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Weekly Update

CMS Allows Audio-Only Medicare Coverage Only for Initial Brief Assessments, Denies Coverage for Longer Outpatient Evaluation and Management

Interim final Calendar Year 2021 Medicare Physician Pay Schedule regulations released December 1 by the Centers for Medicare and Medicaid Services (CMS), will allow Medicare reimbursement, through the end of 2021, for an initial brief preliminary assessment via audio-only telecommunications of a patient's need for a face-to-face evaluation.

However, the regulations do not permit a longer evaluation and management (E/V) session via audio-only means after the COVID-related Public Health Emergency (PHE) has expired on January 20, 2021, as NASMHPD and other members of the behavioral health advocacy community have urged. CMS remains unconvinced that the statute underlying 42 C.F.R. § 410.78 gives it the authority to permit reimbursement for a broader non-emergency use of audio-only telehealth on a permanent basis.

The current emergency authorization for the broader use of audio-only telehealth expires when the PHE expires. But CMS says temporary authorization for the shorter duration use of audio-only telecommunications is justified because a Medicare beneficiary may still be cautious about COVID-19 exposure risks associated with in-person services even after the pandemic subsides.

CMS is granting a 60-day public comment period on the audio-only provisions of the regulations.

CMS does propose permanent or extended emergency authorization through 2021 for some of the audio-visual telehealth services granted emergency authorization in early 2020 as the pandemic hit. It says reimbursement for those services must be at the same level as reimbursement for analogous in-person services. Emergency authorization is being granted for:

- Emergency Department visits for evaluation and management (HCPCS Codes 99281 through 99285);
- Domiciliary, Rest Home, or Custodial Care services, established patient (HCPCS Codes 99336 & 99337);
- Home Visits, established patient (HCPCS Codes 99349 & 99350);
- Psychological and neuropsychological testing (HCPCS 96121, 96130 through 96133 & 96136 through 96139);
- Subsequent Observation and Observation Discharge Day Management (HCPCS Codes 99217 & 99224 through 99226);
- Initial Hospital Care and Hospital Discharge Day Management (HCPCS Codes 99221 through 99223, 99238 & 99239); and
- Critical Care Services (HCPCS Codes 99291 & 99292).

Section 2001(a) of the SUPPORT Act removed the originating site geographic requirements under § 1834(m)(4)(C)(i) of the Social Security Act for telehealth services furnished on or after July 1, 2019 for the purpose of treating individuals diagnosed with a substance use disorder (SUD) or a co-occurring mental health disorder. Section 2001(a) of the SUPPORT Act also added the home of an individual as a permissible originating site for telehealth services for the purpose of treating individuals diagnosed with a SUD or a co-occurring mental health disorder.

HCPCS codes G2086, G2087, and G2088 were previously added to the Medicare telehealth list, beginning in CY 2020,. to describe bundled payments for office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy, and group therapy and counseling.

For CY 2021, CMS is finalizing a revision to these code descriptions to include the treatment by telehealth of any SUD rather than just opioid use disorders (OUDs), beginning in CY 2021. CMS also finalizes the addition of CPT codes 99347 and 99348 (Home visit for the evaluation and management of an established patient) to the Medicare telehealth list for CY 2021, which could be appropriately billed for treatment of an SUD or co-occurring mental health disorder, as well as CPT code 90853 (Group psychotherapy).

In addition, CMS finalizes HCPCS code G2213 (Initiation of medication for the treatment of opioid use disorder in the emergency department setting, including assessment, referral to ongoing care, and arranging access to supportive services.) In response to requests for clarification about which elements are required in order to bill for this code, CMS says practitioners should furnish only those activities that are clinically appropriate for the beneficiary that is being treated. *(Continued on page 6)*

With current *NASMHPD Weekly Update* editor Stuart Gordon retiring at the end of December, Genna Schofield, NASMHPD's Senior Technical Assistance and Communications Associate, will be taking the helm of the publication, starting next week. She can be reached at genna.schofield@nasmhpd.org or 703-682-5180.

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(Continued from page 1) CMS is also revising the definition of opioid use disorder (OUD) treatment services to include overdose education. The term will include educating patients and caregivers on how to recognize respiratory depression, the signs and symptoms of a possible opioid overdose, how to administer naloxone in the event of an overdose, and the importance of calling 911 or getting emergency medical help right away, even if naloxone is administered. The overdose education add-on will be included each time naloxone is furnished by an Opioid Treatment Program (OTP).

Remote Supervision by Telehealth

Many services for which payment is made under the Physician Fee Schedule (PFS) can be furnished under supervision by a physician or nurse practitioner rather than being performed directly by the billing practitioner. Supervision requirements necessitate the presence of the physician or a non-physician practitioner (certified nurse practitioner) in a particular location, usually in the same location as the beneficiary when the service is provided. As described at 42 U.S.C. § 410.26, services furnished by auxiliary personnel incident to a physician's or NPP's professional service usually require the direct supervision of the physician or NPP. In addition to these "incident to" services, there are a number of diagnostics that must be furnished under direct supervision. As currently defined in regulations, direct supervision means the physician or NPP must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. Direct supervision does not require the physician or NPP to be present in the room when the service or procedure is performed.

For the duration of the PHE for COVID-19, for purposes of limiting exposure to COVID-19, CMS adopted an interim final policy revising the definition of direct supervision to include virtual presence of the supervising physician or practitioner using interactive audio/video realtime communications technology. In the context of the PHE, given the risks of exposure, the immediate risk of foregone medical care, the increased demand for healthcare professionals, and the widespread use of telecommunications technology, CMS believed that individual practitioners were in the best position to make decisions about how to meet the requirement to provide appropriate direct supervision based on their clinical judgment in particular circumstances.

When it proposed the PFS regulations, CMS proposed to revise its regulations 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 for COVID-19 ends or December 31, 2021. "Direct supervision" in the office setting would mean the physician (or other supervising practitioner) must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It would not mean that the physician (or other supervising practitioner) must be present in the room when the procedure is performed. CMS proposed to add that, until the later of the end of the calendar year in which the PHE for COVID-19 ends or December 31, 2021, the presence of the physician (or other practitioner) could include virtual presence through audio/video real-time communications technology (excluding audio-only) subject to the clinical judgement of the supervising physician or other supervising practitioner. In response to questions received, CMS clarified that, to the extent the policy allows direct supervision through virtual presence using audio/video real-time communications technology, the requirement could be met by the supervising physician (or other practitioner) being immediately available to engage via audioio/video technology (excluding audio-only), and would not require real-time presence or observation of the service via interactive audio and video technology throughout the performance of the procedure.

While flexibility to provide direct supervision through audio/video real-time communications technology was adopted to be responsive to critical needs during the PHE for COVID-19 to ensure beneficiary access to care, reduce exposure risk, and increase the capacity of practitioners and physicians to respond to COVID-19, CMS expressed concern that direct supervision through virtual presence might not be sufficient to support PFS payment on a permanent basis, due to issues of patient safety.

CMS solicited information from commenters as to whether there should be any additional "guardrails" or limitations to ensure patient safety/clinical appropriateness, beyond typical clinical standards, as well as restrictions to prevent fraud or inappropriate use if it were to finalize a policy to permit direct supervision through audio/video interactive communications technology on a temporary basis through the later of the end of the calendar year in which the PHE for COVID-19 ends or December 31, 2021, or consider it beyond the time specified. After consideration of a range of responses and suggestions in the interest of patient safety and program integrity, CMS finalized its proposal 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 for COVID-19 ends or December 31, 2021.

CDC's Advisory Committee on Immunization Practices Provides Guidance on Vaccination Priorities

The Centers for Disease Control and Prevention (CDC's) Advisory Committee on Immunization Practices (ACIP) voted 13-1 on December 1 to give vaccination priority to health-care workers and long-term care facility residents in vaccinating against COVID-19 infection once vaccines from Moderna and Pfizer are cleared by the Food and Drug administration for public use.

ACIP defined health-care workers as paid and unpaid people serving in health-care settings who have the potential for direct or indirect exposure to patients or infectious materials. It defined long-term care facility residents as adults who reside in facilities that provide a variety of services, including medical and personal care, to persons who are unable to live independently.

Although states do not have to follow the guidance, it provides a framework that states can adopt. Dr. Nancy Messonnier, director of the CDC's National Center for Immunization and Respiratory Diseases, says most states and local jurisdictions expect it to take three weeks to vaccinate all of their health-care workers. Pfizer and Moderna's vaccines require two doses, about a month apart. There are roughly 21 million health-care workers and 3 million long-term care facility residents in the U.S.

Dr. Moncef Slaoui, who is leading the Trump administration's Operation Warp Speed for developing vaccines, says the entire U.S. population of 331 million could be vaccinated by June.

About 10 percent to 15 percent of recipients in trials have reported side effects from the vaccines, according to Dr. Slaoui, including redness and pain at the injection site, fever, chills, muscle aches, and headaches. But Dr. Slaoui says most people have no noticeable side effects. Company officials have suggested the side effects from the vaccine could lay people up for a day or so, prompting a recommendation that health-care facilities plan for workers to take time away from clinical care duties if they experience symptoms after getting vaccinated.