HEALTHCARE REGULATORY ROUND-UP - Episode #39

2023 Medicare Physician Fee Schedule Final Rule: Part I

December 7, 2022

Introductions

Martie Ross, JD
mross@pyapc.com
Director, PYA Center for Rural Health Advancement

pyapc.com
800.270.9629

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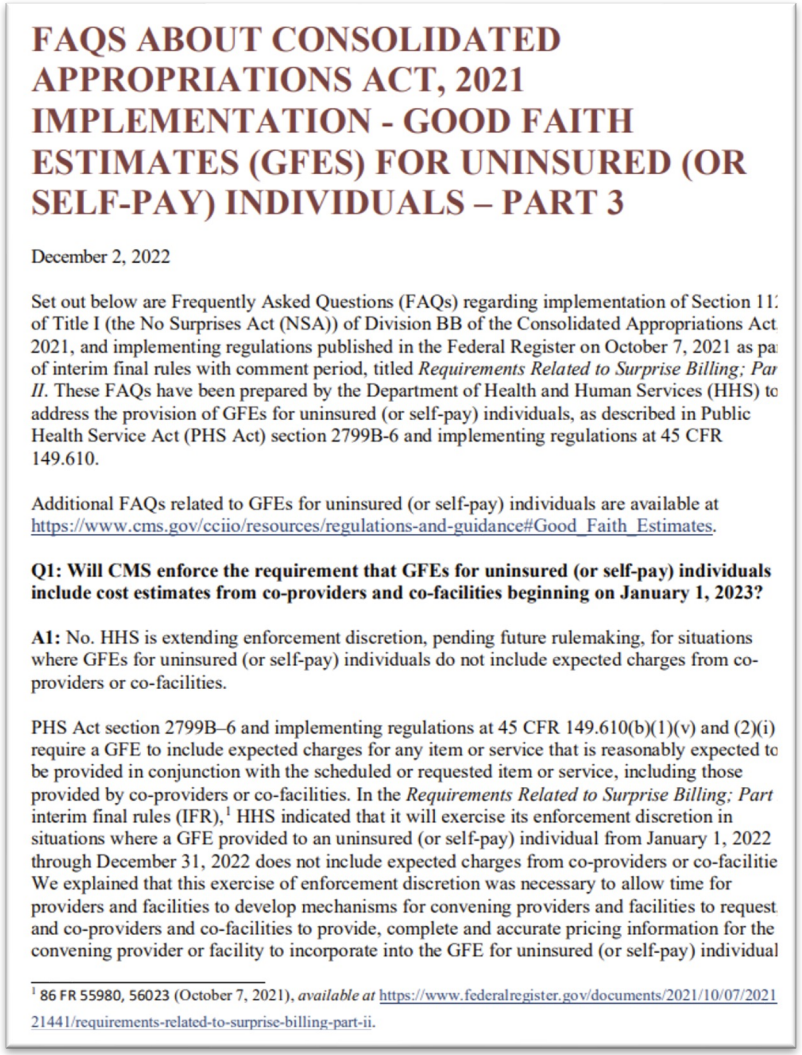
Agenda

1. Conversion Factor
2. Telehealth Services
3. Behavioral Health Services
4. Chronic Pain Management
5. Remote Therapeutic Monitoring
6. Colorectal Cancer Screening
7. RHCs and FQHCs
8. Medicare Shared Savings Program

But First … Some Good News!

- CMS indefinitely delaying enforcement of GFE co-provider/co-facility cost estimate requirement
- "HHS believes that to achieve industry-wide interoperability for the transmission of GFE data between convening providers and facilities and co-providers and co-facilities, the next step is for providers and facilities market-wide to adopt a standards-based application programming interface (API) for this purpose."
- "[A]ny rulemaking to fully implement the requirements . . .related to uninsured (or self-pay) individuals will include a prospective applicability date that gives providers and facilities a reasonable amount of time to comply with any new requirements."



FAQS ABOUT CONSOLIDATED APPROPRIATIONS ACT, 2021 IMPLEMENTATION - GOOD FAITH ESTIMATES (GFES) FOR UNINSURED (OR SELF-PAY) INDIVIDUALS – PART 3

December 2, 2022

Set out below are Frequently Asked Questions (FAQs) regarding implementation of Section 11 of Title I (the No Surprises Act (NSA)) of Division BB of the Consolidated Appropriations Act 2021, and implementing regulations published in the Federal Register on October 7, 2021 as pa of interim final rules with comment period, titled *Requirements Related to Surprise Billing; Par II*. These FAQs have been prepared by the Department of Health and Human Services (HHS) to address the provision of GFEs for uninsured (or self-pay) individuals, as described in Public Health Service Act (PHS Act) section 2799B-6 and implementing regulations at 45 CFR 149.610.

Additional FAQs related to GFEs for uninsured (or self-pay) individuals are available at https://www.cms.gov/cciio/resources/regulations-and-guidance#Good_Faith_Estimates.

Q1: Will CMS enforce the requirement that GFEs for uninsured (or self-pay) individuals include cost estimates from co-providers and co-facilities beginning on January 1, 2023?

A1: No. HHS is extending enforcement discretion, pending future rulemaking, for situations where GFEs for uninsured (or self-pay) individuals do not include expected charges from co-providers or co-facilities.

PHS Act section 2799B–6 and implementing regulations at 45 CFR 149.610(b)(1)(v) and (2)(i) require a GFE to include expected charges for any item or service that is reasonably expected to be provided in conjunction with the scheduled or requested item or service, including those provided by co-providers or co-facilities. In the *Requirements Related to Surprise Billing; Part* interim final rules (IFR),[1] HHS indicated that it will exercise its enforcement discretion in situations where a GFE provided to an uninsured (or self-pay) individual from January 1, 2022 through December 31, 2022 does not include expected charges from co-providers or co-facilitie We explained that this exercise of enforcement discretion was necessary to allow time for providers and facilities to develop mechanisms for convening providers and facilities to request and co-providers and co-facilities to provide, complete and accurate pricing information for the convening provider or facility to incorporate into the GFE for uninsured (or self-pay) individual

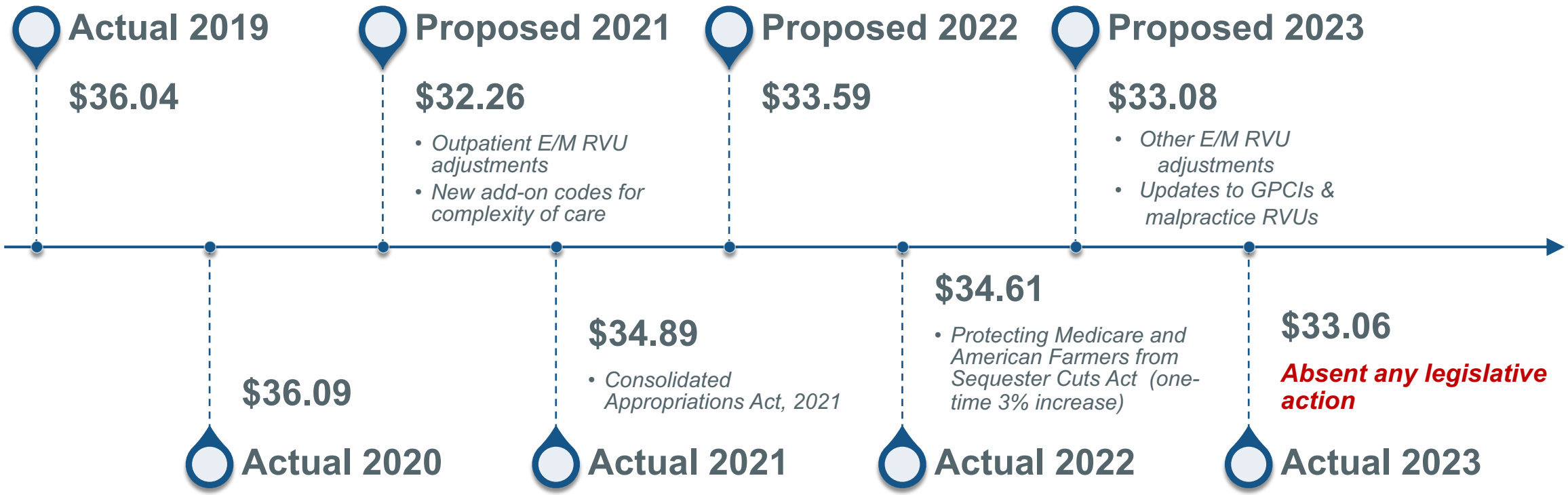
[1] 86 FR 55980, 56023 (October 7, 2021), *available at* https://www.federalregister.gov/documents/2021/10/07/2021-21441/requirements-related-to-surprise-billing-part-ii.

1. Conversion Factor

Calculating Fee Schedule Payments

- **Relative value for the service**
  - Work
  - Practice expense
  - Malpractice expense
- **Conversion factor** (RVU x CF = national payment rate)
  - Dollar amount based on statutory cap on MPFS spending
  - Sustainable Growth Rate replaced in 2015 by MACRA annual adjustment factor
    - 0 adjustment factor for 2020 to 2025
  - Any increases or decreases in RVUs may not cause the amount of Medicare Part B expenditures for the year to differ by > $20 million from what expenditures would have been in the absence of these changes
  - If this threshold is exceeded, CF adjusted to preserve budget neutrality
- **Geographic adjustment factor**
  - Reflects variation in practice costs between metropolitan and non-metropolitan areas between and regions
  - Specific RVU adjustment for each MSA and non-MSA area of state
    - Average = 1 (i.e., if Region A = 1.2, then Region B = 0.8)

Conversion Factor – A Brief History (2019 – 2023)



CY2023 Proposed vs. Conversion Factor

Proposed

CY 2022 Conversion Factor		34.6062
Conversion Factor without CY 2022 Protecting Medicare and American Farmers from Sequester Cuts Act		33.5983
Statutory Update Factor	0.00 percent (1.0000)	
CY 2023 RVU Budget Neutrality Adjustment	-1.55 percent (0.9845)	
CY 2023 Conversion Factor		**33.0775**

Final

CY 2022 Conversion Factor		34.6062
Conversion Factor without CY 2022 Protecting Medicare and American Farmers from Sequester Cuts Act		33.5983
Statutory Update Factor	0.00 percent (1.0000)	
CY 2023 RVU Budget Neutrality Adjustment	-1.60 percent (0.9840)	
CY 2023 Conversion Factor		**33.0607**

More (Really) Bad News

- The Statutory Pay-As-You-Go Act of 2010 (Statutory PAYGO) requires mandatory spending and revenue legislation not increase the federal budget deficit
  - When legislation implemented without offsets or exceptions, OMB must implement sequestration cuts to certain types of mandatory federal spending, including Medicare provider payments
  - At present, there's a 2% sequestration cut to Medicare payments in effect through FY2031
- The 2021 American Rescue Plan did not include any offsets or exceptions, thus triggering 4% sequestration cut to Medicare payments
  - The Protecting Medicare and American Farmers from Sequester Cuts Act deferred this cut through 12/31/22
  - Absent new legislation, 4% cut takes effect 1/1/23 (for all Medicare payments, not just MPFS)
  - At present, unclear how the current 2% cut and this 4% cut will be implemented
    - Congressional Research Service (March 2022): "If a PAYGO sequester were to be triggered in 2023 or another future fiscal year, neither the Statutory PAYGO Act nor the Budget Control Act include any explicit directions as to how the two sequesters would be implemented alongside each other."
  - Worst case scenario: Conversion factor goes from $33.91 (current 2% cut) to $31.08 – an **8.36% reduction**

2. Telehealth Services

Medicare Telehealth Coverage Pre-COVID-19

Section 1834(m)

1. **Geographic** - Patient must reside in rural area
2. **Location** - Patient must be physically present at healthcare facility when service is provided (facility fee)
3. **Service** – Coverage limited to CMS' list of approved telehealth services (CPT and HCPCS codes)
4. **Provider** – Service must be provided by physician, non-physician practitioner, clinical psychologist, clinical social worker, registered dietician, or nutrition professional (excludes therapists and RHCs/FQHCs)
5. **Technology** - Must utilize telecommunications technology with audio *and* video capabilities that permits real-time interactive communication.

Medicare Coverage Pre-COVID-19

With Some Exceptions

- **Telestroke**
  - Effective 01/01/2019, geographic and location requirements do not apply to services furnished to diagnose, evaluate, or treat symptoms of acute stroke
- **ESRD**
  - Effective 01/01/2019, geographic and location requirements do not apply to ESRD services relating to home dialysis
- **Substance Use Disorder**
  - Effective 07/01/2019, geographic and location requirements do not apply to services relating to SUD and co-occurring behavioral health conditions
- **Medicare Advantage**
  - Beginning in 2020 plan year, MA plan may eliminate geographic and location requirements
- **Medicare Shared Savings Program**
  - Waiver of geographic and location requirements for ACO participants in risk models
- **CMMI Initiatives**

Medicare Telehealth Coverage Expansion

1. Legislative Action

- Waived *geographic* and *location* restrictions for duration of PHE; authorized Secretary to waive other Section 1834(m) requirements for duration of PHE

2. CMS Interim Final Rules

- Suspends certain *service* restrictions for duration of PHE
  - Expands list of covered services
  - Eliminates frequency requirements
  - Permits use of telehealth for required face-to-face visits, direct supervision for incident-to billing, teaching physician presence
- Suspends certain *provider* restrictions for duration of COVID-19 PHE
  - Waives Medicare state licensure requirement (but not state law requirements)
  - Permits therapists and S/L pathologists to provide covered services via telehealth
  - Permits FQHCs and RHCs to bill for telehealth services under HCPCS G2025
  - Permits billing for hospital outpatient department and CAH services furnished via telehealth
- Authorizes payment for certain audio-only E/M services (CPT 98966-68, 99441-43)
- Provides reimbursement for telehealth services at higher non-facility rates to compensate practices for telehealth-associated costs

3. Other Agencies' Actions

- OIG - waivers of co-payments
- OCR - HIPAA compliance
- DEA – Prescription of controlled substances

Tele-Behavioral Health

- Consolidated Appropriations Act, 2021 – eliminate geographic and location restrictions for diagnosis, evaluation, and treatment of mental health disorder
- Must have in-person, non-telehealth service by practitioner in same practice as billing practitioner within 6 months prior to initial telehealth service + each 12 months thereafter
  - 6-month in-person visit requirement does not apply if beneficiary initiated telehealth services during PHE (or during 151-day post-PHE period)
  - Exceptions to the 12-month in-person visit requirement may be made based on beneficiary circumstances (with reason documented in beneficiary's medical record)
- May use audio-only communication technology (vs. audio/video required for other telehealth services) but only if -
  - Practitioner has audio/video capability + beneficiary lacks capacity or refuses to use video connection
    - Documented in medical record + include service-level modifier on claim

Telehealth Flexibility Extensions

Enacted March 15, 2022

- Extend for 151 days post-PHE certain PHE-related telehealth policies for services included on Medicare Telehealth Services List as of date of enactment –
  - ✓ Continuation of waiver of geographic and location requirements
  - ✓ Continuation of reimbursement for therapist and S/L pathologist telehealth services
  - ✓ Continuation of reimbursement for audio-only services
  - ✓ Continuation of FQHCs and RHCs for telehealth services
  - ✓ Continuation of use of telehealth to recertify eligibility for hospice case
  - ✓ Delay in in-person requirement for initiation of tele-behavioral health services

Medicare Telehealth Services List

- Extend coverage for all services included on temporary basis for 151 days post-PHE (including those added *after* 3/15/22)
  - https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
- Identify those services included on temporary basis for which coverage will not be continued through 12/31/23 (Table 12). Does NOT include -
  - Telephone E/M visit codes (CPT 99441-43)
  - Initial care (observation, hospital, nursing facility, domiciliary/rest home, home)
- Add new Category I codes

HCPCS	Short Descriptor
G0316	Prolonged inpatient or observation services by physician or other QHP
G0317	Prolonged nursing facility services by physician or other QHP
G0318	Prolonged home or residence services by physician or other QHP
G3002	Chronic pain tx monthly b
G3003	Addition 15m pain mang

HCPCS	Short Descriptor
90875	Psychophysiological therapy
90901	Biofeedback train any meth
92012	Eye exam estab pat
92014	Eye exam & tx estab pt 1/>vst
92507	Speech/hearing therapy
92550	Tympanometry & reflex thresh
92552	Pure tone audiometry air
92553	Audiometry air & bone
92555	Speech threshold audiometry
92556	Speech audiometry complete
92557	Comprehensive hearing test
92563	Tone decay hearing test
92565	Stenger test pure tone
92567	Tympanometry
92568	Acoustic refl threshold tst
92570	Acoustic immitance testing
92587	Evoked auditory test limited
92588	Evoked auditory tst complete
92601	Cochlear implt f/up exam <7
92625	Tinnitus assessment
92626	Eval aud funcj 1st hour
92627	Eval aud funcj ea addl 15
94005	Home vent mgmt supervision
95970	Alys npgt w/o prgrmg
95983	Alys brn npgt prgrmg 15 min
95984	Alys brn npgt prgrmg addl 15
96105	Assessment of aphasia
96110	Developmental screen w/score
96112	Devel tst phys/qhp 1st hr
96113	Devel tst phys/qhp ea addl
96127	Brief emotional/behav assmt
96170	Hlth bhv ivntj fam wo pt 1st
96171	Hlth bhv ivntj fam w/o pt ea
97129	Ther ivntj 1st 15 min
97130	Ther ivntj ea addl 15 min
97150	Group therapeutic procedures
97151	Bhv id assmt by phys/qhp
97152	Bhv id suprt assmt by 1 tech
97153	Adaptive behavior tx by tech
97154	Grp adapt bhv tx by tech
97155	Adapt behavior tx phys/qhp
97156	Fam adapt bhv tx gdn phy/qhp
97157	Mult fam adapt bhv tx gdn
97158	Grp adapt bhv tx by phy/qhp
97530	Therapeutic activities
97537	Community/work reintegration
97542	Wheelchair mngment training
97763	Orthc/prostc mgmt sbsq enc
98960	Self-mgmt educ & train 1 pt
98961	Self-mgmt educ/train 2-4 pt
98962	Self-mgmt educ/train 5-8 pt
99473	Self-meas bp pt educaj/train
0362T	Bhv id suprt assmt ea 15 min
0373T	Adapt bhv tx ea 15 min

Post-PHE Telehealth – Claims Submission and Payment

- Through Day 151 -
  - Payment at non-facility rate will continue for claims with modifier 95
  - Report POS code that would have been reported if service furnished face-to-face
- Day 152 and thereafter –
  - Discontinue modifier 95; use POS 02 (telehealth provided other than patient's home) or POS 10 (telehealth provided in patient's home (ESRD, SUD, behavioral health)
  - Payment at lower facility rate ("We believe that the facility payment amount best reflects the practice expense, both direct and indirect, involved in furnishing services via telehealth")
  - Include modifier 93 for audio-only services (only permitted for SUD, behavioral health)
  - Continue to use FR modifier for "incident to" telehealth services to indicate billing practitioner furnished direct supervision via real-time audio/visual technology
- CMS will issue sub-regulatory guidance as needed to implement Telehealth Flexibilities Extension following end of PHE

Direct Supervision

- Required for incident-to billing, certain diagnostic tests, pulmonary rehab, cardiac rehab, and intensive cardiac rehab
- Current status
  - Pre-PHE: Supervising practitioner physically present and immediately available to provide assistance
  - During PHE: Virtual presence using real-time audio/video technology
  - Post-PHE: Continue virtual presence through December 31 of year in which PHE ends; thereafter, revert to physical presence requirement
- “allowing additional time to collect information and evidence for direct supervision through virtual presence will help us better understand the potential circumstances in which this flexibility could be appropriate permanently”

3. Behavioral Health Services

Incident To Services

- Clarifies that any service furnished primarily for diagnosis or treatment of mental health or substance use disorder can be furnished by auxiliary personnel (e.g., licensed professional counselor, Licensed Marriage & Family Counselor) incident to physician's or non-physician practitioner's professional services
- Creates new exception to direct supervision requirement (i.e., permitting general supervision) for behavioral health services furnished by auxiliary personnel
  - Auxiliary personnel must meet any state licensure requirements for furnishing such services
  - Must satisfy other incident to requirements (services provided consistent with established course of treatment)

General BHI – CPT G0323

- Existing reimbursement under CPT 99484 – 20 minutes/month of assessment and care management services for behavioral health condition performed by clinical staff under general supervision of physician/non-physician practitioner
- Permit clinical psychologist or clinical social worker to bill for similar service under CPT G0323
  - CP or CSW must perform initiating visit that meets requirements for CPT 90791 (integrated biopsychosocial assessment, including history, mental status, and recommendations)
  - General supervision for incident to billing
  - Same reimbursement as CPT 99484 ($41.99)

4. Chronic Pain Management

Chronic Pain Management

- Monthly bundle of chronic pain management and treatment services
  - Bundle includes diagnosis; assessment and monitoring; administration of pain rating scale; care plan development and maintenance; overall treatment management; coordination of behavioral health treatment; medical management; health literacy; crisis care; care coordination with other providers
  - In-person components may be furnished via telehealth (if applicable requirements are met)
- Prerequisites
  - Chronic pain diagnosis (persistent/recurrent pain lasting longer than 3 months)
  - Initial face-to-face visit (min. 30 minutes)
  - Verbal consent
- Reimbursement
  - G3002 ($79.01) – first 30 minutes/month personally performed by billing practitioner
  - G3003 ($28.76) – each additional 15 minutes/month

5. Remote Therapeutic Monitoring

Remote Therapeutic Monitoring

- Maintain current treatment management codes (CPT 98980 and 98981) and permit these services to be furnished under general supervision
  - Had proposed to create new codes for services furnished by PT, OT, or SLPs under therapy plan of care
- Clarification of billing rules
  - Must bill CPT 98975 and 98976/98977 (initial patient education and monthly monitoring) prior to reporting treatment management services
  - Cannot bill RPM services, cardiac device evaluations, or blood pressure self-monitoring in same month as RTM

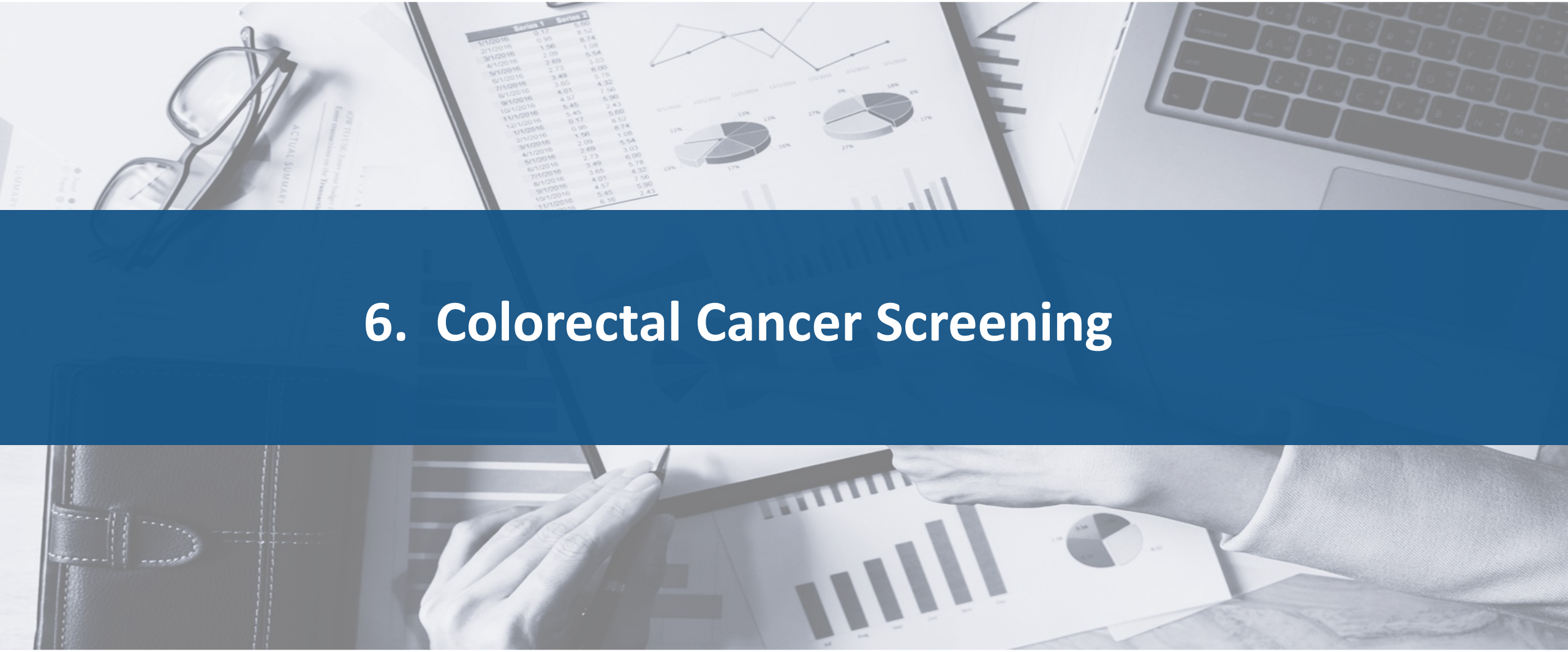
Cognitive Behavioral Therapy Monitoring

- Presently, RTM limited to respiratory system (CPT 98976) and musculoskeletal system (CPT 98977)
- Expanding RTM to include CPT 989X6, monitoring for cognitive behavioral therapy
  - Because technology still evolving, will remain contractor priced

"We appreciate the continuing dialogue about the remote monitoring codes and welcome comments including any additional information that …. may provide further clarity on how remote patient monitoring services are used in clinical practice, and how they would be most appropriately coded, billed and valued under the Medicare PFS."

Other Virtual Services

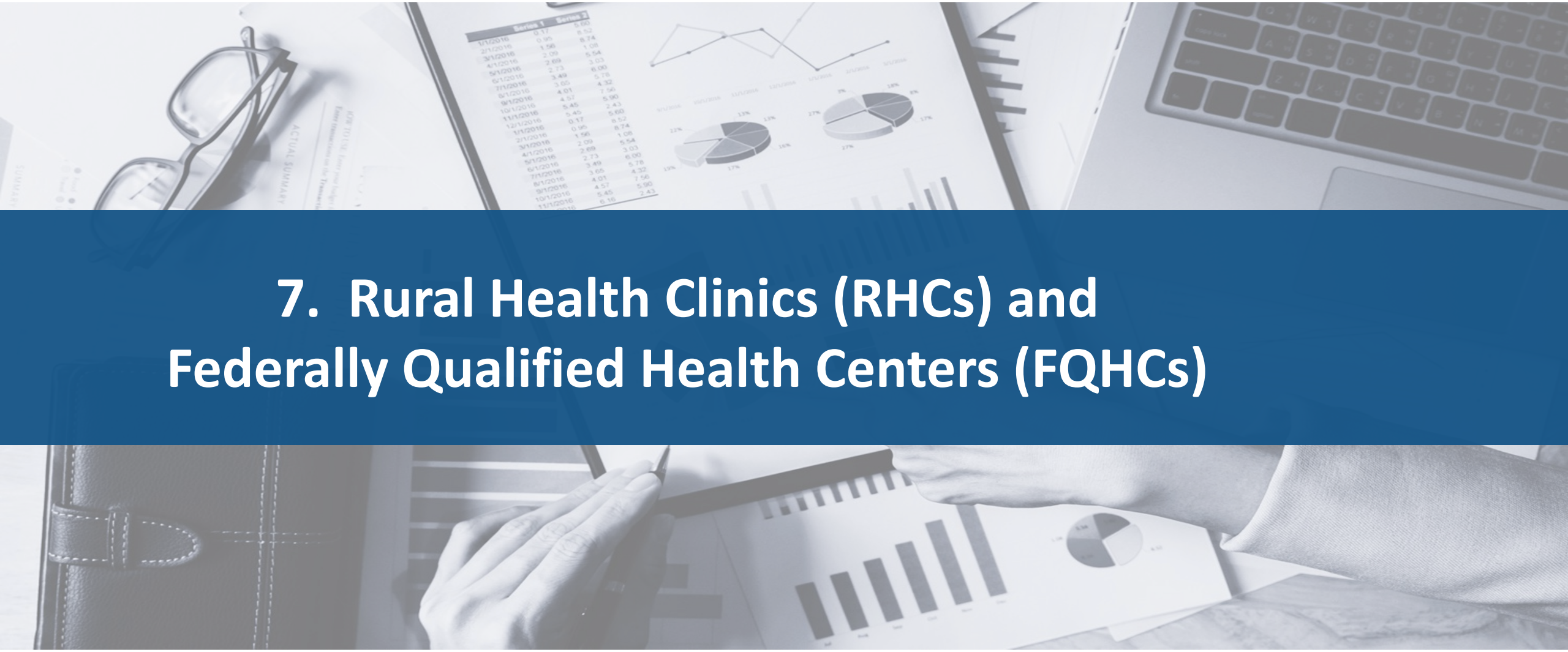
- No proposals relating to transitional care management, chronic care management, or remote physiologic monitoring
  - Generalize RTM billing rules to RPM (e.g., cannot bill treatment management services unless also billing for monthly monitoring)?
  - 2023 Addendum B reflects ~8% reduction in RVUs (and thus reimbursement) for CPT 99454 (RPM monthly monitoring)



6. Colorectal Cancer Screening

Expanded Coverage

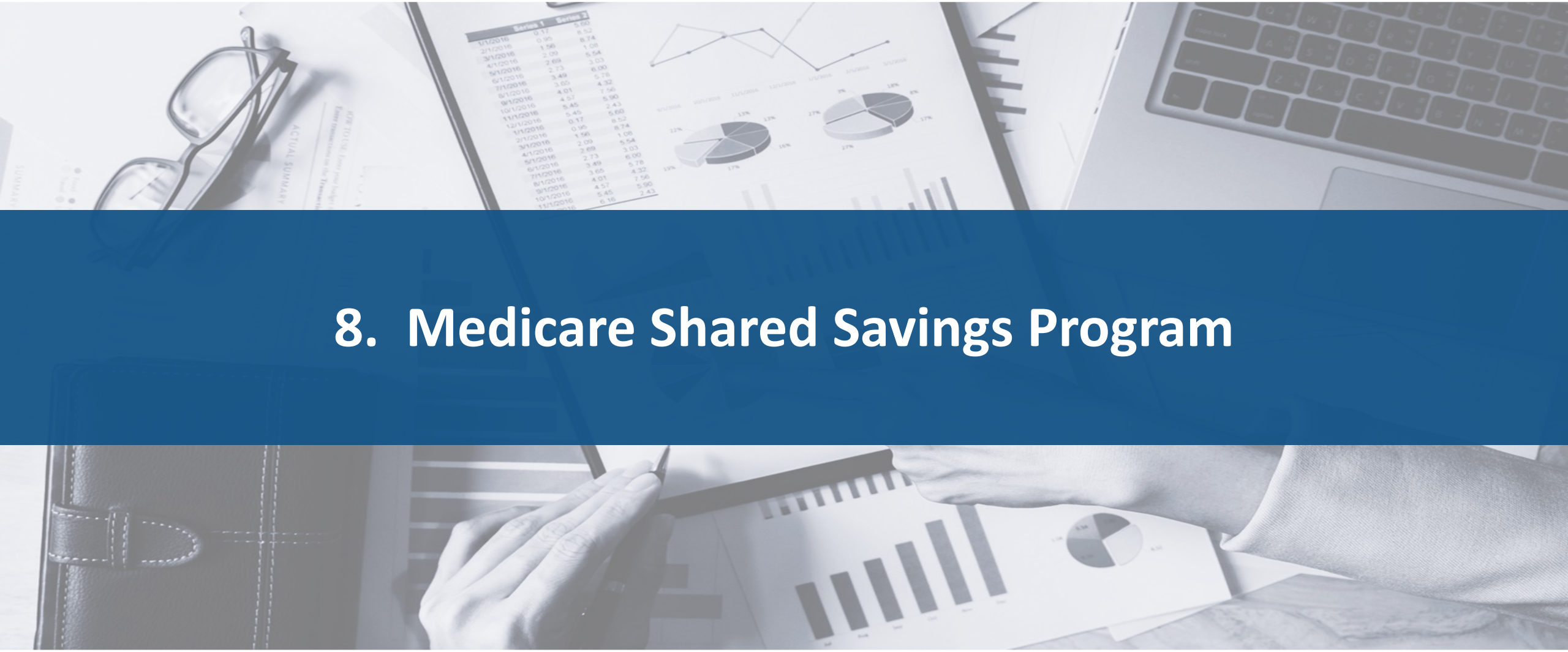
- Reduce minimum age payment and coverage limitation from 50 to 45 years
  - Consistent with recommendation from U.S. Preventive Services Task Force
- Expand definition to of colorectal cancer screening to include follow-on screening colonoscopy when results of stool-based screening test are positive
  - Previously treated such colonoscopy as diagnostic procedure, meaning beneficiary would be responsible for co-insurance



7. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

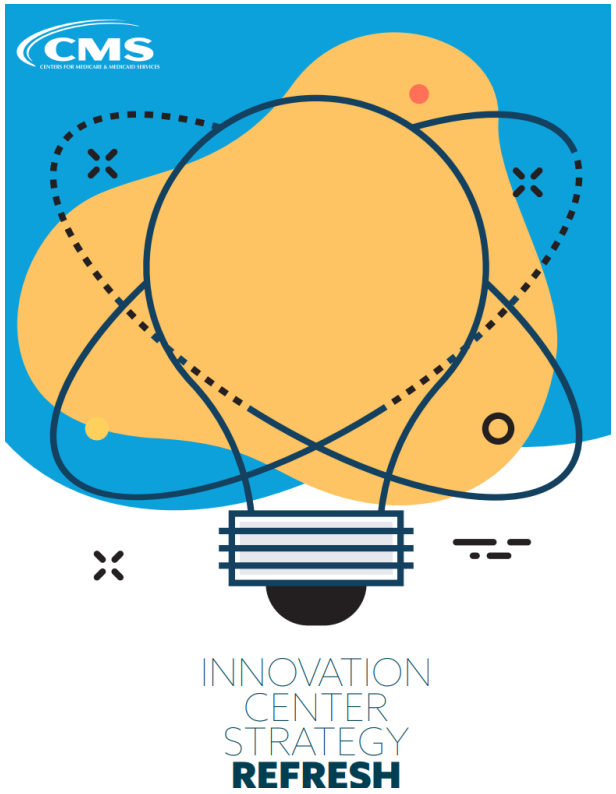
Changes Impacting RHCs and FQHCs

- 2023 telehealth reimbursement rate (through Day 152 post-PHE) $95.88 (down from $97.24 in 2022)
  - RHCs and FQHCs bill all telehealth services under HCPCS code G2025
- Conforming amendments to provide coverage for tele-behavioral health services furnished by RHCs and FQHCs post-pandemic (with payment at same rate as in-person services)
- 2023 RHC payment limit
  - Independent RHCs + non-grandfathered provider-based RHCs - $126.00 (up from $113 in 2022)
  - Grandfathered provider-based RHCs – 2022 rate increased by 3.8% (or $126.00, if greater)
- Care Management Services
  - Services that meet the requirements for care management and general behavioral health codes (CPT 99490, 99487, 99484, and 99491) and principal care management (CPT 99424 and 99425) billed under G0511, with payment equal to average non-facility rate for these codes ($79.25 in 2022)
  - Will expand G0511 to include services that meet the requirements for chronic pain management or general BHI furnished by clinical psychologists and clinical social workers, with no impact on payment calculation
  - RHCs and FQHC still not eligible for reimbursement for RPM or RTM



8. Medicare Shared Savings Program

CMS Accountable Care Strategy



- By 2030, all traditional Medicare beneficiaries and most Medicaid beneficiaries will be in care relationships with accountability for quality and total cost of care
  - Advanced primary care models
  - Specialty episodic payment models
  - Accountable care organizations
- Tactics
  - Engage providers
  - Improve benchmarking and performance measures
  - Enable provider participation in downside risk

https://innovation.cms.gov/strategic-direction-whitepaper

MSSP Changes

1. Delay mandatory transition to two-sided risk
2. Improve benchmarks
3. Add health equity adjustment
4. Provide advanced shared savings payments
5. Update quality scoring metrics
6. Reduce administrative burden

1. Transition to Two-Sided Risk

- Since 2019, ACOs required to transition to two-sided risk within 2 years
  - CMS waived requirement for PY 2021 and PY 2022
    - For PY 2021, 89% of eligible ACOs remained in one-sided risk; 74% did the same in PY 2022
- For PYs 2023 and 2024 , ACOs presently in one-sided risk can elect to remain at current level for remainder of agreement
- Beginning in PY 2024, ACOs inexperienced with downside risk may remain in one-sided risk for up to 7 years (initial 5-year agreement + first 2 years of second 5-year agreement)

2. Benchmark Methodology

- Include Accountable Care Prospective Trend (in addition to national and regional growth rates) to account for impact of MSSP participation on relevant market
- Incorporate prior savings adjustment in historical benchmarks for renewing and re-entering ACOs to mitigate rebasing ratchet effect
- Reduce impact of negative regional adjustment and revise calculation of regional factors
- Revise application of 3% cap on positive prospective HCC risk score growth to better account for high-cost populations (apply cap in aggregate across the 4 Medicare enrollment types)
- No changes to address reduction in utilization in 2020, at least for now

3. Health Equity Adjustment

- Upward adjustment to MIPS quality performance category score for those ACOs serving underserved populations (based on Area Deprivation Index and proportion of dual eligible beneficiaries)
  - “will possibly lead to higher shared savings or reduced shared losses for a broader array of ACOs treating underserved population”

4. Advance Investment Payments

- Option for new (not renewing or re-entering) ACOs whose participants' total Medicare revenue is less than 35% of total Medicare expenditures for ACOs' assigned beneficiaries (low volume ACOs)
- Receive one-time payment of $250,000 + 8 quarterly payments based on characteristics of attributed beneficiaries
- Restricted use of funds
  - Improve provider infrastructure
  - Increase staffing
  - Provide accountable care for underserved beneficiaries (e.g., addressing social needs)
- Payments recouped from future savings; no repayment obligation if no savings (unless terminate participation)
- Same ACOs will receive savings even if do not meet minimum savings rate

5. Quality Measures

- Re-institute use of sliding scale approach to determine shared savings based on quality score (vs. all-or-nothing approach)
- Extend through PY 2024 incentive for reporting eCQMs/MIPS CQMs (to align with the sunsetting of the CMS Web Interface reporting option)
- Adopt benchmarking policies to establish quality measure benchmarks and minimum attainment level for CMS Web Interface measures for PYs 2022, 2023 and 2024

6. Administrative Burden

- Reduce frequency with which beneficiary information notices must be provided (once per agreement period with follow-up communication within 180 days of providing notice)
- Eliminate requirement to submit marketing materials to CMS for review and approval prior to dissemination
- Modifications to streamline the SNF 3-day rule waiver application review process
- Update data sharing regulations to permit ACOs acting as organized health care agreements (OHCAs) to request aggregate reports and beneficiary-identifiable claims data from CMS
- Permit ACOs to structure themselves as OHCAs to reduce burden with reporting eCQMs/MIPS CQMs

Our Next Regulatory Round-Ups

2023 Medicare Physician Fee Schedule Final Rule, Part II – December 14

E/M Changes, Split/Shared Visits, Audiology Services, Dental and Oral Health Services

2023 Medicare Physician Fee Schedule Final Rule, Part III – January 11

Quality Payment Program Update

Register at www.pyapc.com

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