ARIZONA TELEMEDICINE PROGRAM

SOUTHWEST TRC TELEHEALTH RESOURCE · CENTER™

Improving Access to Quality Medical Care Webinar Series

Presented by

The Southwest Telehealth Resource Center, Arizona Telemedicine Program, and the Arizona Department of Health Services

Land Acknowledgement

We respectfully acknowledge the University of Arizona is on the land and territories of Indigenous peoples. Today, Arizona is home to 22 federally recognized tribes, with Tucson being home to the O'odham and the Yaqui. Committed to diversity and inclusion, the University strives to build sustainable relationships with sovereign Native Nations and Indigenous communities through education offerings, partnerships, and community service.

Welcome

- SWTRC region
- Fellow HRSA Grantees
- All other participants

The **Arizona Department of Health Services, the Arizona Telemedicine Program,** and **the Southwest Telehealth Resource Center** welcome you to this free webinar series.

The practice & deliver of healthcare is changing, with an emphasis on **improving quality, safety, efficiency, & access to care**.

Telemedicine can help you achieve these goals!

Webinar Tips & Notes

- When you joined the webinar your phone &/or computer microphone was muted
- Time is reserved at the end for Q&A, please use the **Chat function** to ask questions
- Please fill out the post-webinar survey
- Webinar is being recorded
- Recordings will be posted on the ATP website
    - http://telemedicine.arizona.edu/webinars/previous

Carol Yarbrough

Medicare Physicians' Fee Schedule 2023 draft and the Impact on Rural Health

Disclaimer

- The opinions expressed in this presentation and on the following slides are solely those of the presenter and not necessarily those of the organizations sponsoring this webinar. The organizations do not guarantee the accuracy or reliability of the information provided herein.

Objectives

- Updates in the MPFS telehealth billing guidance
- What's new for RHCs
- Updates for the Evaluation and Management (E&M) guidelines

Updates in the draft MPFS: Telehealth Billing Guidance

What Is The Current Status Of Telehealth?

Non-Behavioral Health Specialties

During PHE	For 151 Days Afterwards	Day 152
Inpatient telehealth 95 mod; POS 02 or if on campus, POS 21	Inpatient telehealth 95 mod; POS 02 or if on campus, POS 21	No inpt telehealth because of HRSA, MSA restrictions GY mod, POS 02
Home telehealth 95 mod; POS 11, 19, 22	Home telehealth 95 mod; POS 11, 19, 22	No home telehealth* GY mod, POS 02
Virtual supervision FR mod	Virtual supervision FR mod	None allowed Comments to be subm
Audio only 99441, 99442, 99443	Audio only 99441, 99442, 99443	No audio only

Behavioral Health: Psychiatry, Psychology, Counseling

During PHE	For 151 Days Afterwards	Day 152
Home telehealth 95 mod; POS 11, 19, 22	Home telehealth 95 mod; POS 11, 19, 22	Home telehealth POS 10
No in-person rqmt	No in-person rqmt	In-person rqmt w/in 6 mo new pts; 12 mo est
Virtual supervision FR mod	Virtual supervision FR mod	Psych Virtual supervision
Audio only Bill as if in clinic	Audio only Bill as if in clinic	Audio only Mod FQ (93), POS 10

Eligible Provider Types

During PHE	For 151 Days Afterwards	Day 152
MD, NPP, Beh Hlth, PA, PT, OT, SLP, RT, Audiologist	MD, NPP, Beh Hlth, PA, PT, OT, SLP, RT, Audiologist	MD, NPP, Beh Hlth, PA

RTM Changes … so … many …

2022 Code	2023 Code	What's Same	What's Different
98975	98975	Education/Set-Up	n/a
98976 (resp)	98976	Device code	
98977 (msk)	98977	Device Code	
n/a	989X6 (CBT)	New! Device Code	Contractor Priced
98980	GRTM3	PT, OT, RT, SLP	98975 and 98976 or 98977 must be billed first; at least 16 days data to bill
98981	GRTM4	Add-on for above providers	Same as above
98980 (2)	GRTM1	MD, NPP	98975 and 98976 or 98977 must be billed first; at least 16 days data to bill
98981 (2)	GRTM2	Add-on for above providers	Same as above

You got RPM figured out?

- CMS suggested that 99457/58 also be tied to 99453/99454 being billed first
  - And that 16 days of data be submitted as well

Feeling Inspired to Act? Deadline Sept 6

- The last day to submit comments to the Federal Register/CMS is September 6, 2022
  - As of July 28, there were 3,464 comments submitted
  - You can search on topics to see what other folks said
  - https://www.regulations.gov/document/CMS-2022-0113-1871/comment

How to search the comments

Great time accounting as an argument against tying Management codes on 16 days of data

and throughout the month. Any provider will be concerned that they are allocating time and intra-service work for activities when they run a significant risk that they may not be paid – at all. Again, it is important to note that for MSK therapy to be effective, early, ongoing, and adherent therapy are critical to achieve optimal results.

Here is an example of the problem:

One Month	# of Days Data Transmitted	Clinician RTM Work Minutes
Week 1 (partial week)	3 days	10 minutes
Week 2	4 days	6 minutes
Week 3	4 days	10 minutes
Week 4	3 days	9 minutes
Week 5 (partial week)	1 day	8 minutes
Total	15 days	43 minutes

In this above example, the provider spent 43 minutes over the calendar month reviewing and analyzing the patient's transmitted data, making adjustments to the program and having several interactive communications with the patient to discuss the program and encourage adherence. However, since only 15 days of data were transmitted during the month, none of the time spent would be paid (i.e., initial 20 minutes of time through either GRTM 1 or GRTM 3; nor an additional 20-minute increment through GRTM 2 or GRTM 4) – a significant risk and deterrent for any provider.

Virtual Supervision

Connected Health Initiative – example of other submission

COVID-19 PHE. CHI strongly urges CMS to permit remote supervision as widely as practicable on a permanent basis to help Medicare providers and beneficiaries realize the widely-recognized efficiencies of remote work being realized across countless other sectors of the economy. CHI agrees with CMS' proposal to use a service-level modifier to identify when the requirements for direct supervision have been met using two-way audio/video communications technology or another digital health modality.

CHI reiterates that it does not share CMS' concern (expressed in previous PFS proposed rules) that virtual supervision inherently gives rise to patient safety issues. Numerous clinical staff and auxiliary personnel perform a wide range of tasks while easily and efficiently supervised virtually. Further, such staff categorically do not perform "complex, high-risk, surgical, interventional, or endoscopic procedures, or anesthesia procedures" that CMS has described in the past to explain its concerns with virtual direct supervision. National Plan and Provider Enumeration System (NPPES), to the

https://www.regulations.gov/comment/CMS-2022-0113-4851

Items from the Draft MPFS re ED

Contrary to what you may hear about things being totally different

- The only substantive change is 99281 can be billed by DPH RNs if the patient is triaged and then leaves prior to being seen by an MD or DPH NP
- Maintained the existing principle that time cannot be used as a key criterion for code level selection.
- Editorial revisions to the code descriptors to reflect the code structure approved in the office visits.

What's new for RHCs

Telehealth

- The proposed rule implements the various telehealth provisions established in the Consolidated Appropriations Act of 2022, or the "omnibus" bill and makes necessary technical changes in the regulation for the following:
  - The temporary Public Health Emergency (PHE) medical telehealth flexibilities including reimbursement through G2025, removal of originating and geographic site requirements, and audio-only provision of services are extended for 151-days post PHE. We still await legislative action to make all Medicare telehealth services permanent.
  - The in-person requirement for mental health visits furnished via telehealth, which can now be permanently offered by RHCs, is also waived for 151-days post PHE.

CCM and PCM – Billable by an RHC

- During CY 2022, RHCs bill HCPCS code G0511 for any of the services described by codes 99484, 99487, 99490, 99491, 99424, and 99426. G0511 pays a consolidated fee schedule amount, $79.25 in 2022, which is the average of the Physician Fee Schedule (PFS) rate for these CCM and principal care management (PCM) services furnished by a physician or other qualified health care professional.
- In this proposed rule, CMS proposed new care management codes for Chronic Pain Management (CPM) and General Behavioral Health Integration (GBHI) that can be reimbursed in RHCs and FQHCs, also by using the general care management code G0511. These codes can be billed alone or in addition to the AIR payment.

Pain Management

CMS proposed two new HCPCS codes to describe the services available under Chronic Pain Management (CPM).

"(1) HCPCS codes GYYY1: Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care, e.g. physical therapy and occupational therapy, and community based care, as appropriate. Required face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; first 30 minutes personally provided by physician or other qualified health care professional, per calendar month. (When using GYYY1, 30 minutes must be met or exceeded.)

and (2) HCPCS code GYYY2: Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month)."

Comment submitted by NARHC

- NARHC appreciates the ways in which CMS continues to expand upon the care management services billable within RHCs. GYYY1 however, which serves as the placeholder code until the development of a CPT code, appears to meet the definition of an RHC encounter and therefore we believe should be billed as an RHC visit and reimbursed at the RHC's All-Inclusive Rate (AIR). It is concerning that a service which clearly meets the definition of an encounter is being considered by CMS as a care management code, and we will include this discrepancy in our comments.

General Behavioral Health Integration

- As clinical psychologists (CPs) and clinical social workers (CSWs) are statutorily authorized to be providers in the RHC setting, CMS proposes that when these practitioners provide services described by GBHI1, the RHC can bill G0511 beginning January 1, 2023. GBHI1 is described as:
  - “Care management services for behavioral health conditions, at least 20 minutes of clinical psychologist or clinical social worker time, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, coordination with and/or referral to physicians and practitioners who are authorized by Medicare law to prescribe medications and furnish E/M services, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team.”

Updates for the Evaluation and Management (E&M) guidelines (2023 draft)

2023 E&M Guideline Updates

- Deletion of observation CPT codes (99217-99220, 99224-99226) and merged into the existing hospital care CPT codes (99221-99223, 99221-99233, 99238-99239).
- Editorial revisions to the code descriptors to reflect the code structure approved in the office visit revisions.

Consultations

- Deletion of confusing guidelines, including the definition of “transfer of care."
- Deletion of lowest level office (99241) and inpatient (99251) consultation codes to align with four levels of MDM

2023: no more HPI, ROS, Unneeded PE elements

History and/or Examination

►E/M codes that have levels of services include a medically appropriate history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information, and the patient or caregiver may supply information directly (eg, by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of the level of these E/M service codes.◄

2023: Time and MDM Over-riding elements

Physician or other qualified health care professional time includes the following activities, when performed:

- preparing to see the patient (eg, review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- care coordination (not separately reported) ◀

Do not count time spent on the following:

- the performance of other services that are reported separately
- travel
- teaching that is general and not limited to discussion that is required for the management of a specific patient

▲**99221** **Initial hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making.

When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

▲**99222** **Initial hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.

▲**99223** **Initial hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded.

►(For services of 90 minutes or longer, use prolonged services code 993X0)◄

★▲**99231** **Subsequent hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making.

When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded.

★▲**99232** **Subsequent hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.

★▲**99233** **Subsequent hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

2023: MDM description in the guidelines is super extensive

MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM is defined by three elements. The elements are:

- ***The number and complexity of problem(s) that are addressed during the encounter.***
- ***The amount and/or complexity of data to be reviewed and analyzed.*** These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported separately. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Ordering a test may include those considered but not selected after shared

MDM Continued

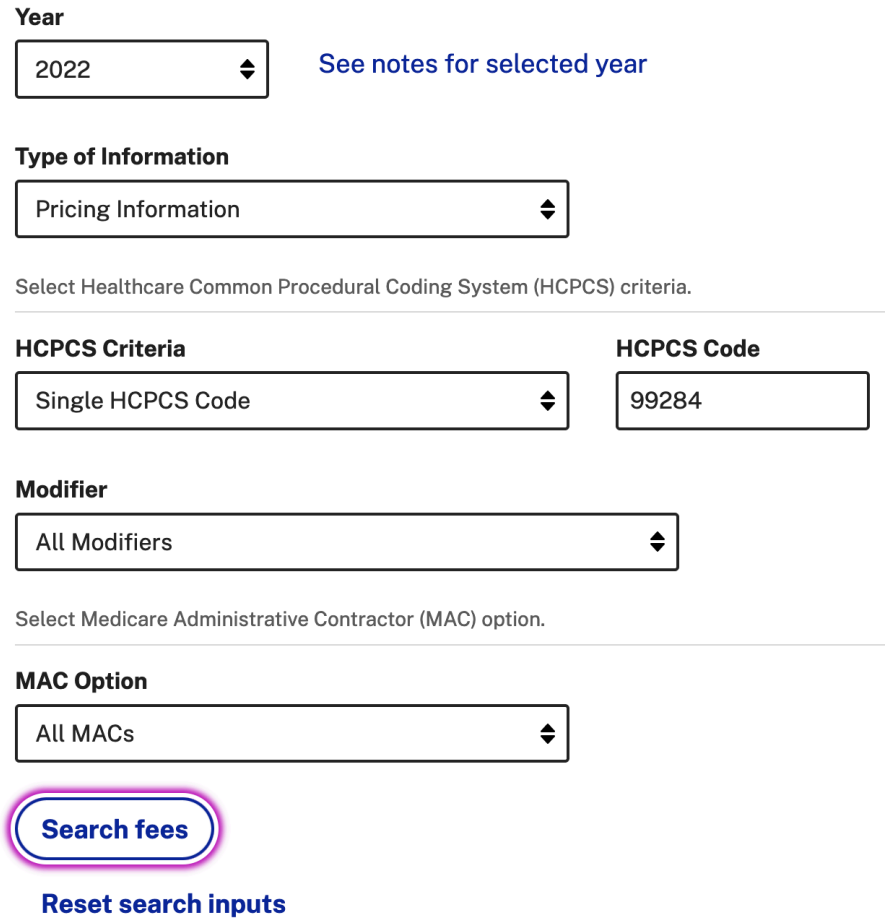
- ***The risk of complications and/or morbidity or mortality of patient management*** . This includes decisions made at the encounter associated with diagnostic procedure(s) and treatment(s). This includes the possible management options selected and those considered but not selected after shared decision making with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.

End Notes

Proposed Legislation

- Connect for Health Act
  - No geographic restrictions
  - Expands originating site locations
  - Provision of tech to Medicare beneficiaries is not remuneration (no fraud)
- Telehealth Expansion and Evaluation Act
  - Also removes geographic restrictions
  - Two-year extension of Covid waivers
- Advancing Telehealth Beyond Covid-19 Act of 2022
  - Passed House; now onto Senate
  - Removes geo restrictions
  - Reimb for telehealth for pts at home
  - Expanded list of providers
  - Audio only for all types of visits

Cool Tool



- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup

Resources and Thanks

- Special thanks to Sarah Hohman, Deputy Director of Government Affairs
  - https://www.narhc.org/News/29438/2023-Medicare-Physician-Fee-Schedule-Proposed-Rule-and-HPSA-Proposed-for-Withdrawal-Status-Update
- https://www.aafp.org/dam/AAFP/documents/advocacy/payment/medicare/ES-2023MPFSProposedRule-072222.pdf
- https://www.federalregister.gov/documents/2022/07/29/2022-14562/medicare-and-medicaid-programs-cy-2023-payment-policies-under-the-physician-fee-schedule-and-other
- https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

QUESTIONS

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https://www.surveymonkey.com/r/2022Webinar-SWTRC-ATP

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