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CY 2022 Medicare Physician Fee Schedule Final Rule Summary

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The CY 2022 Medicare Physician Fee Schedule (PFS) Final Rule (Final Rule) was released on November 2, 2021. The official version of the Final Rule was published in the Federal Register on November 19. Unless otherwise noted in the PFS, changes to Medicare policies will begin on January 1, 2022.

Telehealth/Remote Monitoring Changes

The Final Rule includes several proposals relating to coverage and payment for Medicare telehealth services and extension of temporary coverage for certain telehealth services. Below is a summary of the changes that may be relevant to AACAP members.

CMS Declines to Add New Telehealth Services to Categories 1 & 2, Retains Services Under Category 3 of the Medicare Telehealth Services List

The regulatory process for adding or deleting services from the Medicare telehealth services list was established under the 2003 PFS Final Rule. In general, the public submits requests for adding services and CMS then assigns the service to a category. A requested service is added to Category 1 if it is similar to professional consultations, office visits, and office psychiatry services that are currently on the Medicare telehealth services list. A requested service is added under Category 2 if there is evidence of clinical benefit if provided using telehealth.

In the 2022 PFS Proposed Rule (the Proposed Rule), CMS stated that it received several requests to permanently add a wide variety of services to the Medicare telehealth services list effective for CY 2022 (*see* Tables 15, 16, and 17). In the Final Rule, CMS reiterates that it found that **none** of the requested services met the Category 1 or Category 2 criteria for permanent addition to the Medicare telehealth services list (CMS provides an explanation for why the requested services were denied on pages 145-52). Denied services include several physical, occupational, and speech therapy services and tests which CMS declined because those professionals are not among the providers whose services Medicare covers when provided via telehealth. CMS also denied requests to add several neuropsychological and psychological services (HCPCS 96130-96133, 96136-96139) because these services require close observation by the furnishing practitioner to monitor how a patient responds and "remote observation … to accomplish the testing in question seems impractical and potentially creates the risk of inaccuracies in diagnosis and subsequent treatment." Finally, CMS denied requests to add CPT 90849 – multiple-family group psychotherapy services – to the Medicare telehealth services list because the CPT code has a restricted payment status, indicating that claims must be adjudicated on a case-by-case basis when furnished in-person.

Under the 2021 PFS Final Rule, CMS created a new Category 3 for telehealth services that would allow coverage and payment for such services through the end of calendar year in which the COVID-19 public health emergency (PHE) expires. Category 3 services represent those services that CMS believed were likely to have clinical benefit when furnished via telehealth, but for which there was not sufficient evidence available to consider the services as permanent under Category 1 or 2.

In the Final Rule, CMS announced that it will retain all services previously added to the Medicare telehealth services list on a Category 3 basis during the COVID-19 PHE until the end of CY 2023. Additionally, CMS announced that it would be adding the following CPT/HCPCS codes on a Category 3 basis:

Code	Description	Physician Practice Reimbursement
93797	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)	$16.46
93798	Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)	$25.53
G0422	Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise (per session)	$118.60
G0423	Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise (per session)	$118.60

Consolidated Appropriations Act Mental Health Telehealth Services

The Consolidated Appropriations Act (CAA), passed by Congress in January of 2021, amended the Social Security Act to allow for additional mental health services to be furnished via telehealth. Specifically, it broadened the scope of services to permit coverage for telehealth services furnished for the purpose of diagnosis, evaluation, or treatment of a mental health disorder without regard to the geographic location and to allow the patient's home as a permissible originating site. This expanded coverage takes effect on or after the end of the PHE for COVID-19 and will have the effect of making the temporary telehealth waiver permanent with respect to mental health services. The CAA includes a requirement that providers must conduct an in-person, non-telehealth service with the patient within the six months prior to the initial telehealth service. The CAA also requires CMS to establish a frequency for subsequent in-person visits.

Under the Final Rule, CMS clarified that the initial in-person visit must involve the furnishing of an item or service for which Medicare payment was made in order to meet the six-month in-person requirement. CMS also implemented a requirement that after the first telehealth service at home, a subsequent, in-person visit must take place at least once every 12-months. There is an exception for situations in which the patient and provider agree the risks and burdens of an in-person visit are outweighed by continuing via telehealth, such as possible disruptions in service delivery or the potential to worsen the patient's condition. The decision to not provide an in-person service must be documented in the patient's medical record, along with documentation that the patient is able to obtain needed point of care testing, including vital sign monitoring and laboratory studies.

Audio-Only Mental Health Telehealth Services

In the Proposed Rule, CMS proposed to amend the regulations to define "interactive telecommunications system" at 42 CFR § 410.78(a)(3) to include audio-only communications technology

when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders when the patient is:

- In their home at the time of the service;
- Is an established patient;
- There has been an in-person visit within the last six months; and
- The health care provider is capable of providing the service with both audio and visual communication technology but the patient either is not able to or does not consent to use of audio-visual communications.

CMS finalized the amended definition of "interactive telecommunications system" as proposed and stated that it anticipates that amending the regulation to allow mental health telehealth services furnished to a beneficiary in their home using audio-only communications technology "will have a positive impact on access to care for mental health conditions and contribute to overall health equity." Additionally, CMS clarified that substance use disorder services are considered mental health services for purposes of the amended definition of "interactive telecommunications system" to include audio-only services under the regulation.

Non-Face-to-Face Services Involving Communications Technology

Although provided remotely, the communications technology services discussed here are not considered "telehealth services" and therefore not subject to the statutory telehealth restrictions related to geographic location of the patient or limits on the types of professionals that can furnish services.

- Remote Supervision Requirements

Medicare requires certain types of services to be furnished under specific levels of supervision of a physician or practitioner, including diagnostic tests, services incident to physician services, and other services. During the COVID-19 PHE, CMS changed the definition of "direct supervision" as it pertains to supervision of diagnostic tests, physicians' services, and some hospital outpatient services, to allow the supervising professional to be immediately available through virtual presence using real-time audio/video technology, instead of requiring their physical presence. This relaxed remote supervision requirement will remain in effect through the later of the end of the calendar year in which the PHE for COVID-19 ends or December 31, 2021..

Under the Proposed Rule, CMS solicited comments on whether this flexibility should be continued beyond the later of the end of the PHE for COVID-19 or CY 2021 and also whether the policy should extend, on a permanent basis, the ability of providers to supervise services remotely using audio-visual technology. CMS did not make a decision on whether to extend the relaxed remote supervision requirements but stated that it would "consider addressing the issues raised by [ ] comments in future rules or guidance, as appropriate." Thus, the relaxed "direct supervision" requirement will remain in effect through the end of the calendar year in which the PHE for COVID-19 ends, which could be through the end of 2022.

- Virtual Check-ins

During the COVID-19 PHE, CMS established HCPCS code G2252 to allow for a provider to furnish a longer virtual check-in, in any form of synchronous communications technology, including audio-only, on an interim basis for CY 2021. G2252 is defined as a "brief communication technology based service, e.g. virtual check-in service, by physician or other qualified health care professional who can report E/M services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment, 11-20 minutes of medical discussion." CMS finalized the proposal to permanently establish HCPCS code G2252.

Mental Health Services Provided by Federally Qualified Health Centers and Rural Health Clinics

Generally, federally qualified health centers (FQHCs) and Rural Health Clinics (RHCs) may only act as originating sites (where the eligible telehealth patient is located at the time of the service) when providing telehealth services. CMS made a temporary exception for the duration of COVID-19 PHE that would allow FQHCs and RHCs to also act as a distant site provider (where the physician or practitioner is located at the time of the service).

In the Proposed Rule, CMS recognized that beneficiaries receiving mental health services from RHC and FQHC practitioners should have the same access to mental health care delivered via telecommunications technology as beneficiaries receiving services from practitioners paid under the PFS. To achieve equity in access to mental telehealth services, CMS proposed to amend the regulatory definition of "mental health services" to provide for remote access to RHC and FQHC services.

CMS finalized the proposed changes to amend the definition of a mental health visit for an RHC or FQHC to include encounters furnished through interactive, real-time telecommunications technology when furnishing services for the purposes of diagnosis, evaluation, or treatment of a mental health disorder. This will allow RHCs and FQHCs to report and be paid for mental health visits furnished via real-time, telecommunication technology in the same way they currently do when these services are furnished in-person. FQHCs and RHCs are also eligible to provide mental health services via audio only when the patient is not capable of or does not want to use live video. CMS clarified that FQHCs and RHCs are subject to the same six-month in-person visit and subsequent 12-month in-person visit requirements that were required by the CAA.

Remote Therapeutic Monitoring/Treatment Management

Under the Final Rule, CMS finalized a family of five remote therapeutic monitoring (RTM) CPT codes that are similar to the five existing remote physiological monitoring (RPM) codes, except for two primary distinctions. First, RTM services allow for non-physiologic data to be collected, and second, RTM allows for data to be self-reported as well as digitally uploaded. The finalized values for the RTM codes are as follows:

Code	Description	Reimbursement
98975	Set-up (billable once per episode)	$18.82
98976	Respiratory monitoring	$54.09
98977	Musculo-skeletal monitoring	$54.09
98980	Treatment Mgmt. (first 20 min)	$48.72
98981	Treatment Mgmt. (each add. 20 min.)	$30.57

The AMA CPT Editorial Panel intended RTM primary billers to be non-physician practitioners such as psychologists, nurse practitioners (NPs), and physical therapists (PTs). However, under the Proposed Rule, CMS identified an issue that would have prevented the RTM codes from being used by physical therapists as well as other qualified health care professionals that are not authorized to furnish and bill "incident to" services.

CMS resolved this issue in the final rule and will permit therapists and certain other qualified health care professionals to bill the RTM codes. However, CMS noted that, where the practitioner's Medicare benefit does not include services furnished incident to the professional services, (e.g., physical therapists) the items and services described by the RTM codes must be furnished directly by the physical therapist or a therapy assistant under the PT's or occupational therapist's supervision. In addition, because the RTM codes are not evaluation and management services, CMS states that they cannot be added to the list of services for which only general supervision is required. In contrast, the RPM codes are on that list and can be provided under general supervision. This is an important distinction and creates a significant obstacle to use of the RTM codes which must be provided under direct rather than general supervision. This means that the billing practitioner (e.g., physician or NP) must be in the office at the time the service is provided. CMS indicated that it wants to engage with stakeholders and the CPT Editorial Panel to better resolve some of the RTM issues, but that will likely not happen soon.

CMS provided no new guidance on the RPM codes.

Medical Nutrition Therapy and Diabetic Self-Management Training Telehealth Services

Under the Proposed Rule, CMS proposed to amend the regulatory text at 42 CFR § 410.72(g) to specify that medical nutrition therapy and diabetic self-management training services may be provided as telehealth services when registered dietitians or nutrition professionals act as distant site practitioners. Registered dietitians and nutrition professional are already included on the list of distant site practitioners for telehealth services in § 410.78; however, the proposed amendment would simply provide a cross-reference to this long standing policy. CMS received no comments on this amendment and finalized it as proposed.