



Proposed CY 2022 PHYSICIAN FEE SCHEDULE

FACT SHEET | July 2021

The Center for Medicare and Medicaid Services (CMS) released their proposed Physician Fee Schedule (PFS) for CY 2022. The PFS are the policies that the agency is proposing for Medicare for the following year. This is the typical vehicle utilized by CMS to make administrative changes to telehealth policy in the Medicare program. This is only a proposal at this time and CMS is soliciting public comments before the policies will be finalized later this year. Public comments are due no later than 5 pm on September 13, 2021 (the time zone was not specified).

▶ TELEHEALTH SERVICES

CMS adds services that are eligible to be reimbursed when provided via telehealth if they pass one of two tests:

- **Category 1** – The service is essentially similar to a service already on the eligible list.
- **Category 2** – If the service is not similar to one already on the eligible list, there is evidence that demonstrates clinical benefit to the patient if it is provided via telehealth.

In the PFS for 2021, CMS created a Category 3 which would act as a temporary holding category for some of the services that were placed on the temporary COVID-19 eligible services list. Once the public health emergency (PHE) was declared over, the services in Category 3 would not immediately be ineligible but remain until the end of the year the PHE is declared over. CMS noted that this would give them time to assess whether these services could be made permanently eligible based on a Category 1 or 2 test. Therefore, if the PHE was declared over September 1, 2021, those services not in Category 3 or on the permanent telehealth eligible list would no longer be reimbursed if provided via telehealth, but the services in Category 3 would still be eligible until the end of 2021. However, in the new PFS, CMS is proposing to extend the timeline for the services in Category 3 to the end of CY 2023 to allow time for collecting more information and

evidence. For those services that are on the COVID-19 temporary list but did not make it to the Category 3 list in 2021, CMS is requesting comments on whether any of these services should also be added to Category 3.

Each year the public can make requests to add services on the permanent list. CMS has stated none of the suggestions they have received pass a Category 1 or 2 test so they are not proposing to add any of the submitted services to the eligible list on a permanent basis.

▶ MENTAL HEALTH & AUDIO-ONLY

Several significant proposals were made in regards to mental health.

Consolidated Appropriations Act

In December 2020, Congress passed the Consolidated Appropriations Act (CAA) which included several permanent telehealth changes in Medicare. Among those changes were removing the geographic limitation when providing mental health services and allowing the home to be an eligible originating site for such services. However, a caveat was included that stated for the exception to the geographic limitation and allowing the home as an eligible originating site for these services to occur, the telehealth provider must have had an in-person interaction with the patient within six months prior to the use of telehealth. This in-person requirement does not apply to cases that would be eligible outside of what was required by the CAA. For example, if you were receiving services via telehealth in a site that would qualify under the rural restriction, the prior in-person visit with the telehealth provider need not have taken place. In addition, it does not apply when a patient is being treated for substance use disorder or co-occurring mental health disorder, since previously existing statute provides an exception in those circumstances from the geographic requirement and allows the home as an eligible site.

CMS is soliciting comments on whether they should “adopt a claims-based mechanism to distinguish between” those services that fall into the CAA category and those that do not, and what that mechanism would look like. CMS is also seeking comments on whether the provider who furnishes the in-person visit needs to be the telehealth provider or if it could be another provider in the same specialty and in the same group. CMS is also proposing that the in-person visit takes place within six months before **each** telehealth service.

The CAA also added rural emergency hospitals as eligible originating sites for telehealth. CMS will make this change beginning in CY 2023.

Audio-Only

In federal law, it is stated that telehealth services that are covered by Medicare are furnished via a “telecommunications system.” The term “telecommunications system” is not defined in federal statute. CMS in regulations added the word “interactive” to “telecommunications system.” CCHP has maintained over the years and has provided comments to the agency noting that federal law never defined “telecommunications system,” therefore it is within CMS’ authority to allow for other modalities beyond live video to be used to provide services. Until now, CMS has declined to take this step and last year in response to comments to the PFS on the ability to redefine “telecommunications system,” noted “that we continue to believe that our longstanding regulatory definition of “telecommunication system” reflected the intent of statute and that the term should continue to be defined as including two way, real-time, audio/video communications technology.” However, in analyzing data from COVID-19, CMS determined that audio-only was used frequently to provide services for mental health. For several reasons, including belief that mental health services can be effectively provided via audio-only, a shortage of mental health providers and the likely continued need for audio-only services post-pandemic, CMS revisited its position

on defining “interactive telecommunications system” and is proposing to allow the use of audio-only in the provision of mental health services to an established patient **when the originating site is the patient’s home**. This service will **also** require an in-person visit within six months of the telehealth service similar to what is required in the CAA.

CMS is proposing to allow audio-only only when the patient is located at home because this is likely where they would have difficulty accessing live video. CMS notes that to provide these services via audio-only, the patient must be located in their home, and the

provider must have the technical capability at the time to use live video, but the patient is not capable of or has not consented to the use of live video. A special modifier will be created to identify that the service took place in this manner. CMS is also seeking comment on whether additional documentation in the patient’s medical record should be required to support the use of audio-only in these circumstances, as well as whether or not higher-level services (i.e. level 4 or 5 E/M visit codes) should be excluded from the proposed audio-only mental health telehealth services exception.

TABLE 1. REQUIREMENTS FOR THE PROVISION OF MENTAL HEALTH SERVICES

AUTHORITY	IN-PERSON VISIT W/IN 6 MONTHS	ESTABLISHED PATIENT	PATIENT AT HOME	PROVIDER HAS CAPABILITY OF DOING LIVE VIDEO	PATIENT CANNOT OR DOES NOT WANT TO DO LIVE VIDEO	PATIENT CANNOT OR CONSENTS TO AUDIO-ONLY
Consolidated Appropriations Act	●	●	Possible but not required	-	-	-
Audio-Only Proposal	●	●	●	●	●	-
FQHC Audio-Only Proposal	Seeking comments	-	-	-	-	●

▶ FQHCs/RHCs

For Medicare, federally qualified health centers (FQHCs) and Rural Health Clinics (RHCs) may only act as originating sites under current federal law. A temporary exception was made for the PHE to allow them to be distant site providers, but the permanent policy as of now, July 2021, remains unchanged. Under the CY 2022 PFS, CMS proposes to redefine what a mental health visit

is for an FQHC and an RHC. CMS currently defines a visit for these two entities as “medically necessary, **face-to-face** encounters between a patient and an RHC or FQHC practitioner, during which time one or more RHC or FQHC qualifying services are furnished.” This definition appears to be one based on an administrative decision, not one in federal statute.

Citing concerns of disruption of services, its analysis of data that indicate that mental health services via telehealth will continue to be in demand and other factors, CMS is proposing redefining what a **mental** health visit is for an FQHC and RHC to “also 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. Additionally, to align with the aforementioned provision of mental health services via audio-only, CMS is also proposing to allow FQHCs and RHCs to be eligible to provide mental health services via audio-only when the patient is not capable of or consents to the use of live video. CMS is seeking comment on whether it should also require the six month in-person visit for FQHCs and RHCs or if it would be unduly burdensome for the patients they serve.

RHCs are paid an all-inclusive rate (AIR) and FQHCs are paid a prospective payment system (PPS) rate. During the PHE, RHCs and FQHCs are allowed to act as distant site providers but do not receive their typical AIR or PPS rates. Instead, under federal law, a methodology was created to determine one flat rate, regardless of the service. For CY 2021 that rate is \$99.45. This rate and methodology employed was only meant to apply for services provided during the COVID-19 PHE. Therefore, for the above mental health services, FQHCs and RHCs would receive their usual PPS or AIR rates. However, as FQHCs and RHCs are not allowed to provide services via telehealth, the reporting for these services will be different.

make them permanent. This may be especially relevant for physical therapists, occupational therapists and speech language pathologists who are not eligible Medicare telehealth providers without the PHE waivers and may need to rely on virtual supervision when delivering services ‘incident to’ physician services.

- Permanent adoption of G2252, virtual check-in service of 11-20 minutes, which can include audio-only discussion.
- CMS is seeking comments on potentially creating separate coding and payment for medically necessary activities involved with chronic pain management, or are already recognized in current coding. One of the activities listed that could be included is care provided through telehealth.
- CMS is also proposing to revise the definition of primary care services in the Shared Savings Program to include chronic care management, principal care management, prolonged office or other outpatient evaluation and management services and communication technology-based service code G2252 if made permanent through CY 2022 PFS.
- CMS is proposing new CPT codes and RUC values for certain chronic care management and principal care management codes. They are also seeking insight into the standard practice used by practitioners to obtain beneficiary consent for these services.
- CMS is additionally proposing to allow audio-only in limited circumstances for certain Opioid Treatment Program (OTP) counseling and therapy services, rather than only via two-way interactive audio/video communication technology. This would take effect following the end of the PHE in cases where audio/video communication technology is not available to the beneficiary and all other billing and documentation requirements are met.

▶ ADDITIONAL ITEMS

- During the PHE, CMS allowed for certain in-person supervision requirements or the availability of the supervisor in-person to be provided virtually through telehealth. CMS is soliciting comments on whether they should continue these policies beyond the PHE and/or



► ANALYSIS

CMS is limited in what it can do administratively regarding telehealth. Previous PFS have focused on what services will be added to the permanent eligible telehealth list in Medicare and that is the one area that statutorily has been left to the Administration to decide. Other policy issues that are barriers to the utilization of telehealth such as location limitations, eligible providers and modality, have been viewed in the past as requiring Congressional action before CMS could act. CCHP has noted in previous years, as recently as 2020 when we provided comments to the 2021 PFS and again in December of 2020 in a request for comments regarding federal temporary waivers, that CMS could redefine “telecommunications system” and “visit” for FQHCs/RHCs to include greater use of telehealth. How they have decided to use those avenues to narrowly focus in on mental health was unanticipated and an interesting development.

Continuation of audio-only and allowing FQHCs and RHCs to act as distant site providers beyond the PHE have been two of the most discussed policies. For audio-only, both federal and state policymakers have grappled with how much of audio-only policy, if any, to retain. Additionally, since on the federal level FQHCs and RHCs could not act as distant site providers pre-COVID-19, their continued ability to provide services via telehealth has been a long-standing issue that pre-dates the pandemic. CMS will be allowing audio-only to be a modality and FQHCs and RHCs may deliver services via ‘interactive, real-time telecommunications technology’, but only for the delivery of mental health services and only if certain parameters are met. The proposals are very specific scenarios and very narrow, but it does offer at least some certainty for these cases. Additionally, CMS is stating that payment for these services will be at parity, including for FQHCs and RHCs.

However, it is noted in the PFS that the redefining of mental health visits will not be considered telehealth, as FQHCs and RHCs are not eligible to provide services via telehealth in the Medicare program. Therefore, presumably FQHCs and RHCs will not face the same limitations other providers face utilizing telehealth such as geographical limitations because under this proposal, the services are not regarded as telehealth. They are merely visits. Should this proposal be finalized, more details likely will be offered by CMS on exact implementation.

Overall, an interesting path was taken by CMS in addressing these issues. It should be noted that these are only proposals and comments by the public may alter what was provided in this PFS. It can be confusing to navigate the mental health proposals, so to assist with this, CCHP has prepared the chart below demonstrating how the proposed policy might work with certain scenarios.

CMS will be allowing audio-only to be a modality and FQHCs and RHCs may deliver services via ‘interactive, real-time telecommunications technology’, but only for the delivery of mental health services and only if certain parameters are met.



MENTAL HEALTH SERVICES IN MEDICARE PROVIDED VIA TELEHEALTH (INCLUDING AUDIO-ONLY) AS PROPOSED BY CY 2022 PFS

NOTE: “Original Telehealth Policy” refers to the currently existing permanent federal telehealth statutory policy in Medicare without the Consolidated Appropriations Act (CAA) exceptions.

TELEHEALTH ELEMENT	ORIGINAL TELEHEALTH POLICY (Permanent Telehealth Policy That Exists Without CAA Exception)	CONSOLIDATED APPROPRIATIONS ACT (CAA) EXCEPTIONS	FQHCs/RHCs
Geographic Limitation	Does not apply for treatment of substance use disorder (SUD) and co-occurring mental health conditions	No geographic limitation	No geographic limitation
Home As Originating Site	Exception for treatment of SUD and co-occurring mental health conditions	Home is eligible as an originating site	Visits may take place in the home.
Audio-Only for mental health services	Yes, but must be for an established patient, patient is at home, provider could do live video, but patient is unable or does not want live video. Six month in-person visit is also required.	Yes, but must be for an established patient, patient is at home, provider could do live video, but patient is unable or does not want live video. Six month in-person visit is also required.	Yes, when patient is not capable or does not want services via live video.
In-person visit prior to telehealth services	N/A, unless audio-only is used.	Would require an in-person visit with telehealth provider within a six-month period before every service via telehealth takes place	Exploring possibility of requiring the in-person visit prior to telehealth being used

► SCENARIOS

SCENARIO 1



Patient A is being treated for anorexia. Patient A would like to receive services at home via telehealth.

Under Original Telehealth Policy Patient A could not receive services in the home because it's not a co-occurring mental health condition with SUD.

Under Consolidated Appropriations Act, Patient A could receive services but would need the six month in-person visit to take place before services could be provided via telehealth. Additionally, if all the conditions are met, Patient A could receive services via audio-only if the proposal under the 2022 PFS is finalized.

SCENARIO 2



Patient A is being treated for SUD and depression. Patient A would like to receive services from home via telehealth.

Under Original Telehealth Policy, Patient A could receive services in the home to treat depression as it is co-occurring to SUD. Additionally, those services could be provided via audio-only if the other requirements are met which includes the six month in-person visit with the telehealth provider. The six month in-person requirement would NOT apply if Patient A was seeking services via live video as Patient A's situation would fall under Original Telehealth Policy.

SCENARIO 3



Patient A is being treated for anxiety and it is not co-occurring with SUD. Patient A lives in a geographically eligible site and would like to receive services via audio-only at home. Patient A never had an in-person visit with the telehealth provider who will provide treatment.

Under Original Telehealth Policy, Patient A would not be eligible to receive services via telehealth at home. Patient A does not fall into the Original Telehealth Policy exception of being treated for SUD with the mental health condition co-occurring. Additionally, to receive services via audio-only, the patient must be in the home.

However, Patient A may come under the Consolidated Appropriations Act exception. If Patient A has an in-person visit with the telehealth provider within the six months prior to the telehealth services takes place, Patient A could receive those services in the home. By being able to receive those services in the home and meeting all other requirements for audio only (provider has ability to use live video and Patient A cannot or does not want to use live video), Patient A would be able to receive services via audio-only.

SCENARIO 4



Patient A is being treated for depression. Patient A is not in a geographically eligible location and wants the services to be done via live video and provided by an FQHC.

Services can be provided by the FQHC as this is not regarded as a "telehealth" visit for the clinic and the geographic location of the patient does not matter.

SCENARIO 5



Patient A is being treated for rash caused by an allergic reaction. Patient A would like services via audio-only.

The exceptions would not apply as this is not a mental health condition being treated.

Center for Connected Health Policy

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This fact sheet was made possible by Grant #G22RH30365 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS.