Illinois Health and Hospital Association

MEDICARE POLICY FACT SHEET

NOVEMBER 2022

BEHAVIORAL HEALTH AND TELEHEALTH: MEDICARE UPDATE

The Centers for Medicare & Medicaid Services (CMS) used the calendar year (CY) 2023 Medicare payment rules to implement several behavioral health and telehealth policies. These policies are described in the CY 2023 Outpatient Prospective Payment System (OPPS) final rule and the CY 2023 Medicare Physician Fee Schedule (PFS) final rule.

This fact sheet provides an overview of these policies. An IHA summary of the CY 2023 OPPS final rule is here. CMS also published fact sheets summarizing the CY 2023 OPPS and PFS final rules.

Statutory Telehealth Flexibilities

The Consolidated Appropriations Act, 2022 (CAA, 2022) extended several telehealth flexibilities established during the COVID-19 public health emergency (PHE). These extensions last 151 days after the COVID-19 PHE ends, and include:

- Waiving the geographic and originating site rules to allow telehealth services to be furnished in any geographic area and in any originating site setting, including the beneficiary's home;
- Allowing certain services to be furnished via audio-only telecommunications systems;
- Allowing physical therapists, occupational therapists, speech-language pathologists and audiologists to furnish telehealth services; and
- Allowing continued payment for telehealth services furnished by Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) using the methodology established during the COVID-19 PHE.

The CAA, 2022 also delays the in-person visit requirements for mental health services furnished via telehealth until 152 days after the end of the COVID-19 PHE (more information below).

OPPS Updates

Direct Supervision via Telehealth

CMS modified the definition of direct supervision for certain services during the COVID-19 PHE. The modified definition allows the required presence of a physician to be met via virtual presence through audio/video real-time communication technology (i.e. telehealth). This modification applies to outpatient diagnostic, cardiac rehabilitation, intensive cardiac rehabilitation, and pulmonary rehabilitation services.

This year, CMS used the OPPS final rule to extend the duration of the modified definition of direct supervision for these services until the later of Dec. 31, 2023 or the end of the calendar year in which the COVID-19 PHE ends.

Remote Outpatient Mental Health Services

In April 2020, CMS created PHE-related flexibilities allowing hospital staff to furnish certain outpatient therapy, counseling, and education services to beneficiaries in remote locations, including the beneficiary's home.

In the CY 2023 OPPS final rule, CMS established permanent payment for many of these services. Specifically, CMS designated certain mental health services performed remotely by clinical hospital staff using two-way, or synchronous, audio/video technology to beneficiaries in their homes as covered outpatient department (OPD) services. CMS will allow hospital staff to use audio-only communication technology if the beneficiary is not capable of, or does not wish to use, two-way audio/video technology. However, the hospital/staff must maintain the capability of furnishing two-way audio/video services.

CMS created three new Healthcare Common Procedure Coding System (HCPCS) codes for diagnosis, evaluation, or treatment of a mental health or substance use disorder. These codes specify that the beneficiary must be in their home, and that there are no associated professional services billed under the PFS. These services must be furnished under general supervision, but the physician's presence is not required during the performance of the service.

Payment for these OPD-covered services is made under the OPPS. However, CMS believes remote mental health services do not accrue the same costs as an in-person visit. Rather, the costs associated with these remote mental health services more closely resemble costs under the PFS. Thus, CMS will assign the new HCPCS codes to Ambulatory Payment Classifications (APCs) based on PFS facility payment rates for similar Current Procedural Terminology (CPT) codes. Payment for the add-on code will be packaged. The final OPD covered remote mental health service codes and pricing are as follows:

HCPCS Code	Description	CPT Comparison	PFS Facility Rate	Proposed APC	APC Rate
C7900	Remote mental health service, initial 15-29 minutes	96159	$19.52	5821	$30.48
C7901	Remote mental health service, initial 30-60 minutes	95158	$56.56	5822	$77.67
C7902	Remote mental health service, each additional 15 minutes	Not Applicable			

CMS also finalized in-person service requirements for remote outpatient mental health services. Specifically, beneficiaries must receive an in-person service within six months prior to the first remote mental health service, and within 12 months after each remote mental health service. CMS will permit exceptions to in-person requirements if the provider and beneficiary agree that the risks and burdens of an in-person service outweigh its benefits. This decision must be documented in the patient's medical record. Hospitals must also document that the patient has a regular source of general medical care and the ability to obtain any needed point-of-care testing.

These in-person requirements were delayed by the CAA, 2022 and only apply to remote mental health services beginning 152 days after the end of the COVID-19 PHE. Beneficiaries that began receiving these services during the PHE or in the 151 day post-PHE period do not need to have an in-person service within six months prior to receiving remote mental health services. Such beneficiaries will, however, be subject to the requirement for an in-person visit within 12 months of each remote mental health service.

Partial Hospitalization Program (PHP) Services

The final CY 2023 PHP APC geometric mean per diem costs and payment rates are as follows:

CY 2023 APC	Group Title	Final PHP APC Geometric Mean per Diem Costs	Final Payment Rate
5853	Partial Hospitalization (three or more services per day) for Community Mental Health Centers (CMHCs)	$135.68	$142.70
5863	Partial Hospitalization (three or more services per day) for hospital-based PHPs	$275.83	$268.22

While hospitals will not be permitted to bill PHP services when said services are provided remotely, they can bill for other remote mental health services on an individual basis. CMS expects physicians caring for patients receiving both PHP and non-PHP remote mental health services from a hospital outpatient department to update the patient's medical record to support the patient's eligibility for participation in a PHP. CMS also clarified that non-PHP remote mental health services furnished to a beneficiary in a PHP will not be counted as PHP services in the determination of payment for a PHP day, and will not limit a patient's eligibility for continued participation in a PHP.

CMHCs are not permitted to bill Medicare for any remote mental health services furnished to a patient in their home.

PFS Updates

Updated Originating Site Facility Fee

The CY 2023 originating site facility fee is $28.64 (increased from $27.59 in CY 2022).

Medicare Telehealth Services List

The list of Medicare-allowed telehealth services is available here. CMS considers requests for adding or deleting services from the list of Medicare telehealth services by categorizing them based on a variety of factors. Historically, CMS has used two categories to consider such requests:

- Category 1: services that are similar to those currently on the Medicare telehealth list.
- Category 2: services that are not similar to those currently on the Medicare telehealth list, and that require supporting evidence of the clinical benefit of adding such a service to the list.

In the CY 2021 PFS final rule, CMS created a third category for services added to the Medicare telehealth list on a temporary basis. Specifically, Category 3 includes services added during the COVID-19 PHE for which there are clinical benefits when furnished via telehealth, but for which there is not yet sufficient evidence to support permanently adding to the list under Categories 1 or 2. Any service added under Category 3 will remain on the Medicare telehealth services list through the calendar year in which the COVID-19 PHE ends. At that time, the service must meet criteria under Categories 1 or 2 in order to be permanently added to the Medicare telehealth list.

Services that do not fall into any of these three categories, but have been temporarily added to the Medicare telehealth list during the COVID-19 PHE, will remain on the list for 151 days following the end of the COVID-19 PHE as required by the CAA, 2022.

In CY 2023, CMS added five codes to the Medicare telehealth list under Category 1 (see Table 13, p. 69459 of the final rule) and 54 codes under Category 3 (see Table 12, p. 69458 of the final rule).

Use of Modifiers for Medicare Telehealth Services Following the End of the COVID-19 PHE

In response to the COVID-19 PHE, CMS finalized the interim use of modifier "95" for Place of Service during the PHE. This modifier ensured payment at the same rate that would have been paid if the services were furnished in-person. In the CY 2023 PFS final rule, CMS made several updates related to the use of modifiers for Medicare telehealth services following the end of the COVID-19 PHE.

First, providers will continue to bill telehealth services using a "95" modifier, along with the Place of Service code corresponding to where the service would have been administered in-

person. This billing process remains in place through the end of CY 2023 or the end of the year in which the COVID-19 PHE ends, whichever is later. CMS will continue to maintain payment as though the service was delivered in-person and will continue non-facility-based rates through the end of CY 2023 or end of the year in which the PHE ends.

Additionally, all providers, including RHCs, FQHCs, and Opioid Treatment Programs (OTPs) must use Medicare modifier "FQ" for allowable audio-only services furnished in those settings. Beginning Jan. 2023, all providers, including RHCs, FQHCs and OTPs, must use modifier "93" when billing for eligible mental health services furnished via audio-only communication technology. Providers can use either "FQ" or "93" modifiers or both where appropriate since they are identical in meaning.

Finally, supervising practitioners will continue to use the "FR" modifier as appropriate for encounters where they provide direct supervision for a service using real-time, audio/video communication technology.

Expiration of COVID-19 PHE Flexibilities for Direct Supervision Requirements

As discussed in the OPPS section above, CMS modified the definition of direct supervision requirements for certain services including diagnostic tests, physicians' services and some hospital outpatient rehabilitation services using real-time audio/video communication technology. In the CY 2023 PFS final rule, CMS stated it expects to continue to permit direct supervision through virtual presence through at least the end of CY 2023.

New Coding and Payment for General Behavioral Health Integration (BHI) Billed by Clinical Psychologists (CPs) and Clinical Social Workers (CSWs)

CMS created HCPCS code G0323 which describes general BHI performed by CPs or CSWs. This code covers care management services for behavioral health conditions using at least 20 minutes of CP or CSW time per calendar month with the following elements:

- Initial assessment or follow-up monitoring, including the use of applicable validated rating scales;
- Behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes;
- Facilitating and coordinating treatment such as psychotherapy, coordination with and/or referral to physicians and practitioners who are authorized by Medicare law to prescribe medications and furnish E/M services, counseling and/or psychiatric consultation; and
- Continuity of care with a designated member of the care team.

These services will be allowed under general supervision. CMS values the code based on a crosswalk to CPT code 99484. CPs are authorized to furnish and bill for services that are provided by clinical staff incident to their professional services, whereas CSWs are only be able

to bill for services they personally furnish. G0323 can be billed during the same month as other care management bundles.

Under current BHI requirements, providers must conduct an initiating visit for new patients or beneficiaries not seen within a year of commencement of BHI services. Existing eligible initiating visit codes are not entirely within the scope of the CP's practice, so CMS will allow a psychiatric diagnostic evaluation (CPT code 90791) to serve as the initiating visit for BHI.

Direct Supervision Requirements for "Incident To" Behavioral Health Services

CMS does not currently pay separately for auxiliary personnel professional services (e.g. licensed professional counselors). Instead, payment for these services are made indirectly under the PFS when auxiliary personnel perform services under the direct supervision of the billing physician or practitioner.

In an effort to improve access to behavioral healthcare, CMS changed supervision requirements from direct to general supervision of a physician or non-physician practitioner when those services are provided incident to the services of a physician or non-physician practitioner.

CMS notes that this provision does not change the existing definition, scope of practice or requirements governing auxiliary personnel, nor does it change the definition of "incident to" services.

Medicare Opioid Treatment Program (OTP) Pricing Updates

Methadone Pricing: While CMS previously finalized a methodology for annually updating methadone payments, it found that voluntarily reported data suggested a drastic drop in the average sales price for oral methadone. In response, CMS issued an interim final rule establishing a limited exception to the annual update. After considering alternative payment methods, CMS finalized a CY 2023 payment amount for the drug component of HCPCS codes G2067 (Medicare assisted treatment, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed) and G2078 (take-home supply of methadone; up to seven additional-day supply; list separately in addition to code for primary procedure) of $39.37 (based on CY 2021 payments for methadone). CMS will update this amount annually for inflation using the Producer Price Index for Pharmaceuticals for Human Use (Prescription).

Rate for Individual Therapy: Following feedback that CMS' current payment rate for individual therapy included in the non-drug component of the bundled payment for an episode of care (crosswalk to CPT code 90832, 30 minutes of psychotherapy) is insufficient, CMS finalized a rate for individual therapy based on a crosswalk to CPT code 90832, 45 minutes of psychotherapy.

Mobile Components Operated by OTPs: CMS will amend regulatory language to clarify that it will apply geographic locality adjustments to payments for services furnished via mobile OTP units as if the services were furnished at the OTP registered with the Drug Enforcement Agency.

Use of Telecommunications for Initiation of Treatment with Buprenorphine: CMS will allow OTPs to initiate treatment with buprenorphine via two-way audio/video communications, and via audio-only communication technology when audio/video technology is not available to the beneficiary. CMS believes it appropriate to permanently allow this mode of service, as long as all other applicable requirements are met. In a Nov. 16 letter, Illinois Attorney General Kwame Raoul joined a bipartisan coalition of 45 attorneys general urging the Drug Enforcement Administration and Substance Abuse and Mental Health Services Administration to make these flexibilities permanent. Otherwise, the rule allowing buprenorphine to be prescribed virtually is set to expire once the COVID-19 PHE ends. In addition to the provision permitting treatment initiation with buprenorphine using telecommunications, CMS will also allow periodic assessments to continue to be furnished using audio-only communication technology through the end of 2023 for patients receiving treatment with buprenorphine, methadone or naltrexone.

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