Proposed CY 2020 Physician Fee Schedule

On July 29, 2019, the Center for Medicare and Medicaid Services (CMS) published their CY 2020 proposed revisions related to the Physicians Fee Schedule (PFS). Comments on the proposals are due no later than 5 pm on September 27, 2019. For items related to telehealth, CMS is proposing to add three new codes for a bundled episode of care for treatment of opioid use disorder to the list of services that are eligible for telehealth reimbursement. Additionally, CMS is proposing a bundled payment structure for opioid use disorder (OUD) treatment by opioid treatment programs (OTPs), and would allow the counseling and therapy (face-to-face) components to be delivered via live interactive video under the proposed rule. CMS is also taking steps to further refine the codes for transitional care management (TCM) and chronic care management (CCM), and create new codes for principal care management (PCM) services for patients that have only one serious chronic condition. Finally, CMS is requesting comments on consent requirements for technology-based communication services. Each of these elements is discussed in detail below.

ADDITION OF MEDICARE TELEHEALTH SERVICES

CMS has an established process for adding codes to the list of Medicare telehealth services eligible for reimbursement. The process includes assigning qualifying requests to either one of two categories. Category 1 is reserved for services that are similar to services already approved on the Medicare telehealth list such as professional consultations, office visits and office psychiatry services. Category 2 (which entails a more extensive qualification process) is for services that are not similar to current telehealth services on the Medicare list, but pose a significant benefit for the patient. For the CY 2020 proposed PFS, CMS did not receive any requests from the public to add new codes. Instead, CMS proposes to add three newly created codes, which are detailed in subsequent sections of the PFS, for office-based treatment for OUD.

- **HCPCS code GYYY1**: Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month.
- **HCPCS code GYYY2**: Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month.
• **HCPCS code GYYY3**: Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling, each additional 30 minutes beyond the first 120 minutes (List separately in addition to code for primary procedure).

CMS is proposing to cover these codes under a Category 1 consideration because the face-to-face psychotherapy services included in the codes are sufficiently similar to services already on the Medicare telehealth list. Other care management components of the codes are often furnished remotely and do not require in-person contact.

CMS will be accepting codes for consideration for the CY 2021 PFS until Feb. 10, 2020.

**OPIOID USE DISORDER TREATMENT SERVICES BY OPIOID TREATMENT PROGRAMS**

Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act established a Part B benefit category for OUD treatment services by an OTP beginning Jan. 1, 2020. It also provides for coverage of OUD treatment services and establishes a bundled payment for OTPs certified by SAMHSA for OUD treatment services during an episode of care. To comply with the Act, CMS is proposing a duration of an episode of care includes a one-week (7 day) period and the bundle of care which a patient receives during that period includes one substance use counseling session, one individual therapy session, one group therapy session and one toxicology test. If the patient received 51% or more of those services, then they can bill the full weekly bundle. If they received less, then the OTP could bill a partial episode of care. There would be no limits on the maximum number of weeks allowed.

CMS is also establishing separate payment methodologies for the drug and non-drug component of the bundled payment. The non-drug component would include counseling, therapy and toxicology testing during weeks where medication is not administered. CMS considers OUD treatment services to include services furnished through communication technology, and are proposing to allow OTPs to furnish the substance use counseling, individual therapy, and group therapy included in the bundle via two-way interactive audio-video communication technology, as clinically appropriate, in order to increase access to care for beneficiaries. CMS acknowledges that OTPs are not eligible providers under Medicare’s telehealth restrictions, but state that because they are not considered to be services provided by a physician or other practitioner, the statutory telehealth requirements of 1834(m) does not apply to OTPs. They note that the counseling or therapy services furnished via communication technology as part of OUD treatment services furnished by an OTP must not be separately billed because these services would already be paid through the bundled payment made to the OTP.

CMS is requesting comments regarding whether the use of communication technology is clinically appropriate to deliver substance use counseling and individual and group therapy services, as well as if
other components of the bundle may be appropriate to deliver via communication technology.

CCHP ANALYSIS

If the statutory telehealth requirements in 1834(m) do not apply for OTPs delivering services through audio-video communication technology, it is unclear why there would be a limitation on store-and-forward technology being used for the same purpose. Additionally, it raises the question of if OTPs are exempt from the requirements of 1834(m) because they are not a physician or other eligible practitioner, would other providers not currently on the telehealth list, such as FQHCs and RHCs be able to deliver services via audio-video communication technology, using the same reasoning, without being subject to the requirements of 1834(m)?

BUNDLED PAYMENT FOR SUBSTANCE USE DISORDER

CMS is proposing to establish bundled payment for treatment of OUD, including management, care coordination, psychotherapy, and counseling activities. It would not include payment for the medication itself in medication assisted treatment (MAT). These bundled codes would be a monthly reported code, with a code for the initial month (GYYY1) for intake activities and development of a treatment plan, as well as assessment, therapy and counseling, a code for subsequent months (GYYY2) and finally, an add on code (GYYY3) when needed. These are the codes that CMS is proposing adding to the list of telehealth eligible codes for reimbursement discussed earlier.

CMS notes that some components of the codes involve care coordination which are typically furnished using telecommunications technology and do not require in-person contact and are therefore not considered telehealth. The care coordination components on their own do not necessitate being on the telehealth list, but because they are combined with the face-to-face elements of the code, they are included for this bundled payment.

In accordance with the SUPPORT Act, which created an exception from the Medicare geographic and facility requirement for SUD treatment or co-occurring mental health disorders, CMS is allowing these services to be delivered at any telehealth originating site, including the patient’s home without regard for the geographic requirement. Because certain required services (psychotherapy) are included in the OUD bundled payment codes, they would qualify and could be furnished more broadly under the exceptions in the SUPPORT Act. If the CPT Editorial Panel establishes similar codes, CMS will consider replacing GYYY1, GYYY2, and GYYY3 in the CY 2021 PFS.

CMS is not proposing adding a new G code for OUD treatment for RHCs and FQHCs, since they can already bill using G0511 and G0512.
CARE MANAGEMENT SERVICES

Transitional Care Management
CMS is proposing to remove several components from the bundled payment for TCM because they are separately payable under Medicare. These services include:

- Prolonged services without direct patient contact
- Home and outpatient international normalized ration monitoring services
- End stage renal disease services
- Interpretation of physiological data (RPM)
- Complex chronic care management services
- Care plan oversight services.

CMS notes that TCM codes could be billed concurrently with these codes.

Chronic Care Management
CMS proposes to adopt two new G codes with new increments of clinical staff time instead of the existing single CPT code (99490). The first code (GCC1) would include the initial 20 minutes of clinical staff time and the second (GCC2), would describe each additional 20 minutes. These codes would be temporary until the CPT Editorial Board establishes permanent codes. CMS is seeking comments on whether or not additional limitations should apply to these codes.

Additionally, CMS is also proposing to adopt two new G codes (GCC3 and GCC4) that would be use to establish and revise a comprehensive care plan, that would be used instead of codes 99487 and 99489. They also redefine the definition of a “care plan” in an effort to make it less burdensome for physicians. Finally, for federally qualified health centers (FQHCS) and rural health centers (RHCs), CMS is proposing to use the non-facility rate for HCPCS codes GCC1 and GCC3 instead of the non-facility rate for CPT codes 99490 and 99487 for valuating code C0511 (the code for general care management services for FQHCs and RHCs) if these changes are finalized.

Principal Care Management
CMS is proposing separate coding and payment for principal care management (PCM) services, which describes care management services for one serious chronic condition (as opposed to the multiple chronic conditions covered by CCM). A qualifying condition would be expected to last between 3 months and a year or until death, may have led to a recent hospitalization and/or place the patient at significant risk of death, acute exacerbation, decompensation or functional decline. The services would include coordination of medical and/or psychosocial care related to the single complex chronic condition, provided by a physician or clinical staff under the direction of a physician or other qualified health professional.

Due to the similarity between the description of the PCM and CCM services, both of which involve non-
face-to-face care management services, the full CCM scope of service requirements would apply to PCM, including documenting the patient’s verbal consent in the medical record. PCM could not be billed by the same practitioner for the same patient concurrent with certain other care management services, such as CCM, behavioral health integration services and monthly capitated ESRD payments.

**New Principle Care Management Codes:**

- **HCPCS code GPPP1** - Comprehensive care management services for a single high-risk disease, e.g., Principal Care Management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities.

- **HCPCS code GPPP2** - Comprehensive care management for a single high-risk disease services, e.g. Principal Care Management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities.

CMS expressed concerns that this separate coding could result in a patient with multiple chronic conditions having their care managed by multiple practitioners, each only billing for PCM, which could potentially result in fragmented patient care, overlaps in services, and duplicative services. They are seeking comment on whether there should be additional requirements to prevent potential care fragmentation or service duplication. They are also seeking comment on whether or not there is duplication in PCM services with other services such as interprofessional telephone/internet/electronic health record assessment and management services.

**CHRONIC CARE REMOTE PHYSIOLOGIC MONITORING SERVICES**

One of the codes established in Sept. 2018 CPT Editorial Board for remote physiologic monitoring was 99457. Effective for CY 2020, the code has been revised, still with 99457 as the base code that describes the first 20 minutes of treatment management services, but then allows for use of an add on code, for subsequent 20 minute intervals (994X0). The codes now only require that these services be delivered with general supervision of auxiliary personnel by a physician or other qualified healthcare professional, as
opposed to direct supervision, as previously required.

CONSENT FOR COMMUNICATION TECHNOLOGY-BASED SERVICES

In the CY 2019 PFS, CMS finalized payment for a number of communication technology-based services, including brief virtual check in services and interprofessional consultation. Currently consent is required for each service delivered through communication technology-based services, in part to ensure that patients are aware of any fee sharing they may be responsible for. However, CMS has received feedback from practitioners that obtaining consent for each and every one of these services is burdensome. Therefore, CMS is seeking comments on the possibility of obtaining advance consent for a number of communication technology-based services.

OTHER REFERENCES TO TELEHEALTH

- **Calculations Under the Merit-based Incentive Payment System (MIPS)** – CMS is proposing changes to the way scoring is calculated in certain categories involving telehealth, including the area of promoting interoperability, adult major depressive disorders, heart failure, coronary artery disease, tobacco use, and alcohol and drug dependence treatment.
- **Remote Interrogation Device Evaluation** – A new code (GTTT1) is proposed for remote interrogation device evaluation to describe services previously covered under CPT code 93299, which is being deleted for CY 2020.
- **Long-Term EEG Monitoring** – CMS is proposing revised valuation for these services. See page 400 of the manual for further information.