished as a telehealth service) provided within the previous 7 days by the same physician or other qualified health care professional, this service would be considered bundled into that previous E/M service and would not be separately billable</li> </ul>
<p>Comment Solicitation on Continuation of Payment for Audio-Only Visits</p>	<ul style="list-style-type: none"> <li>• CMS is not proposing to continue to recognize these codes for payment under the PFS after conclusion of the PHE for the COVID-19 pandemic because, outside of the circumstances of the PHE, CMS is not able to waive the requirement that telehealth services be furnished using an interactive telecommunications system that includes two-way, audio/video communication technology</li> <li>• Seeking comment on whether CMS should develop coding and payment for a service similar to the virtual check-in but for a longer unit of time and with an accordingly higher value <ul style="list-style-type: none"> <li>○ Seeking input from the public on the appropriate duration interval for such services and the resources in both work and PE that would be associated with furnishing them</li> <li>○ Seeking comment on whether separate payment for such telephone-only services should be a provisional policy to remain in effect until a year or some other period after the end of the PHE or if it should be PFS payment policy permanently</li> </ul> </li> </ul>
<p>Comment Solicitation on Coding and Payment for Virtual Services</p>	<ul style="list-style-type: none"> <li>• Seeking comment on whether there are additional services that fall outside the scope of telehealth services under section 1834(m) of the Act where it would be helpful for us to clarify that the services are inherently non-face-to-face, so do not need to be on the Medicare telehealth services list in order to be billed and paid when furnished using telecommunications technology rather than in person with the patient present</li> <li>• Also seeking comment on physicians' services that use evolving technologies to improve patient care that may not be fully recognized by current PFS coding and payment, including, for example, additional or more specific coding for care management services</li> <li>• Broadly seeking comment on any impediments that contribute to healthcare provider burden and that may result in practitioners being reluctant to bill for CTBS</li> </ul>

Updates to Certified Electronic Health Record Technology due to the 21<sup>st</sup> Century Cures Act Final Rule

- Because of updates included in the 21st Century Cures Act Final Rule, CMS proposes that the technology used by healthcare providers to satisfy the definitions of CEHRT must be certified under the Certification Program in accordance with the updated 2015 Edition of health IT certification criteria as finalized in the 21st Century Cures Act final rule
- This would include technology used to meet the 2015 Edition Base EHR definition, technology certified to the criteria necessary to be a meaningful EHR user under the Promoting Interoperability Programs, and technology certified to the criteria necessary to report on applicable objectives and measures specified for the MIPS Promoting Interoperability performance category, as specified in the CEHRT definitions
- While the 21st Century Cures Act final rule did not finalize a new Edition of certification criteria, this approach is similar to the prior policy for transition periods between Editions.
  - For example, during the transition period in which the ONC Health IT Certification Program included both the 2014 Edition and the 2015 Edition, a health IT module certified to either Edition was considered certified and could be used by healthcare providers to meet the CEHRT definitions and demonstrate meaningful use
  - After the end of the transition period, only health IT certified to the 2015 Edition could be used by healthcare providers to meet the CEHRT definitions and demonstrate meaningful use, and health IT modules certified to only the 2014 Edition were no longer considered certified under the ONC Health IT Certification Program
  - In the same manner, after the current transition period ends in which health IT certified to either the existing 2015 Edition certification criteria or the 2015 Edition Cures Update criteria is considered certified, healthcare providers must use technology certified to only the updated version of the certification criteria finalized in the 21st Century Cures Act final rule to meet the CEHRT definitions and demonstrate meaningful use
- Under the definitions of CEHRT, CMS proposes to replace the reference to the “Advancing Care Information” performance category with the “Promoting Interoperability” performance category, to reflect the performance category name change that CMS made previously
- Under the definition of Meaningful EHR user for MIPS, CMS proposes to replace the reference to the “Advancing Care Information” performance category with the “Promoting Interoperability” performance category, to reflect the performance category name change that CMS made previously

<p>Remote Physiologic Monitoring Services</p>	<ul style="list-style-type: none"> <li>• <a href="#">Table 13</a> contains newly created CPT codes that describe services involving direct patient contact or do not involve direct patient contact</li> <li>• Proposes to establish as permanent policies two of the changes CMS made on an interim basis to the requirements for furnishing RPM services in response to PHE for the COVID-19 pandemic</li> <li>• Proposes to permanently allow consent to be obtained at the time RPM services are furnished</li> <li>• Proposes to allow auxiliary personnel to furnish services described by CPT codes 99453 and 99454 under the general supervision of the billing physician or practitioner. <ul style="list-style-type: none"> <li>○ Auxiliary personnel include individuals who are not clinical staff but are employees or leased/contracted employees</li> </ul> </li> <li>• Requiring that RPM services must be furnished only to an established patient even after the PHE for the COVID-19 pandemic ends</li> <li>• Seeking comment on whether the current RPM coding accurately and adequately describes the full range of clinical scenarios where RPM services may be of benefit to patients. <ul style="list-style-type: none"> <li>○ Seeking information that could prove to be beneficial in considering to establish coding payment rules that would allow practitioners to bill and be paid for RPM services with shorter monitoring periods</li> </ul> </li> </ul>
<p>Direct Supervision by Interactive Telecommunications Technology</p>	<ul style="list-style-type: none"> <li>• Proposes to extend the interim final policy which revised the definition of direct supervision to include virtual presence of the supervising physician or practitioner using interactive audio/video real-time communications technology. <ul style="list-style-type: none"> <li>○ Proposes to extend this policy until the later of the end of the calendar year in which the PHE ends or December 31, 2021.</li> </ul> </li> <li>• Proposes to allow direct supervision to be provided using real-time, interactive audio and video technology through the later of the end of the calendar year in which the PHE ends or December 31, 2021 <ul style="list-style-type: none"> <li>○ More specifically, CMS proposes to continue the current rule that “Direct supervision” in the office setting means the physician (or other supervising practitioner) must be present in the office and immediately available to furnish assistance and direction throughout the performance of the procedure. Does not mean the physician/supervising practitioner must be present in the room.</li> <li>○ Also proposes that the presence of the physician (or other practitioner) may include virtual presence through audio/video real-time communications technology (excluding audio-only).</li> </ul> </li> <li>• Seeking information as to whether there should be any additional guardrails or limitations to ensure patient safety/clinical appropriateness, beyond typical clinical standards, as well as</li> </ul>

	<p>restrictions to prevent fraud or inappropriate use of direct supervision through audio/video interactive communications technology.</p> <ul style="list-style-type: none"> <li>○ Also seeking information on what risks this policy might introduce to beneficiaries</li> <li>○ Also seeking comment on potential concerns around induced utilization and fraud, waste, and abuse and how these might be addressed</li> </ul>
<p>Medicare Diabetes Prevention Program (MDPP)</p>	<ul style="list-style-type: none"> <li>• Proposes to amend CMS regulation to create more flexible MDPP policies that will apply during certain emergencies <ul style="list-style-type: none"> <li>○ Furthermore, proposes to modify the definition of “beneficiary engagement period” and to address beneficiary engagement incentives that are furnished to MDPP beneficiaries who are receiving MDPP services virtually pursuant to the Emergency Policy</li> </ul> </li> <li>• Proposes to amend the MDPP policies where the Secretary has authorized section 1135 waivers for such emergency area and period where such 1135 waiver event may cause a disruption to in-person MDPP services <ul style="list-style-type: none"> <li>○ Further proposes that CMS would determine that an 1135 waiver event could disrupt in-person, or MDPP beneficiaries would likely be unable to attend in-person classes</li> <li>○ Proposes that should CMS determine an 1135 waiver event may disrupt in-person MDPP services, CMS would notify all impacted MDPP suppliers via email and other means appropriate</li> </ul> </li> <li>• Proposes to allow temporary flexibilities that prioritize availability and continuity of services for MDPP suppliers and beneficiaries affected by extreme and uncontrollable circumstances that CMS determines may disrupt in-person MDPP services during a PHE</li> <li>• Proposes to amend the MDPP regulations to provide certain changes including: <ul style="list-style-type: none"> <li>○ Allowing MDPP suppliers to start new cohorts</li> <li>○ Allowing MDPP suppliers to either deliver MDPP services virtually or suspend in-person services and resume during a later date during an applicable 1135 waiver event.</li> </ul> </li> <li>• Proposes that MDPP beneficiaries who choose to receive services virtually are not eligible to restart the set of MDPP services at a later date</li> <li>• Proposes the following approach for permitting MDPP beneficiaries to resume or restart the set of MDPP services in the event that in-person sessions are suspended and the beneficiary does not choose to receive services virtually: <ul style="list-style-type: none"> <li>○ Beneficiaries who are within the first 12 month set of MDPP services at the beginning of an 1135 waiver event would be eligible to restart the set of MDPP services either at the</li> </ul> </li> </ul>

	<p>beginning, or resume with the most recent session on record, after the end of the waiver event</p> <ul style="list-style-type: none"> <li>○ Beneficiaries who are within the second year of services at the start of the waiver event would only be permitted to resume the set of services with the most recent session on record. Cannot restart the set of services at the beginning</li> <li>○ The election to resume the set of services can only be done once per 1135 waiver event</li> <li>● Proposes that the limit placed on number of virtual make-up sessions would not apply during the remainder of COVID-19 PHE or any future applicable 1135 waiver event</li> <li>● Proposes to amend the regulations clarifying that all sessions may be offered virtually consistent with the in-person class curriculum</li> <li>● Proposes that virtual sessions may be furnished to achieve both attendance and weight-loss goals</li> <li>● Proposes an MDPP supplier may offer the following to an MDPP beneficiary: <ul style="list-style-type: none"> <li>○ 16 virtual sessions offered weekly during the core session period</li> <li>○ 6 virtual sessions offered monthly during the core maintenance session interval periods</li> <li>○ 12 virtual sessions offered monthly during the ongoing maintenance session interval periods</li> <li>○ Furnish a maximum of one regularly schedule virtual session and a maximum of one virtual make-up session per week</li> </ul> </li> <li>● Proposes that the requirement for in-person attendance at first core-session would not apply</li> <li>● Proposes that MDPP suppliers may obtain weight measurements from beneficiaries through the following methods (during the remainder of COVID-19 PHE and future 1135 waiver event): <ul style="list-style-type: none"> <li>○ In-person</li> <li>○ Via digital technology</li> <li>○ Self-reported weights</li> <li>○ Also proposes that waiver of minimum weight loss requirements for beneficiary eligibility in the ongoing maintenance session intervals end.</li> </ul> </li> <li>● Seeking comment on the following proposed changes <ul style="list-style-type: none"> <li>○ An MDPP supplier may furnish in-kind beneficiary engagement incentives to a beneficiary if certain requirements are satisfied <ul style="list-style-type: none"> <li>▪ In-kind item or service must be furnished only during the “engagement incentive period”</li> </ul> </li> <li>○ Adding a requirement governing the provision of an in-kind item or service as a beneficiary engagement incentive during the COVID-19 PHE <ul style="list-style-type: none"> <li>▪ Proposing this requirement to deter abuse and ensure incentives furnished during an 1135 waiver event will achieve the intended purpose</li> </ul> </li> </ul> </li> </ul>
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	<ul style="list-style-type: none"> <li>• Proposes to amend the definition of “engagement incentive period” to further qualify when the period ends in the case of the COVID-19 PHE or an 1135 waiver event</li> <li>• Proposes to amend the definition to state that the MDPP supplier has not had direct contact with the beneficiary for more than 90 consecutive calendar days during the services period</li> <li>• Proposes to define “COVID-19 Public Health Emergency” to mean the emergency period and emergency area <ul style="list-style-type: none"> <li>○ Also proposes to define “1135 waiver event” to mean an emergency period and emergency area</li> </ul> </li> </ul>
<b>Quality Payment Program</b>	
<b>Issue Area</b>	<b>CMS Proposal</b>
Promoting Interoperability Performance Category	<ul style="list-style-type: none"> <li>• Propose to establish a performance period for the Promoting Interoperability performance category of a minimum of a continuous 90-day period within the calendar year that occurs 2 years prior to the applicable MIPS payment year, up to and including the full calendar year, for the 2024 MIPS payment year and each subsequent MIPS payment year</li> <li>• Proposing for the performance period in CY 2021 to maintain the Electronic Prescribing objective’s Query of PDMP measure as optional</li> <li>• Proposing for the performance period in CY 2021 to increase the amount of the bonus points for the Query of PDMP measure from 5 points to 10 points to reflect the importance of this measure and to further incentivize clinicians to perform queries of PDMPs</li> <li>• Proposing to rename the Support Electronic Referral Loops by Receiving and Incorporating Health Information Measure to the Support Electronic Referral Loops by Receiving and Reconciling Health Information measure</li> <li>• Proposing an alternative measure for bidirectional exchange through a HIE under the Health Information Exchange objective</li> <li>• CMS believes that incentivizing participation in HIEs that support bi-directional exchange will contribute to a longitudinal care record for the patient and facilitate enhanced care coordination across settings</li> </ul>

- The current COVID-19 PHE has further highlighted the need to encourage interoperable HIE infrastructure and bi-directional exchange across the country that can ensure patients, health care providers, and public health authorities have the data they need to support quality care
- In addition to supporting general care coordination, HIEs can specifically support the PHE response by: enabling enhanced use of telehealth and telemedicine for obtaining and aggregating patient information including when the patient’s health care provider(s) may not be known
  - Particularly for visits with a new health care provider, the HIE may provide an option for health care providers to access critical health information
- In order to incentivize MIPS eligible clinicians to engage in bi-directional exchange through an HIE, CMS is proposing to add the following new measure under the HIE objective beginning with the performance period in 2021: Health Information Exchange (HIE) Bi-Directional Exchange measure
  - Propose to add this new HIE Bi-Directional Exchange measure to the HIE objective as an optional alternative to the two existing measures: the Support Electronic Referral Loops by Sending Health Information measure and the Support Electronic Referral Loops by Receiving and Incorporating Health Information measure
  - Proposing that clinicians either may report the two existing measures and associated exclusions OR may choose to report the new measure
  - Propose that the HIE Bi-Directional Exchange measure would be worth 40 points
  - Proposing the HIE Bi-Directional Exchange measure would be reported by attestation and would require a yes/no response
  - Propose that clinicians would attest to the following:
    - I participate in an HIE in order to enable secure, bi-directional exchange to occur for every patient encounter, transition or referral, and record stored or maintained in the EHR during the performance period.
    - The HIE that I participate in is capable of exchanging information across a broad network of unaffiliated exchange partners including those using disparate EHRs, and does not engage in exclusionary behavior when determining exchange partners.
    - I use the functions of CEHRT for this measure
  - Propose requirement to query for or receive health information for all new and existing patients
  - The new optional measure would require that bi-directional engagement occurs for all patients and for all patient records without exclusion, exception, or allowances made for partial credit

	<ul style="list-style-type: none"> <li>○ To successfully attest to this measure, the eligible clinician must use the capabilities defined for CEHRT to engage in bi-directional exchange via the HIE, which includes exchanging the clinical data within the CCDS or USCDI</li> <li>● <a href="#">Table 42</a> reflects changes to the scoring methodology for the performance period in CY 2021</li> <li>● Proposing to continue the existing policy of reweighting the Promoting Interoperability performance category for NPs, PAs, CRNAs, and CNSs for the performance period in 2021</li> <li>● Proposing to continue the existing policy of reweighting the Promoting Interoperability performance category for physical therapists, occupational therapists, qualified speech-language pathologist, qualified audiologists, clinical psychologists, and registered dieticians or nutrition professionals</li> <li>● In future years of the Promoting Interoperability performance category, CMS will continue to consider changes which support a variety of HHS goals, including: reducing administrative burden; supporting alignment with the Medicare Promoting Interoperability Program; supporting alignment with the 21st Century Cures Act; advancing interoperability and the exchange of health information; and promoting innovative uses of health IT</li> </ul>
Electronic Prescribing of Controlled Substances	<ul style="list-style-type: none"> <li>● In 2020, EPCS has increased to 50 percent of all PDEs being prescribed as compared to 38 percent in 2019</li> <li>● Any electronic controlled substance prescription issued by a practitioner must meet the requirements in the 2010 DEA EPCS interim final rule</li> <li>● Section 2003 of the SUPPORT Act mandates that EPCS begin on January 1, 2021</li> <li>● CMS believes that requiring EPCS by January 1, 2022 strikes the balance between not providing too large of a burden on providers and helping ensure that the benefits of EPCS are leveraged expeditiously</li> <li>● Separate from this rule, CMS plans to conduct future standalone rulemaking to propose penalties for non-compliance</li> <li>● Proposing that all prescribers conduct electronic prescribing of Schedule II, III, IV, and V controlled substances using the NCPDP SCRIPT 2017071 standard by January 1, 2022, except in circumstances in which the Secretary waives the requirement</li> </ul>