The American Heart Association (AHA) is the nation's oldest and largest voluntary organization dedicated to fighting heart disease and stroke, whose mission is to be a relentless force for a world of longer, healthier lives. We thank the Division of Insurance and MassHealth for the productive listening session held on March 12, 2021 relative to the implementation of telehealth provisions within Chapter 260 of Acts of 2020. We appreciate the opportunity to provide written comments in follow up to the thoughtful discussion about what constitutes a telehealth visit and the definitions of services.

The outbreak of COVID-19 has put a strain on the healthcare industry and laid bare significant gaps in access to quality care in the United States. Issues such as large populations of uninsured and underinsured, primary and specialty care shortages, hospital closures, and the disproportionate impact of chronic disease on minority ethnic and racial populations have been magnified exponentially by the outbreak. Additionally, many states and local communities have implemented stay-at-home edicts, thereby further restricting patients' access to traditional healthcare. The crisis has forced healthcare systems and regulatory bodies to turn to turn to telehealth to provide healthcare. Telehealth has enabled patients, healthcare providers and health systems to communicate through virtual channels in in-patient, ambulatory, and non-healthcare environments. The American Heart Association (AHA) recognizes the potential impact of telehealth on access to quality care and supports policies that ensure patients and healthcare providers are adequately reimbursed for it and have access to its benefits when it is clinically appropriate. The COVID-19 pandemic shifted the paradigm, however, when it comes to ensuring all patients have access to adequate and affordable care. Telehealth filled the void and quickly shifted from a previously slow adoption path to a record pace of uptake. Although telehealth has been showcased as a primary means for accessing care, and for its ability to address long-standing barriers to accessing care for vulnerable populations, it has also shown to be a vehicle for exposing new barriers. Evidence suggests that telehealth can make health care more effective, accessible, and efficient, particularly for those who otherwise lack access to quality healthcare. Telehealth potentially allows quality health care to be delivered to patients in communities where in-person subspecialty services are not available, providing support and training for complex medical conditions to local providers, increasing accessibility for families to specialists, and minimizing time away from work and home.

While access to affordable and adequate care is extremely important during a pandemic, the barriers to care that existed prior to the COVID-19 pandemic remain and new ones have arisen. The actions taken by the Federal and various state governments to expand access to telehealth services have been a step in the right direction, but they have been limited in scope and their impact has been mitigated by disparities in access to adequate broadband and technology. Permanent laws and regulations are needed that establish both public and private reimbursement that is equitable with traditional, in-person care and that does not discriminate based on the patient's or provider's geographical location. Additionally, public health and technological infrastructures must be fully and equitably modernized to ensure that all patients have optimal access to the benefits of telehealth and that all providers have optimal opportunities to procure, implement, and use telehealth to treat patients. The AHA believes that telehealth has the potential to expand access to quality care for all.

Utilizing a broad definition of chronic disease management ensures that the state's implementation of telehealth includes relevant and critical space to remain aligned with evolving medical evidence, precludes the need to establish a process by which we could revisit a pre-established list of conditions, and removes the potential for bottlenecks in the provision of accessible care that do not exist within in-

office settings. Additionally, we would encourage DOI & MassHealth, when considering reimbursement for chronic disease management care and services, to allow those providers who are providing care and treatment for in-person chronic disease management services to also provide telehealth care and services.

Most importantly, we would note that healthcare providers have been providing care and treatment to patients via telehealth throughout the pandemic – which has been reimbursed on-par with in-person visits. Should such reimbursement parity for the services and patients be reduced, there is the potential for access to telehealth to be reduced, thereby compelling patients to seek in-person services, many of whom have transportation issues, childcare issues, and/or are immunocompromised or at higher risk of contracting, becoming severely ill or being hospitalized with COVID-19. To compel in-person services for such patients could reify existing systemic disparities in accessing healthcare, thereby undoing the significant equity benefits of telemedicine.

We are asking as you work to clarifying the regulations that you ensure that patients have access to clinically appropriate telehealth services, by including patient homes as an originating site, expanding allowable telehealth services to include cardiac rehabilitation and stroke rehabilitation. In response to the Covid-19 pandemic, CMS specifically added reimbursement for cardiac rehabilitation delivered through telehealth within the Medicare program https://www.federalregister.gov/d/2020-06990/p-262. The added services primarily cover cardiac rehabilitation and point to an increased interest among healthcare providers to use remote patient monitoring platforms to improve care management for cardiac care patients at home because recent studies suggest that patients with cardiac issues aren't accessing routine checkups and other services during the pandemic, putting them at higher risk of a serious health issue. In addition, if it is helpful, the CPT codes for cardiac rehabilitation that CMS is reimbursing via telehealth in Medicare are 93797 and 93798 (these relate to cardiac rehab) and G0422 and G0423 (these relate to intensive cardiac rehab).

Thank you very much for your time and your consideration of these matters. We appreciate the opportunity to offer these comments as you craft and formulate policies to implement Ch. 260 of the Acts of 2020 to advance and expand access to telehealth services in Massachusetts. Should you have any questions or concerns, please do not hesitate to reach out Allyson Perron Drag at allyson.perron@heart.org or 857-540-9686.

Sincerely,
Allyson Perron Drag
American Heart Association/ Stroke Association
Government Relations Director

Mass General Brigham

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Massachusetts Division of Insurance
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Boston, MA 02118

Mr. Kevin Beagan
Deputy Commissioner

March 23, 2021

Dear Mr. Beagan,

Mass General Brigham appreciates the ongoing process hosted by the Division of Insurance (The Division) and MassHealth for their open and transparent process related to the development of regulation for the telehealth provisions included in Chapter 260 of the Acts of 2020.

The second session hosted by The Division on March 12, 2021 explored questions critical to the success of the telehealth expansion included in the legislation. Defining what constitutes billable telehealth visit and shared definitions of primary care, behavioral health care and chronic disease care are critical for patient transparency, standardized provider understanding and operationalizing telehealth at the local and state levels.

Telehealth Visits

A goal of the regulations under development needs to be to limit complexity for patients and providers. The same considerations a physician or other provider makes around in-person visits can and should apply to virtual visits. These include:

- Clinical appropriateness. Mass General Brigham supports the suggestion raised by Harvard Medical faculty physicians to refer to the American Medical Association's framework which uses complexity as the clinical orientation and synchs up how physicians can be compensated for time and expertise.
- Adherences to existing patient visit consent requirements.
- A minimum time frame for which a visit can be billable.
- The application of the same utilization management requirements as its corresponding in-person visit.
- Coverage of inter-provider consultations.
- Standardization across all carriers and providers to reduce administrative burden and patient confusion.

Throughout the federal public health emergency associated with COVID-19, providers were exempted from components of the data security requirements of HIPAA. Mass General Brigham believes that post-PHE, providers should return to utilizing only HIPAA-compliant platforms so that patient information is secure. To support providers that currently use Facetime or other non-secure platforms, there could be a ramp-up time for providers to transition from non-HIPAA compliant platforms to those that are compliant. We request that The Division align with the federal HIPAA compliant modalities.

The Division requested comment on Bulletin 2020-04 and its potential applicability to the regulations under contemplation. Mass General Brigham believes that the bulletin places undue burden on providers caring for their existing patients through its requirement that, prior to each telehealth appointment, the provider ensure services can be accommodated by a telehealth visit, rather than an in-person visit. Thorough review of a patient's history is an essential component of a visit, but a provider cannot predict the unexpected. As such, if a new complaint or issue arises in a telehealth visit, the provider may not have been prepared for such an event but may still be well positioned to address it over telehealth. If the provider determines that in-person care is required for the new issue, s/he should still be compensated for the care delivered via telehealth. Bulletin 2020-04 is written such that it precludes the possibility of the unknown and therefore should be modified or ruled out as a baseline for telehealth appropriateness moving forward. We would suggest that The Division consider the use of the practice guidelines from the American Telehealth Association (ATA), in lieu of Bulletin 2020-04.

<u>Definition of Chronic Disease</u>

Mass General Brigham urges The Division to utilize the Center for Disease Control's (CDC) definition of chronic disease care and management: *Chronic diseases are defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both.*

Mass General Brigham believes that the CDC's definition allows for patients' conditions to grow and change overtime, as well as, broadly encapsulates the scope of conditions that qualify as chronic.

The CMS chronic care management (CCM) codes offered by The Division as a source document are insufficient as they speak to non-physician virtual check-ins by case managers. The topic at hand in these regulations is a telehealth reimbursement system that parallels the in-person physician/patient relationship; the CCM codes are distinct from this relationship. In addition, the CMS standards required 2+ comorbidities to qualify, which precludes providers managing a single, serious chronic illness from parity in payment for telehealth visits that could be effective in disease management.

Physical and Occupational therapies play a pivotal role in the management of certain chronic conditions. Mass General Brigham has found that PT and OT visits delivered via telehealth during the pandemic have been effective and efficient in managing care. We urge The Division to include them in the definition and payment parity offered until January 2023. Unlike many physician services, which have historically billed telehealth via professional billing, therapeutic services such as PT and OT are billed via hospital billing. As such: for chronic disease to be fully managed, PT and OT must be included; for PT and OT to be included, providers must be able to bill as a hospital for these services.

Definition of Primary Care

Mass General Brigham believes that the definition of primary care should be expansive. Traditional primary care providers (PCPs) are physicians trained in internal medicine, family medicine, pediatrics and obstetrics/gynecology. These physicians should of course be considered PCPs. For many patients with chronic conditions, or others who have an established relationship with a specialist, they consider the specialist with whom they work most closely to be functioning as their PCP. Individual patients should be asked to specify their primary care provider with their carrier and the carrier should honor that selection. An example could be an individual with multiple sclerosis who considers his neurologist his PCP, or an individual with cancer that considers her oncologist her PCP.

Mass General Brigham appreciates the collaborative and transparent process that the Division of Insurance and MassHealth have embarked upon to promulgate regulations related to the telehealth provisions included in Chapter 260 of the Acts of 2020. We look forward to upcoming telehealth listening sessions and other opportunities for collaboration with DOI and MassHealth on telehealth and other matters. Should there be any questions regarding this comment letter please contact Kelly Driscoll, Director Government Payer Policy, kdriscoll12@partners.org.

Sincerely,

Lee H. Schwamm, MD, FAHA, FANA
Vice President, Virtual Care- Mass General Brigham
Director, Center for Telehealth- Mass General Hospital

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March 29, 2021

Kevin Patrick Beagan
Deputy Commissioner, Health Care Access Bureau
Massachusetts Division of Insurance
1000 Washington Street
Boston, MA 02118

Dear Deputy Commissioner:

On behalf of the Massachusetts Psychiatric Society, thank you for the opportunity to participate in the listening session on March 12, 2021 to discuss implementation of telehealth provisions within Chapter 260 of Acts of 2020. The Massachusetts Psychiatric Society (MPS) wishes to submit the following comments for your consideration:

Regarding What Constitutes a telehealth visit:

Massachusetts Psychiatric Society (MPS) notes that the law rightly states that services provided by telehealth conform to the applicable standards of care. We strongly discourage definitions of a visit to go beyond standards of care for each profession providing the service. MPS supports the *t*Med Coalition's position that there should be no additional non-quantitative treatment limits (NQTL) such as prior authorization dictating the appropriateness of telehealth as a modality or the platform used for telehealth. We strongly believe that the decision about the location and modality of the treatment including in-person versus telehealth should be a clinical and person-centered decision that should be determined together by clinicians and the patient, and is inherently dictated by the required standard of care.

MPS also strongly believes that guidance on telehealth which defines necessary component parts of a visit are a backward step and inconsistent with changes to the current Procedural Terminology (CPT) codes. CPT codes were developed by the American Medical Association (AMA) and universally adopted by the Center for Medicare and Medicaid Services (CMS) and insurance carriers. For the first time in 30 years, starting Jan. 1, 2021 CPT codes have incorporated streamlined documentation requirements for Evaluation and management (E/M) with a renewed emphasis on medical decision making instead of requiring a myriad of separate component component parts of a visit. (See link #1 below and attached) The new proposed changes E/M CPT code changes were based on public comment with the goal of decreasing unnecessary documentation. In essence, the billing codes have less emphasis on a score for components of the documentation and have more emphasis on the degree of medical decision making and hence accurately reflect the actual practice of medicine. Previous emphasis on necessary component parts led to practice and documentation inefficiencies whereby providers were penalized or rewarded from a billing perspective for evaluation components which were not relevant for the visit. This contributed to excessive documentation burdens, physician burnout and decreased carrier network participation.

MPS also agrees with the *t*Med Coaltion and advocates that the definition of telehealth recognize, cover, and reimburse for **e-consults or interprofessional telephone/internet/electronic consultation**. Starting in 2019, CMS introduced CPT codes 99451 and 99452 that will reimburse both the referring provider (PCPs) and the consulting provider (Specialist) for performing an e-consult. These services have been added in recognition of the importance of integrated care. Telehealth modalities should also be adopted in the service of care coordination and integration. The American Psychiatric Association have issued guidance regarding documentation for such visits. (Attached) Likewise, MPS advocates that the definition of telehealth should also include recognition,

coverage, and **reimbursement for e-visits** which are patient-initiated, non-face-to face digital communications over HIPAA-complaint, secure platforms or portals that require a clinical decision that otherwise typically would have been provided in the office. Such visits were provided with CPT codes (physician codes 99421, 99422, 99423, and non-physician health professional—98970, 98971, 98972) that were published in 2020 by CMS.

In summary, we do not think it is appropriate that DOI guidance go beyond these established standards by adding defined components to visits.

Regarding the definition of services, we applaud the expansion of the definition of Behavioral Health Services to include the care and services for individuals with developmental disabilities who have suffered from all of the social distancing brought on by the Covid-19 pandemic which limits in-person care and necessitates telehealth services.

Best Regards,

Sally Reyering, MD, DFAPA
President, Massachusetts Psychiatric Society

(1) https://www.ama-assn.org/system/files/2020-04/e-m-office-visit-changes.pdf

The Massachusetts Medical Society, representing more than 25,000 physicians, residents, and medical students, would like to thank the Division of Insurance and MassHealth for the productive listening session held on March 12th, 2021 relative to the implementation of telehealth provisions within Chapter 260 of Acts of 2020. We appreciate the opportunity to provide written comments in follow up to the thoughtful discussion about defining a telehealth "visit" and definitions of behavioral health, chronic disease management, and primary care services.

Defining a "Visit" & Telehealth "Appropriateness"

The Medical Society does not believe the Division or MassHealth should be further defining a medical telehealth "visit" in regulatory guidance any more so than a visit currently regulated for in-office care. Telehealth is not a separate medical specialty; it is a delivery tool – a modality to provide care. As with care provided in-person, there are existing billing and coding systems in place to quantify the services a physician provides and a patient receives, and these mechanisms can and should apply equally to telehealth visits. We understand and appreciate the Division's perspective in seeking clarification and a bright line for patients so that they may understand their financial responsibility for any encounter with their physician that could be considered a visit. We share in that goal of transparency and are striving for a system of fair reimbursement for care where our patients are informed about all co-payments or cost-sharing responsibilities.

A medical visit fundamentally entails the application of medical judgment, which is typically identified by clinical documentation of the services rendered. The statute defines telehealth as the use of various technologies "for the purpose of evaluating, diagnosing, consulting, prescribing, treating or monitoring of a patient's physical health, oral health, mental health or substance use disorder condition." This accurately encompasses the parameters of a visit. As such, MMS does not support the creation of additional criteria to define a visit, for example requiring a minimum time for an encounter or requiring that an encounter be pre-scheduled to constitute visit. Billing and coding systems already account for time, complexity, and medical judgment; many patient-provider interactions are urgent and unexpected and while these encounters are not scheduled, they often involve evaluation, assessment, and treatment that involves the application of complex medical judgment and thus would constitute a visit. The Medical Society further cautions against setting reimbursement rates solely based on the modality, which is not indicative of medical complexity; rather the contents of the clinical encounter and complexity of the medical-decision making should drive reimbursement.

Consistent with our comments above, as to whether a 2-minute phone call would be considered a "visit", this would not likely meet the current standards for billing a visit. However, patient refill requests often trigger an assessment as to whether the medication requires dosage adjustment, review of laboratory values, vital signs, etc. This type of evaluation necessarily entails medical judgment and constitutes a visit, so the determining factor should be the need for clinical judgment. This is important clinical care and that can and should be covered. Patient notification of this type of circumstance would be appropriate.

Relative to the questions pertaining to documentation requirements, we have seen significant variation in documentation requirements across payers during this pandemic, which has proven very burdensome from an administrative perspective. There is tremendous value in, to the extent possible, consistency

across payors in line with the documentation guidance noted in MassHealth All Provider Bulletin 289[1], which requires documentation consistent with all applicable health records standards that apply to care delivered in-person.

The Medical Society understands that the topic of appropriateness will be further addressed in a later listening session. For now, we would like to note that in conformity with BORIM Policy 2020-01 (amended June 25, 2020), physicians are bound by the same medical standards of care whether that care is delivered in-person or via telemedicine; the standard of care does not deviate based on the modality of care delivery. As was detailed in DOI Bulletin 2020-04, it is the physician offering care through telemedicine who is most apt and responsible to ensure they are able to deliver services to the same standard of care as required for in-office care and in compliance with the physician's licensure regulations and requirements, programmatic regulations, and performance specifications related to the service. When the appropriate standard of care cannot be met via telemedicine, physicians are already obligated to make this determination prior to delivery of services and to notify the patient and advise them instead to seek appropriate in-person care. Physicians already make these determinations when triaging patients; when a patient calls, practices make the determination to come in, to talk with a nurse, to have a telehealth visit, etc.

The Medical Society strongly believes that whether care can be appropriately delivered via telehealth is a clinical decision that should be made by the physician. Because the standard of care inherently dictates the appropriateness of telehealth to provide care, we do not believe this warrants further guidance from the Division or from individual plans' medical directors. As it stands, carriers can apply existing medical necessity criteria, as they would apply to care delivered in-office.

Definitions of Behavioral Health, Chronic Disease Management, and Primary Care Services

Behavioral Health

Chapter 260 provides a broad definition of behavioral health services and, importantly, does not limit coverage or reimbursement of those services by the type of provider offering them. If the legislature had intended to limit parity in reimbursement for behavioral health services to services provided by licensed mental health professionals, they would have explicitly done so or otherwise cross-referenced the statutory definition. As such, the Medical Society does not believe that coverage, and therefore parity in reimbursement, for behavioral health services should be restricted to the provision of services by specific provider types, as this would be contrary to the legislative intent. The definition of

[1] MH All Provider Bulletin 289:
Providers delivering services via telehealth must meet all health records standards required by the applicable licensing body as well as any applicable regulatory and program specifications required by MassHealth. This includes storage, access, and disposal of records.

In addition to complying with all applicable MassHealth regulations pertaining to documentation of services, providers must include a notation in the medical record that indicates that the service was provided via telehealth, the technology used, and the physical location of the distant and the originating sites.

The provider must also include the CPT code for the service rendered via telehealth in the patient's medical record. MassHealth may audit provider records for compliance with all regulatory requirements, including record keeping and documentation requirements, and may apply appropriate sanctions to providers who fail to comply.

behavioral health in Ch. 260 includes three separate types of health care: mental health, developmental and substance use disorders. Each clinical subcategory in this definition could be treated by a different type of physician, including psychiatrists, developmental pediatricians, addiction medicine physicians, and primary care physicians. A limited approach to defining behavioral health based solely upon the type of clinician providing the care would necessarily limit patients' access to services, which the legislature intended to be covered through the expansive behavioral health definition.

In addition, the collaborative care model supports integrated behavioral health care within the primary care setting. This is important to keep in mind as, as primary care providers are key to promoting and improving access to behavioral health care. For too long, the health care system has carved out mental and behavioral health care. Mental health care is health care. Massachusetts should be striving toward a more integrated system of mental health care delivery so Massachusetts residents can access the care they need and deserve. The Division and MassHealth have a tremendous opportunity with implementation guidance to promote the integration of mental health care into overall health care by clarifying that primary care physicians and other physicians providing behavioral health services are covered under the behavioral health sections of Ch. 260.

Chronic Disease Management

The Medical Society does not believe the chronic conditions identified by Centers for Medicare and Medicaid Services (CMS) is sufficiently inclusive of the breadth and types of chronic conditions that can and should be allowed to be managed effectively through telehealth. The CMS list of chronic conditions is not and was not intended to be a comprehensive list of chronic conditions, but rather an example of certain conditions for which CMS tracks relevant utilization and spending data for purposes of the Medicare program. As such, the CMS list is very adult-centric and excludes some of the most common pediatric chronic conditions, such as cystic fibrosis, attention deficit disorder, or obesity, which would detrimentally impact pediatric patients.

The Division should consider issuing guidance allowing for a broader, more inclusive spectrum of chronic diseases to ensure that patients can access appropriate care management, including through telehealth. A more inclusive approach would not require carriers to cover any illness or disease beyond what is already required to be covered through a different modality. Instead of devising an exclusive list of eligible conditions, the Division should consider crafting a definition of chronic disease that is applicable to clinical practice and reflects the plethora of diseases that impact patients on a chronic basis. Most groups, including several carriers in Massachusetts, do not define chronic conditions based on a list, but rather through a descriptive approach. For example, the American Medical Association, the Centers for Disease Control and Prevention, and Tufts Health Plan generally define chronic diseases as conditions that last one year or more and require ongoing medical attention, or limit activities of daily living, or both. The need for disease management is so pervasive, as it is noted on one plan's website that "six in ten adults in the US have a chronic disease and four in ten adults have two or more," referencing the CDC/National Center for Chronic Disease Prevention and Health Promotion.

The Medical Society strongly urges the Division to reject the incredibly narrow interpretation offered by some, which would limit reimbursement parity for chronic disease management to 4 CPT management codes identified in Medicare's Chronic Care Management (CCM) program. There is a difference between providing Chronic Care Management as defined by Medicare and managing chronic conditions. They are not the same and should not be treated as such. The CMS Chronic Care

Management program is intended for Medicare patients that have two chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. This program is intended for Medicare patients and has resulted in very limited uptake among providers, making it ill-suited for application to commercial and Medicaid populations in Massachusetts. The legislature was certainly not intending to limit parity in reimbursement for chronic disease management to this specific Medicare program, excluding the vast majority of patients who suffer from chronic illness.

Instead, we believe the plain text of the law evinces a legislative intent to connote a broader interpretation of chronic disease management. Specifically, the definition in Chapter 260 of "chronic disease management" includes the "care and services for the management of chronic conditions" and lists out many examples of the types of care that should be covered at parity under the law. The legislature sought to promote greater care management and access to services for patients suffering from chronic disease, which has an outsized impact on health care costs. It is important to facilitate access to these services through telehealth by ensuring reimbursement parity. A narrow interpretation would exclude critical care that can be delivered through telemedicine from reimbursement parity and undermine efforts to promote access to that very care in a coordinated, cost-efficient manner.

Primary Care Services

The Medical Society urges the Division to consider approaching guidance relative to primary care services similarly to the approach for behavioral health. That is, the focus and determinative factor for reimbursement should be the services provided as opposed to the specialty of the provider. Traditionally a "primary care provider" is thought of as those physicians with a specialty in family medicine, internal medicine, general medicine, pediatrics, or obstetrics/gynecology – these are specialists who provide what are conventionally thought of as primary care services. However, the current statutory definition of "primary care provider" does not specify a list of who is or is not a primary care provider, but instead focuses on the types of services provided and importantly who is coordinating and maintaining continuity of care. This is consistent with health system goals to promote quality and continuity of care. As such, parity in reimbursement for services should not be limited to single designated "primary care provider."

Under M.G.L c. 1760, many who are considered specialists outside of "primary care" would meet the current statutory definition of primary care provider because of the nature of the services provided to patients. For example, multiple sclerosis (MS) is a common neurologic issue that is managed longitudinally with regular visits to maintain control of the disease. While a patient with MS likely has a designated "primary care provider" for insurance purposes, MS is primarily managed by neurologists. The neurologist would be responsible for supervising, coordinating, and prescribing, and otherwise providing health care services – fitting the statutory definition of a primary care provider. We recognize the complexity of this approach and the challenges it may pose as the Division seeks a clean, bright-line way to designate primary care services for purposes of the statutorily mandated parity in reimbursement for primary care services. As the Division grapples with this, we urge you to avoid narrow designations of a single, "primary care provider", which do not reflect the realities of clinical practice, and instead consider a broader approach that recognizes relationships between patients and physicians that promote quality and continuity of care.

Thank you very much for your time and your consideration of these matters. We appreciate the opportunity to offer these comments as you craft and formulate policies to implement Ch. 260 of the Acts of 2020 to advance and expand access to telehealth services in Massachusetts. Should you have any questions or concerns, please do not hesitate to reach out to Leda Anderson, Legislative Counsel, at (781) 434-7668 or landerson@mms.org or Yael Miller, Director of Practice Solutions & Medical Economics, at ymiller@mms.org.

MASSACHUSETTS GASTROENTEROLOGY ASSOCIATION

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Kevin Beagan
Deputy Commissioner, Division of Insurance
1000 Washington Street, Suite 810,
Boston, MA 02118

March 15, 2021

Dear Mr. Beagan

I am submitting these comments on behalf of the Massachusetts Gastroenterology Association in reference to the DOI listening session of March 12, 2021 in which the definition of Chronic Disease Management for the purposes of implementation of Chapter 260 of the Acts of 2020 and reimbursement for telehealth services were discussed. The purpose of this communication is to request that Inflammatory Bowel Disease, including but not limited to Crohn's disease and ulcerative colitis, be included in the definition of Chronic Disease Management.

According to the Centers for Disease Control and Prevention (CDC), **Chronic diseases are defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both.** The CDC characterizes Crohn's disease and ulcerative colitis, collectively referred to as inflammatory bowel disease (IBD), as conditions characterized by chronic inflammation of the gastrointestinal tract, and falls within the definition of chronic disease. Relative to the question of need, the Morbidity and Mortality Weekly Report, referenced below, noted that the number of older adults with Crohn's disease or ulcerative colitis, collectively referred to as inflammatory bowel disease (IBD), is expected to increase as the U.S. population ages. (Hospitalizations for Inflammatory Bowel Disease Among Medicare Fee-for-Service Beneficiaries — United States, 1999–2017 | MMWR (cdc.gov)).

Also, the National Institutes of Health (NIH) defines inflammatory bowel disease as a chronic condition: "Inflammatory bowel disease (IBD) is a chronic inflammatory disease of the gastrointestinal tract and is divided into Crohn disease and ulcerative colitis."-- "Both disorders have a genetic predisposition; neither is curable and they both carry enormous morbidity. Finally, both increase the risk of colorectal cancer."(Inflammatory Bowel Disease - StatPearls - NCBI Bookshelf (nih.gov))

Turning to state law, Mass. General Laws, Chapter 94I, Section 1, defines Crohn's Disease as a debilitating medical condition: "Debilitating medical condition", cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, Parkinson's disease, multiple sclerosis and other conditions as determined in writing by a registered qualifying patient's registered healthcare professional."

In conclusion, it is clear that inflammatory bowel disease is indeed a chronic condition which must be managed closely and over period of time. Without such, the risk of costly hospitalization is likely. Encouraging the use of telehealth services allows gastroenterologists more flexibility to better manage their patients with such conditions and increases access to care for patients that cannot make a face to face visit, or prefer a virtual visit for various reasons, including age, transportation issues, physical limitations, or in need of more timely attention that can be scheduled face to face.

Thank you for your consideration of this request. We look forward to the Division's response.

Sincerely,

Raj Devarajan, MD
MGA President

n

MASSACHUSETTS GASTROENTEROLOGY ASSOCIATION

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April 12, 2021

Kevin Beagan
Deputy Commissioner, Division of Insurance
1000 Washington Street, Suite 810,
Boston, MA 02118

Dear Deputy Commissioner Beagan,

This letter is intended to follow up on Massachusetts Gastroenterology Association's (MGA) previous communication dated March 15, 2021. That communication requested that Inflammatory Bowel Disease, including but not limited to Crohn's disease and ulcerative colitis, be included in the definition of Chronic Disease Management for the purposes of reimbursement for telehealth services.

As noted in the MGA's 3/15/21 letter, the CDC characterizes Crohn's disease and ulcerative colitis, collectively referred to as inflammatory bowel disease (IBD), as conditions characterized by chronic inflammation of the gastrointestinal tract, and thus, falls within the definition of chronic disease. The National Institutes of Health (NIH) also defines inflammatory bowel disease as a "chronic inflammatory disease of the gastrointestinal tract." However, we wish to point out that Crohn's disease and ulcerative colitis are not the only inflammatory bowel diseases and moreover, that inflammatory bowel diseases are not the only chronic disease management routinely performed by gastroenterologists.

For these reasons, and as a member of the Massachusetts Telemedicine (tMED) Coalition, the MGA wishes to support that organization's position that the DOI adopt a broader definition for chronic disease management akin to the definition utilized by the Centers for Disease Control and Prevention (CDC) which state that **"Chronic diseases are defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both."** The value of this approach is to eliminate the need for specific diagnosis and instead to focus on conditions that can be controlled, but not cured.

Moreover, and again as noted by the tMED Coalition, utilizing a broad definition of chronic disease management ensures that the state's implementation of telehealth includes relevant and critical space to remain aligned with evolving medical evidence and precludes the need to pre-established a list of conditions.

In conclusion, encouraging the use of telehealth services through parity in reimbursement allows gastroenterologists more flexibility to better manage their patients with chronic conditions, reduce the need for costly hospitalizations, increase access to care for patients that cannot make a face to face visit, or prefer a virtual visit for various reasons, including age, transportation issues, physical limitations, or are in need of more timely attention that can be scheduled face to face.

Thank you for your consideration of the MGA's position on telehealth reimbursement for our patients with chronic conditions.

Sincerely,

Benjamin Hyatt, MD
MGA President

March 30, 2021

Kevin Beagan
Deputy Commissioner, Massachusetts Division of Insurance
1000 Washington Street, Suite 810
Boston, MA 02118

Dear Deputy Commissioner Beagan,

We appreciate the opportunity to provide input on implementation of Chapter 260 of the Acts of 2020, as it applies to telehealth.

We are a coalition of sexual and reproductive health (SRH) providers and advocates serving hundreds of thousands of patients across the CommonWealth. **We urge the Division of Insurance to include sexual and reproductive health services in the definition of primary care for the purposes of reimbursement parity for telehealth services.**

There is clear precedent at the federal level establishing sexual and reproductive health (SRH) as essential, preventive health care and part of primary care. The Affordable Care Act (ACA) identifies sexual and reproductive health services as part of the "10 essential health benefits," under the category of "preventive and wellness services." A wide range of SRH services can be provided by telehealth – including prenatal care, contraceptive counseling, testing and treatment of sexually transmitted infections (STI), screening for intimate partner violence, and abortion care. These essential services are also time-sensitive, with serious life-changing outcomes:[1] unreliable access to birth control can result in unintended pregnancies;[2] untreated STIs can lead to pelvic inflammatory disease and fertility complications;[3] and delayed care for conditions such as endometriosis and fibroids can increase patient morbidity.[4]

During the COVID-19 pandemic, telehealth helped patients maintain access to essential sexual and reproductive health services – especially when many faced complex barriers to care. According to a 2020 Guttmacher survey, **a quarter** of patients using hormonal birth control pills reported switching to a telehealth appointment to have their prescription refilled. In the same survey, **one in three** women reported having trouble accessing timely SRH care due to delays or cancellations of in-person visits related to the pandemic.[5]

Telehealth alleviates gaps and inequities in sexual and reproductive health care that persisted well before the pandemic. According to a 2017 survey by the Kaiser Family Foundation, **one in four** women reported they did not obtain SRH care because they could not

[1] Weigel G, Salganicoff A, and Ranji UI. Potential Impacts of Delaying "Non-Essential" Reproductive Health Care. *Kaiser Family Foundation.* 2020.
[2] American College of Obstetricians and Gynecologists. Access to contraception. Committee Opinion No. 615. O*bstet Gynecol* 2015;125:250–5.
[3] Sexually Transmitted Diseases. *National Institute of Allergy and Infectious Disease*. 2015. Accessed March 26, 2021.
[4] Endometriosis. American College of Obstetricians and Gynecologists. 2021. Accessed March 26, 2021.
[5] Lindberg L, VandeVusse AI, Mueller J, and Kirstein M. Early Impacts of the COVID-19 Pandemic: Findings from the 2020 Guttmacher Survey of Reproductive Health Experiences. *Guttmacher Institute*. 2020.

find the time or take time off work.[6] Rural communities and low-income patients are also much less likely to have access to OB/GYN or family planning providers.[7] Several studies underscore how telehealth has helped address these gaps and barriers, increasing patient access.[8] [9]

It is crucial that patients can continue to access sexual and reproductive health services by telehealth through their primary care and other sexual and reproductive health providers – both during and after the COVID-19 pandemic. We ask that the Division of Insurance prioritizes the inclusion of sexual and reproductive health services in the definition of primary care within the telehealth regulations.

Thank you for your consideration of our request. We are happy to be a resource on this subject and answer any questions you have.

Sincerely,

ABCD Health Services
Cambridge Health Alliance
Citizens for Citizens
Health Quarters
Massachusetts Family Planning Association (MFPA)
NARAL Pro-Choice Massachusetts
Partners in Contraceptive Choice and Knowledge (PICCK)
Planned Parenthood Advocacy Fund of Massachusetts
Tapestry Health
Upstream USA

[6] Ranji U, Rosenzweig C, Gomez I, and Salganicoff A. Executive Summary: 2017 Kaiser Women's Health Survey. *Kaiser Family Foundation*. 2018.
[7] Mobile Optical Detection Technologies. Whitepaper: How Telehealth Solutions Can Counter America's Growing OB/GYN Provider Shortage. 2018. Accessed March 26, 2021.
[8] American Hospital Association. Telehealth: Helping Hospitals Deliver Cost-Effective Care. 2014. Accessed March 26, 2021.
[9] Marcin J, Shaikh U, and Steinhorn R. Addressing health disparities in rural communities using telehealth. *Pediatric Research*. 2016;79:169-176.

MASSACHUSETTS PSYCHIATRIC SOCIETY

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Mayuri Patel
Member Relations Coordinator

March 29, 2021

Kevin Patrick Beagan
Deputy Commissioner, Health Care Access Bureau
Massachusetts Division of Insurance
1000 Washington Street
Boston, MA 02118

Dear Deputy Commissioner:

On behalf of the Massachusetts Psychiatric Society, thank you for the opportunity to participate in the listening session on March 12, 2021 to discuss implementation of telehealth provisions within Chapter 260 of Acts of 2020. The Massachusetts Psychiatric Society (MPS) wishes to submit the following comments for your consideration:

Regarding What Constitutes a telehealth visit:

Massachusetts Psychiatric Society (MPS) notes that the law rightly states that services provided by telehealth conform to the applicable standards of care. We strongly discourage definitions of a visit to go beyond standards of care for each profession providing the service. MPS supports the *t*Med Coalition's position that there should be no additional non-quantitative treatment limits (NQTL) such as prior authorization dictating the appropriateness of telehealth as a modality or the platform used for telehealth. We strongly believe that the decision about the location and modality of the treatment including in-person versus telehealth should be a clinical and person-centered decision that should be determined together by clinicians and the patient, and is inherently dictated by the required standard of care.

MPS also strongly believes that guidance on telehealth which defines necessary component parts of a visit are a backward step and inconsistent with changes to the current Procedural Terminology (CPT) codes. CPT codes were developed by the American Medical Association (AMA) and universally adopted by the Center for Medicare and Medicaid Services (CMS) and insurance carriers. For the first time in 30 years, starting Jan. 1, 2021 CPT codes have incorporated streamlined documentation requirements for Evaluation and management (E/M) with a renewed emphasis on medical decision making instead of requiring a myriad of separate component component parts of a visit. (See link #1 below and attached) The new proposed changes E/M CPT code changes were based on public comment with the goal of decreasing unnecessary documentation. In essence, the billing codes have less emphasis on a score for components of the documentation and have more emphasis on the degree of medical decision making and hence accurately reflect the actual practice of medicine. Previous emphasis on necessary component parts led to practice and documentation inefficiencies whereby providers were penalized or rewarded from a billing perspective for evaluation components which were not relevant for the visit. This contributed to excessive documentation burdens, physician burnout and decreased carrier network participation.

MPS also agrees with the *t*Med Coaltion and advocates that the definition of telehealth recognize, cover, and reimburse for **e-consults or interprofessional telephone/internet/electronic consultation**. Starting in 2019, CMS introduced CPT codes 99451 and 99452 that will reimburse both the referring provider (PCPs) and the consulting provider (Specialist) for performing an e-consult. These services have been added in recognition of the importance of integrated care. Telehealth modalities should also be adopted in the service of care coordination and integration. The American Psychiatric Association have issued guidance regarding documentation for such visits. (Attached) Likewise, MPS advocates that the definition of telehealth should also include recognition,

coverage, and **reimbursement for e-visits** which are patient-initiated, non-face-to face digital communications over HIPAA-complaint, secure platforms or portals that require a clinical decision that otherwise typically would have been provided in the office. Such visits were provided with CPT codes (physician codes 99421, 99422, 99423, and non-physician health professional—98970, 98971, 98972) that were published in 2020 by CMS.

In summary, we do not think it is appropriate that DOI guidance go beyond these established standards by adding defined components to visits.

Regarding the definition of services, we applaud the expansion of the definition of Behavioral Health Services to include the care and services for individuals with developmental disabilities who have suffered from all of the social distancing brought on by the Covid-19 pandemic which limits in-person care and necessitates telehealth services.

Best Regards,

Sally Reyering, MD, DFAPA
President, Massachusetts Psychiatric Society

(1) https://www.ama-assn.org/system/files/2020-04/e-m-office-visit-changes.pdf

AMA
AMERICAN MEDICAL ASSOCIATION

Evaluation and Management (E/M) Office Visits—2021

Peter Hollmann, MD
Christopher Jagmin, MD
Barbara Levy, MD

Agenda

- History of E/M Workgroup
- E/M Revisions for 2021: Office and Other Outpatient Services
    - New Patient (99201-99205)
    - Established Patient (99211-99215)
    - Medical Decision Making (MDM)
    - Time
    - Prolonged Services
- AMA CPT® E/M Education

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How Did We Get Here?

Medicare E/M Initial 2019 Fee Schedule Proposal (Released July 2018): SUMMARY

The goal was administrative simplification and CMS perceived current E/M codes as “outdated” based on past comment letters

- Medical Necessity:
  - Eliminate the requirement to document medical necessity of furnishing visits in the home rather than office
  - Eliminates the prohibition of same-day E/M visits billing by physicians in the same group or medical specialty
  - Documentation of level 2 necessity for Office E/M is sufficient
- Documentation redundancy:
  - Eliminates the need to re-enter information regarding chief complaint and history that is already recorded by ancillary staff or the beneficiary. The practitioner must only document that they reviewed and verified the information.

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How Did We Get Here?

Medicare E/M Initial 2019 Fee Schedule Proposal (Released July 2018): SUMMARY

1. Simplify code level selection and remove unnecessary history and examination elements

- Physicians may choose method of documentation
    - CMS 1995/1997 Documentation Guidelines (ie, current standards)
    - MDM only, or
    - Face-to-Face time
- Simplification included elimination of payment differentials between services

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Medicare E/M Initial 2019 Proposal (Released July 2018): Summary

2. Condensing Visit-Payment Amounts

CMS calls the system of 10 visits for new and established office visits "outdated" and proposes to retain the codes but simplify the payment by applying a single-payment rate for level 2 through 5 office visits.

CPT® Code New Office Visits	CY 2018 Non-Facility Payment Rate	CY 2019 Proposed Non-Facility Payment Rate
99201	$45	$43
99202	$76	$134
99203	$110	
99204	$167	
99205	$211	

CPT Code New Office Visits	CY 2018 Non-Facility Payment Rate	CY 2019 Proposed Non-Facility Payment Rate
99211	$22	$24
99212	$45	$92
99213	$74	
99214	$109	
99215	$148	

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Medicare E/M Initial 2019 Proposal (Released July 2018): Summary

- CMS projected that the payment groups created significant impact (positive or negative) on specialties as a whole and might not address complexity adequately
- CMS proposed solutions to address this with a specialty add-on code ($14) and prolonged services add-on ($67)
- Adjustments created budget issues, which CMS addressed by reducing payment for perceived overlap when E/M is performed the same day as a procedure (50% reduction)

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Medicare E/M Initial 2019 Proposal (Released July 2018)

3. Other Related Coding/Payment Proposals
   - CMS identifies several specialties that often report higher level office visits
   - CMS proposes offsets via the addition of $14 to each office visit performed by the specialties listed below with a new code:
     - GCG0X,*Visit complexity inherent to evaluation and management associated with*

Proposed Specialties Affected	
Allergy/Immunology	Neurology
Cardiology	Obstetrics/Gynecology
Endocrinology	Otolaryngology
Hematology/Oncology	Rheumatology
Interventional Pain Management-Centered Care	Urology

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Proposed Rule's Major Concerns: Comment Letter (170 Organizations Signed)

- Physicians are extremely frustrated by "note bloat"
- CMS should finalize proposals to streamline required documentation by:
  - Only requiring documentation of interval history since previous visit
  - Eliminating requirement to re-document information from practice staff or patient
  - Removing need to justify home visits in place of office visits
- CMS should not implement collapsed payment rates and add-on codes
- CMS should not reduce payment for office visits on same day as other services
- CMS should set aside office visit proposal, work with medical community on mutually agreeable policy to achieve shared goal and avoid unintended consequences

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CPT®/RUC Workgroup Formed

In July 2018, CMS released the 2019 Medicare Physician Payment Schedule Proposed Rule

In response, the CPT Editorial Panel Co-Chairs, Doctors Ken Brin and Mark Synovec, and the RUC Chair, Doctor Peter Smith formed a Workgroup

Workgroup Members

Name	CPT/RUC	Specialty	Other
Peter Hollmann, MD	RUC, AMA Alternate Representative	Geriatric	AMA
Co-Chair	CPT Editorial Panel, Former Chair	Medicine	HoD
Barbara Levy, MD	CPT Editorial Panel Member	Obstetrics &	AMA
Co-Chair	RUC, Former Chair	Gynecology	HoD
Margie Andreae, MD	RUC Member	Pediatrics	
Linda Barney, MD	CPT Editorial Panel	General	
Patrick Cafferty, PA-C	CPT Editorial Panel Member (former)	Physician	
	Health Care Professionals Advisory Committee	Assistant	
Scott Collins, MD	RUC Member	Dermatology	
David Ellington, MD	CPT Editorial Panel Member (former)	Family	AMA
	Chair of Previous CPT E/M Workgroup	Medicine	HoD
Chris Jagmin, MD	CPT Editorial Panel Member	Family	
	Medical Director, Aetna	Medicine	
Douglas Leahy, MD	RUC Member	Internal	
Scott Manaker, MD	RUC Member	Pulmonary	
	Chair, PE Subcommittee	Medicine	
Robert Piana, MD	CPT Editorial Panel Member	Cardiology	
Robert Zwolak, MD	RUC Member (Former & Present Alternate)	Vascular	

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CPT®/RUC Workgroup Charge

- Capitalize on the CMS proposal:
  - The Workgroup will solicit suggestions and feedback on the best coding structure to foster burden reduction, while ensuring appropriate valuation.
- Act quickly to present CMS with a tangible alternative
  - A coding proposal may be submitted by early November 2018 for consideration at the February 7-8, 2019 CPT Editorial Panel meeting
  - Demonstrate the effectiveness of and follow the CPT and RUC processes

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Workgroup Process: –Focus On Transparency & Inclusion

- The Workgroup held 7 open calls and 1 face-to-face meeting to discuss issues
- On average over 300 participants participated on each call, representing medical specialty societies, commercial and government payers, and CMS policy staff
- The Workgroup conducted five surveys designed to collect targeted feedback from the large, interested-party community and those results were summarized by AMA staff and presented to the Workgroup and call-in participants
    - On average, the surveys received nearly 60 unique responses representing stakeholder organizations
- Many of the major decisions by the Workgroup including, the definition of time and key definitions of MDM criteria, were based on these stakeholder-surveys results

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Workgroup Process: Focus On Transparency & Inclusion

Workgroup established Guiding Principles from the beginning:

The CPT/RUC Workgroup on E/M is committed to changing the current coding and documentation requirements for office E/M visits to **simplify** the work of the health care provider and **improve the health** of the patient.

Guiding Principles:

1. To decrease administrative burden of documentation and coding
2. To decrease the need for audits
3. To decrease unnecessary documentation in the medical record that is not needed for patient care
4. To ensure that payment for E/M is resource based and has no direct goal for payment redistribution between specialties.

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Guiding Principles: Reduce Burden

PRINCIPLE	ACTIONS
Decrease administrative burden	Remove scoring by History and Examination Code the way physicians/other qualified health care professional (QHP) think
Decrease needs for audits	More detail in CPT® codes to promote payer consistency if audits are performed and to promote coding consistency
To decrease unnecessary documentation that is not needed for patient care in the medical record	Eliminate History and Examination scoring Promote higher-level activities of MDM
To ensure that payment for E/M is resource based and has no direct goal for payment redistribution between specialties	Use current MDM criteria (CMS and educational/audit tools to reduce likelihood of change in patterns)

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Summary of Major E/M Revisions for 2021: Office or Other Outpatient Services

Lase Ajayi, MD
Member since 2013

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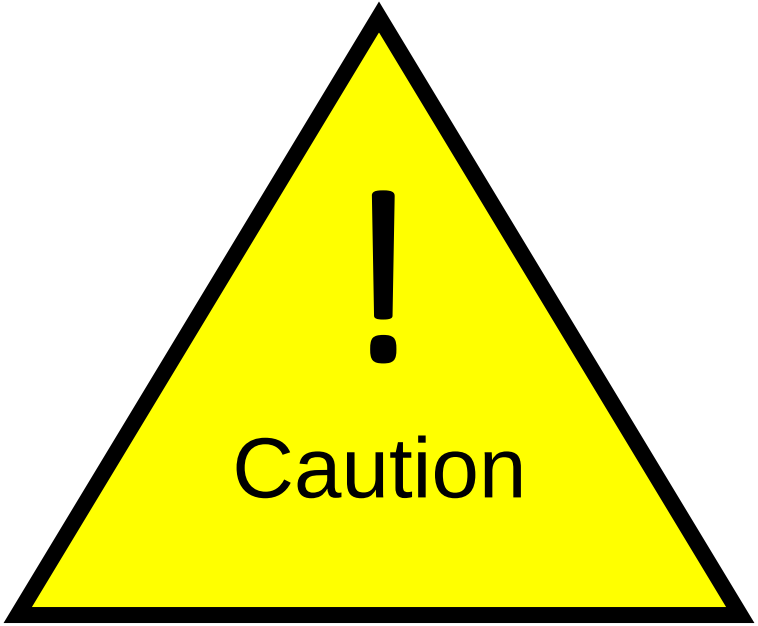
It is not 2021 yet and this is ONLY E/M Office codes



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Summary of Major E/M Revisions for 2021: Office or Other Outpatient Services

- Extensive E/M guideline additions, revisions, and restructuring
- Deletion of code 99201 and revision of codes 99202-99215
  - Codes 99201 and 99202 currently both require straightforward MDM
- Components for code selection:
  - Medically appropriate history and/or examination*
  - MDM or
  - Total time on the date of the encounter

**Not used in code level selection*

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Summary of Major E/M Revisions for 2021: Office or Other Outpatient Services

- E/M level of service for office or other outpatient services can be based on:
  - MDM
    - Extensive clarifications provided in the guidelines to define the elements of MDM
  - Time: *Total* time spent with the patient on the date of the encounter
    - Including non-face-to-face services
    - Clear time ranges for each code
- Addition of a shorter 15-minute prolonged service code (99XXX)
  - To be reported only when the visit is based on time **and** after the total time of the highest-level service (ie, 99205 or 99215) has been exceeded.

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Overview of Major E/M Revisions for 2021: Office or Other Outpatient Services Compared to Other E/M Codes

Component(s) for Code Selection	Office or Other Outpatient Services	Other E/M Services (Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home or Custodial Care, Home)
History and Examination	• As medically appropriate. Not used in code selection	• Use Key Components (History, Examination, MDM)
Medical Decision Making (MDM)	• May use MDM or total time on the date of the encounter	• Use Key Component (History, Examination, MDM)
Time	• May use MDM or total time on the date of the encounter	• May use face-to-face or time at the bedside and on the patient's floor or unit when counseling and/or coordination of care dominates. *Time is **not** a descriptive component for E/M levels of emergency department services*
MDM Elements	• Number and complexity of problems addressed at the encounter • Amount and/or complexity of data to be reviewed and analyzed • Risk of complications and/or morbidity or mortality of patient management	• Number of diagnoses or management options • Amount and/or complexity of data to be reviewed • Risk of complications and/or morbidity or mortality

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Office or Other Outpatient Services (99201-99215)

Betty Chu, MD
Member since 1997

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Office or Other Outpatient Services: New Patient

Office or Other Outpatient Services/New Patient

★~~99201 **Office or other outpatient** visit for the evaluation and management of a new patient, which requires these 3 key components:~~

- ~~**A problem focused history;**~~
- ~~**A problem focused examination;**~~
- ~~**Straightforward medical decision making.**~~

~~Counseling and/or coordination with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or the family's needs.~~

~~Usually the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.~~

►(99201 has been deleted. To report, use 99202)◄

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Office or Other Outpatient Services: New Patient

Office or Other Outpatient Services/New Patient

★▲99202 **Office or other outpatient** visit for the evaluation and management of a new patient, which requires ~~these 3 key components:~~a medically appropriate history and/or examination and straightforward medical decision making.

- ~~**An expanded problem focused history;**~~
- ~~**An expanded problem focused examination;**~~
- ~~**Straightforward medical decision making.**~~

~~Counseling and/or coordination with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or the family's needs.~~

~~Usually the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.~~

When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

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Office or Other Outpatient Services: New Patient

Office or Other Outpatient Services/New Patient

★▲99203 **Office or other outpatient** visit for the evaluation and management of a new patient, which requires ~~these 3 key components:~~a medically appropriate history and/or examination and low level of medical decision making.

- ~~**A detailed history;**~~
- ~~**A detailed examination;**~~
- ~~**Medical decision making of low complexity.**~~

~~Counseling and/or coordination with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or the family's needs.~~

~~Usually the presenting problem(s) are of low to moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.~~

When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

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Office or Other Outpatient Services: New Patient

Office or Other Outpatient Services/New Patient

★▲99204 **Office or other outpatient** visit for the evaluation and management of a new patient, which requires ~~these 3 key components:~~a medically appropriate history and/or examination and moderate level of medical decision making.

- ~~**A comprehensive history;**~~
- ~~**A comprehensive examination;**~~
- ~~**Medical decision making of moderate complexity.**~~

~~Counseling and/or coordination with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or the family's needs.~~

~~Usually the presenting problem(s) are of low to moderate severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.~~

When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

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Office or Other Outpatient Services: New Patient

Office or Other Outpatient Services/New Patient

★▲99205 **Office or other outpatient** visit for the evaluation and management of a new patient, which requires ~~these 3 key components:~~a medically appropriate history and/or examination and high level of medical decision making.

- ~~**A comprehensive history;**~~
- ~~**A comprehensive examination;**~~
- ~~**Medical decision making of high complexity.**~~

~~Counseling and/or coordination with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or the family's needs.~~

~~Usually the presenting problem(s) are of low to moderate severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.~~

When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

►(For services 75 minutes or longer, see Prolonged Services 99XXX)◄

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Office or Other Outpatient Services: Established Patient

Office or Other Outpatient Services/Established Patient

▲99211 **Office or other outpatient visit** for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. ~~Typically, 5 minutes are spent performing or supervising these services.~~

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Office or Other Outpatient Services: Established Patient

Office or Other Outpatient Services/Established Patient

★▲99212 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires ~~at least 2 of these 3 key components:~~a medically appropriate history and/or examination and straightforward medical decision making.

- ~~**A problem focused history;**~~
- ~~**A problem focused examination;**~~
- ~~**Straightforward medical decision making.**~~

~~Counseling and/or coordination with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or the family's needs.~~

~~Usually the presenting problem(s) are of low to moderate severity. Typically, 10 minutes are spent face-to-face with the patient and/or family.~~

When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

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Office or Other Outpatient Services: Established Patient

Office or Other Outpatient Services/Established Patient

★▲99213 and low

Office or other outpatient visit for the evaluation and management of an established patient, which requires ~~at least 2 of these 3 key components:~~a medically appropriate history and/or examination level of medical decision making.

- ~~**An expanded problem focused history;**~~
- ~~**An expanded problem focused examination;**~~
- ~~**Medical decision making of low complexity.**~~

~~Counseling and/or coordination with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or the family's needs.~~

~~Usually the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.~~

When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

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Office or Other Outpatient Services: Established Patient

Office or Other Outpatient Services/Established Patient

★▲99214 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires ~~at least 2 of these 3 key components:~~a medically appropriate history and/or examination and moderate level of medical decision making.

- ~~**A detailed history;**~~
- ~~**A detailed examination;**~~
- ~~**Medical decision making of moderate complexity.**~~

~~Counseling and/or coordination with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or the family's needs.~~

~~Usually the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.~~

When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

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Office or Other Outpatient Services: Established Patient

Office or Other Outpatient Services/Established Patient

★▲99215 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires ~~at least 2 of these 3 key components:~~a medically appropriate history and/or examination and high level of medical decision making.

- ~~**A comprehensive history;**~~
- ~~**A comprehensive examination;**~~
- ~~**Medical decision making of high complexity.**~~

~~Counseling and/or coordination with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or the family's needs.~~

~~Usually the presenting problem(s) are of low to moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.~~

When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

►(For services 55 minutes or longer, see Prolonged Services 99XXX)◄

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Related Revisions (99201-99215)

Guidelines and parenthetical notes throughout the code set have been updated to reflect the deletion of code 99201.

- Evaluation and Management Section
- Surgery Section
- Medicine Section

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Selecting a Level of Service (Office or Other Outpatient E/M Service)

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Selecting a Level of Service (Office or Other Outpatient E/M Service)

2019

The appropriate level of E/M service is based on the following:

- Key components
  - History
  - Examination
  - MDM

  Or

  - Time

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Selecting a Level of Service (Office or Other Outpatient E/M Service)

2020

Time Rules:

- When counseling and/or coordination of care dominates (more than 50%) of the encounter with the patient and/or family
- Only face-to-face time in the office on the date of the encounter

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Selecting a Level of Service (Office or Other Outpatient E/M Service)

Effective January 1, 2021

The appropriate level of E/M service is based on the following:

- The level of the MDM as defined for each service; ***or***
- The total time for E/M services performed on the date of the encounter.

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Medical Decision Making (MDM)

Vijaya Appareddy, MD
Member since 1993

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Medical Decision Making (MDM)

Modifications to the criteria for MDM:

- Create sufficient detail in CPT® code set to reduce variation between contractors/payers
- Attempt to align criteria with clinically intuitive concepts
- Use existing CMS and contractor tools to reduce disruption in coding patterns

Workgroup came back to real-life examples in their deliberations

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Medical Decision Making (MDM)

Modifications to the criteria for MDM:

- Current CMS Table of Risk used as a foundation to create the Level of Medical Decision Making Table
- Current CMS Contractor audit tools also consulted to minimize disruption in MDM level criteria
- Removed ambiguous terms (eg, “mild”) and defined previously ambiguous concepts (eg, “acute or chronic illness with systemic symptoms”)

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CMS Table of Risk from the Documentation Guidelines

(minimal to moderate shown)

TABLE OF RISK

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	• One self-limited or minor problem, eg, cold, insect bite, tinea corporis	• Laboratory tests requiring venipuncture • Chest x-rays • EKG/EEG • Urinalysis • Ultrasound, eg, echocardiography • KOH prep	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness, eg, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH • Acute uncomplicated illness or injury, eg, cystitis, allergic rhinitis, simple sprain	• Physiologic tests not under stress, eg, pulmonary function tests • Non-cardiovascular imaging studies with contrast, eg, barium enema • Superficial needle biopsies • Clinical laboratory tests requiring arterial puncture • Skin biopsies	• Over-the-counter drugs • Minor surgery with no identified risk factors • Physical therapy • Occupational therapy • IV fluids without additives
Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis, eg, lump in breast • Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis • Acute complicated injury, eg, head injury with brief loss of consciousness	• Physiologic tests under stress, eg, cardiac stress test, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, eg, arteriogram, cardiac catheterization • Obtain fluid from body cavity, eg lumbar puncture, thoracentesis, culdocentesis	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation

- Two or more self-limited or minor problems
- One stable chronic illness, eg, well controlled hypertension, non-insulin dependent diabetes, cataract, BPH
- Acute uncomplicated illness or injury, eg, cystitis, allergic rhinitis, simple sprain

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Definition Examples

Self-limited or minor problem: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.

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Definition Examples

Stable, chronic illness: A problem with an expected duration of at least a year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). "Stable" for the purposes of categorizing medical decision making is defined by the specific treatment goals for an individual patient. A patient who is not at their treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, a patient with persistently, poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic. The risk of morbidity **without** treatment is significant. Examples may include well-controlled hypertension, noninsulin-dependent diabetes, cataract, or benign prostatic hyperplasia.

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Definition Examples

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor, but is not resolving consistent with a definite and prescribed course is an acute uncomplicated illness. Examples may include cystitis, allergic rhinitis, or a simple sprain.

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Medical Decision Making (MDM)

Effective January 1, 2021

Level of Medical Decision Making Table

- Guide to assist in selecting the level of MDM
- Used for office or other outpatient E/M services only
- Includes 4 levels of MDM **(unchanged from current levels of MDM)**
  - Straightforward
  - Low
  - Moderate
  - High

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Medical Decision Making Table

MDM 2020		MDM Effective January 1, 2021
Number of Diagnoses or Management Options	→	Number and Complexity of Problems Addressed at the Encounter
Amount and/or Complexity of Data to be Reviewed	→	Amount and/or Complexity of Data to be Reviewed and Analyzed
Risk of Complications and/or Morbidity or Mortality	→	Risk of Complications and/or Morbidity or Mortality of Patient Management

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Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed ** - Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	**N/A**			
99202 **99212**	**Straightforward**			
99203 **99213**	**Low**			

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MDM: Number and Complexity of Problems Addressed at the Encounter

- Based on CMS Documentation Guidelines' Table of Risk
- New guidelines and numerous definitions added to clarify each type of problem addressed in the MDM table
  - Stable, chronic illness
  - Acute, uncomplicated illness or injury
- Removed examples
  - Some were not office oriented
  - Examples in guidelines to make MDM table less complex

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Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed at the Encounter		
99211	**N/A**	N/A		
99202 **99212**	**Straightforward**	**Minimal** • **1** self-limited or minor problem		
99203 **99213**	**Low**	**Low** • **2** or more self-limited or minor problems; **or** • **1** stable chronic illness; **or** • **1** acute, uncomplicated illness or injury		

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99204 **99214**	**Moderate**	**Moderate** • **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** • **2** or more stable chronic illnesses; **or** • **1** undiagnosed new problem with uncertain prognosis; **or** • **1** acute illness with systemic symptoms; **or** • **1** acute complicated injury		

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99205 **99215**	**High**	**High** • **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; **or** • **1** acute or chronic illness or injury that poses a threat to life or bodily function		

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MDM: Number and Complexity of Problems Addressed at the Encounter: Clinically Relevant

- Straightforward
  - Self-limited
- Low
  - Stable, uncomplicated, single problem
- Moderate
  - Multiple problems or significantly ill
- High
  - Very ill

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MDM: Amount and/or Complexity of Data to be Reviewed and Analyzed

- Simplified and standardized contractor scoring guidelines
- Emphasized clinically important activities over number of documents
- Need to account for quantity of documents ordered/reviewed (as it is MDM work) and create “counting rules”

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MDM: Amount and/or Complexity of Data to be Reviewed and Analyzed

- Data are divided into three categories:
  - Tests, documents, orders, or independent historian(s)—each unique test, order, or document is **counted** to meet a threshold number
  - Independent interpretation of tests not reported separately
  - Discussion of management or test interpretation with external physician/other QHP/appropriate source (not reported separately)

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Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
			Amount and/or Complexity of Data to be Reviewed and Analyzed ***Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.***	
99211	**N/A**		N/A	
99202 **99212**	**Straightforward**		**Minimal or none**	

99203
99213
	Low		**Limited**
			(Must meet the requirements of at least 1 of the 2 categories)
			
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	

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99204 **99214**	**Moderate**		**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** **Any combination of 3 from the following**: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	

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99205
99215
	High		**Extensive**
			
			(Must meet the requirements of at least 2 out of 3 categories)
			
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following**:
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	

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MDM: Amount and/or Complexity of Data to be Reviewed and Analyzed

- Straightforward
  - Minimal or None
- Low (one category only)
  - Two documents or independent historian
- Moderate (one category only)
  - Count: Three items between documents and independent historian; or
  - Interpret; or
  - Confer
- High (two categories)
  - Same concepts as moderate

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MDM: Risk of Complications and/or Morbidity or Mortality of Patient Management

- Risk of complications and/or morbidity, or mortality of patient management decisions made at the visit, associated with the patient's problem(s), treatment(s)
  - Includes possible management options selected and those considered, but not selected
  - Addresses risks associated with social determinants of health

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TABLE OF RISK

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis, eg, lump in breast • Acute illness with systemic symptoms, eg, pyelonephritis, pneumonitis, colitis • Acute complicated injury, eg, head injury with brief loss of consciousness	• Physiologic tests under stress, eg, cardiac stress test, fetal contraction stress test • Diagnostic endoscopies with no identified risk factors • Deep needle or incisional biopsy • Cardiovascular imaging studies with contrast and no identified risk factors, eg, arteriogram, cardiac catheterization • Obtain fluid from body cavity, eg lumbar puncture, thoracentesis, culdocentesis	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation without manipulation
High	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illnesses or injuries that pose a threat to life or bodily function, eg, multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure • An abrupt change in neurologic status, eg, seizure, TIA, weakness, sensory loss	• Cardiovascular imaging studies with contrast with identified risk factors • Cardiac electrophysiological tests • Diagnostic Endoscopies with identified risk factors • Discography	• Elective major surgery (open, percutaneous or endoscopic) with identified risk factors • Emergency major surgery (open, percutaneous or endoscopic) • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

- Minor surgery with identified risk factors
- Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors
- Prescription drug management
- Therapeutic nuclear medicine
- IV fluids with additives
- Closed treatment of fracture or dislocation without manipulation

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Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
				Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	**N/A**			N/A
99202 **99212**	**Straightforward**			**Minimal risk of morbidity from additional diagnostic testing or treatment**
99203 **99213**	**Low**			**Low risk of morbidity from additional diagnostic testing or treatment**

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99204 **99214**	**Moderate**			**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health

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99205 **99215**	**High**			**High risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization • Decision not to resuscitate or to de-escalate care because of poor prognosis

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MDM: Risk of Complications and/or Morbidity or Mortality of Patient Management

- Straightforward
  - Minimal risk from treatment (including no treatment) or testing. (Most would consider this effectively as no risk)
- Low
  - Low risk (ie, very low risk of anything bad), minimal consent/discussion
- Moderate
  - Would typically review with patient/surrogate, obtain consent and monitor, or there are complex social factors in management
- High
  - Need to discuss some pretty bad things that could happen for which physician or other qualified health care professional will watch or monitor

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Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed at the Encounter	**Amount and/or Complexity of Data to be Reviewed and Analyzed** ***Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.***	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
99211	**N/A**	N/A	N/A	N/A
99202 **99212**	**Straightforward**	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• **2** or more self-limited or minor problems;
		or
		• **1** stable chronic illness;
		or
		• **1** acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

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99204 **99214**	**Moderate**	**Moderate** • **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** • **2** or more stable chronic illnesses; **or** • **1** undiagnosed new problem with uncertain prognosis; **or** • **1** acute illness with systemic symptoms; **or** • **1** acute complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following**: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health

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99205
99215
	High	**High**
		• **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		or
		• 1 acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following**:
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				High risk of morbidity from additional diagnostic testing or treatment
				
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				• Decision regarding elective major surgery with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

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Medical Decision Making Table

To qualify for a particular level of medical decision making, <u>two of the three</u> elements for that level of decision making must be met or exceeded **(concept unchanged from current guidelines)**.

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
99203 99213	Low	**Low** • **2** or more self-limited or minor problems; or • **1** stable chronic illness; or • **1** acute, uncomplicated illness or injury	**Limited** *(Must meet the requirements of at least 1 of the 2 categories)* **Category 1: Tests and documents** • **Any combination of 2 from the following:** ◦ Review of prior external note(s) from each unique source*; ◦ review of the result(s) of each unique test*; ◦ ordering of each unique test* or **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	**Low risk of morbidity from additional diagnostic testing or treatment**

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Time

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Time: Office and Other Outpatient E/M Services

Key elements addressed regarding time:

1. Ambiguity
   - “What is the exact increment of time I can move to the next code level?”
   - “Which elements of my visit can be included as part of my E/M and which should be reported separately or not at all?”
2. Too restrictive
   - “Why can’t E/M codes be more flexible to allow the most accurate elements to be considered for code selection?”

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Time: Office and Other Outpatient E/M Services

2020

- When counseling and/or coordination of care dominates (**over 50%)** the encounter with the patient and/or family, time shall be the key or controlling factor to qualify for a particular level of E/M service
- Only face-to-face time counted

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Time: Office and Other Outpatient E/M Services

Effective January 1, 2021

- Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service
- Time may only be used for selecting the level of the other E/M services when counseling and/or coordination of care dominates the service

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Time: Office and Other Outpatient E/M Services

Total Time on the date of the encounter

- Includes physician/other QHP face-to-face and non-face-to-face time
- Time spent by clinical staff is not included
- More than one clinician addressed (count only 1 person per minute)

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Time: Office and Other Outpatient E/M Services

Total Time on the date of the encounter

- Recognizes the important non-face-to-face activities
- Uses easy to remember increments based on time data of past valuations
- Removes “midpoint” vs “threshold” by giving exact ranges
- Is for *Code Selection When Using Time*
    - Not a required minimum amount when using MDM

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Code Selection *Is* Not Code Valuation

- CPT® code selection is total time on the date of the encounter
- RUC valuation includes work before and after the date of the encounter

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Time: Office and Other Outpatient E/M Services

Physician/other QHP time includes the following activities (when performed):

- Preparing to see the patient (eg, review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically necessary appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver

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Time: Office and Other Outpatient E/M Services

- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not reported separately)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not reported separately) and communicating results to the patient/family/caregiver
- Care coordination (not reported separately)

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Time: Office and Other Outpatient E/M Services—New Patient *(Total time on the Date of the Encounter)*

New Patient E/M Code	Typical Time (2020)	Total Time (2021)
99201	10 minutes	Code deleted
99202	20 minutes	15-29 minutes
99203	30 minutes	30-44 minutes
99204	45 minutes	45-59 minutes
99205	60 minutes	60-74 minutes

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Time: Office and Other Outpatient E/M Services—Established Patient *(Total time on the Date of the Encounter)*

Established Patient E/M Code	Typical Time (2020)	Total Time (2021)
99211	5 minutes	Time component removed
99212	10 minutes	10-19 minutes
99213	15 minutes	20-29 minutes
99214	25 minutes	30-39 minutes
99215	40 minutes	40-54 minutes

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Related Revisions: Time

- Revised and relocated Time guidelines in the Evaluation and Management (E/M) Services Guidelines to clarify how time is used with the following services:
  - Office or other outpatient E/M services (99202-99205, 99212-99215)
  - Outpatient services (99241-99245, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99483)
  - Hospital observation services (99218-99220, 99224-99226, 99234-99236), hospital inpatient services (99221-99223, 99231-99233), inpatient consultations (99251-99255), nursing facility services (99304-99318)

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Prolonged Services (Office or Other Outpatient E/M Service)

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Prolonged Services (99XXX)

- The E/M Workgroup identified the need for a prolonged service code to capture services for a patient that required longer time on the date of the encounter
- The Workgroup agreed with CMS that a shorter time was appropriate

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Prolonged Services (99354, 99358, 99XXX)

2020

- Prolonged services codes with direct patient contact (99354, 99355) and without direct patient contact (99358, 99359)
  - First hour (base code)
  - Each additional 30 minutes (add-on code)
- Currently, prolonged services of 30 minutes or less beyond the *typical time* of the E/M service is not reported separately
- If criteria met, 99354 and/or 99358 may be reported on the date of service.

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Prolonged Services (99XXX)

Effective January 1, 2021

- Shorter prolonged services code to capture each 15 minutes of critical physician/other QHP work beyond the time captured by the office or other outpatient service E/M code.
  - Used only when the office/other outpatient code is selected using time
  - **For use only with 99205, 99215**
  - Prolonged services of less than 15 minutes should not be reported

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Prolonged Services (99XXX)

- Allows for face-to-face and non-face-to-face care on the date of the encounter
- Therefore, do not report 99354 or 99358 for time on the date of the encounter
- 99358 (non-face-to-face prolonged services of 30 minutes in a single day) may be reported on a date ***other than*** the date of the encounter, just as it may be reported in 2019

(Per CPT®, but note CMS comments in 2020 PFS Final Rule)

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Prolonged Services (99XXX)

Prolonged Services/Prolonged Service With or Without Direct Patient Contact on the Date of an Office or Other Outpatient Service

★+●99XXX Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient **Evaluation and Management** services)

►(Use 99XXX in conjunction with 99205, 99215)◄

►(Do not report 99XXX in conjunction with 99354, 99355, 99358, 99359, 99415, 99416)◄

►(Do not report 99XXX for any time unit less than 15 minutes)◄

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Prolonged Services (99XXX)

Total Duration of New Patient Office or Other Outpatient Services (use with 99205)	Code(s)
Less than 75 minutes	Not reported separately
75-89 minutes	99205 X 1 and 99XXX X 1
90-104 minutes	99205 X 1 and 99XXX X 2
105 or more	99205 X 1 and 99XXX X 3 or more for each additional 15 minutes

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Prolonged Services (99XXX)

Total Duration of Established Office or Other Outpatient Services (use with 99215)	Code(s)
Less than 55 minutes	Not reported separately
55-69 minutes	99215 X 1 and 99XXX X 1
70-84 minutes	99215 X 1 and 99XXX X 2
85 or more	99215 X 1 and 99XXX X 3 or more for each additional 15 minutes

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TIMELINE →							
NEW	1-14	15-29	30-44	45-59	60-74	75-89	90-104
	Do not use time (99202 by MDM)	99202	99203	99204	99205	99205+ 99XXX	99205+ 2 units 99XXX
ESTABLISHED	1-9	10-19	20-29	30-39	40-54	55-69	70-84
	Do not use time (99212 by MDM)	99212	99213	99214	99215	99215+ 99XXX	99215+ 2 units 99XXX

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Related Revisions (99XXX)

- Addition of Prolonged Service With or Without Direct Patient Contact on the Date of an Office or Other Outpatient Service (99XXX) guidelines
- Existing prolonged service codes (99354, 99355, 99356) revised to restrict reporting with office or other outpatient E/M services (99202-99215)
- Revised Prolonged Services with Direct Patient Contact and Prolonged Services without Direct Patient Contact guidelines

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Final Rule – 2021 Medicare Reporting Rules on Prolonged Services

- CMS finalized decision to adopt CPT code 99XXX to report all prolonged time spent on the date of the primary office or other outpatient E/M visit (99205/99215)
- CMS states confusion with the reporting guidelines for codes 99358, 99359
  - "The new prefatory language seemed unclear regarding whether CPT codes 99358, 99359 could be reported instead of, or in addition to, CPT code 99XXX, and whether the prolonged time would have to be spent on the visit date, within 3 days prior or 7 days after the visit date, or outside of this new 10-day window relevant."
- Finalized Medicare 2021 reporting instructions that codes 99358, 99359 will no longer be reportable in conjunction with office or other outpatient E/M visits
  - "When using time to select office/outpatient E/M visit level, any additional time spent by the reporting practitioner on a prior or subsequent date of service (such as reviewing medical records or test results) could not count toward the required times for reporting CPT codes 99202-99215 or 99XXX, or be reportable using CPT codes 99358, 99359."

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Kevin McKinney, MD
Member since 1989

AMA CPT® E/M Education

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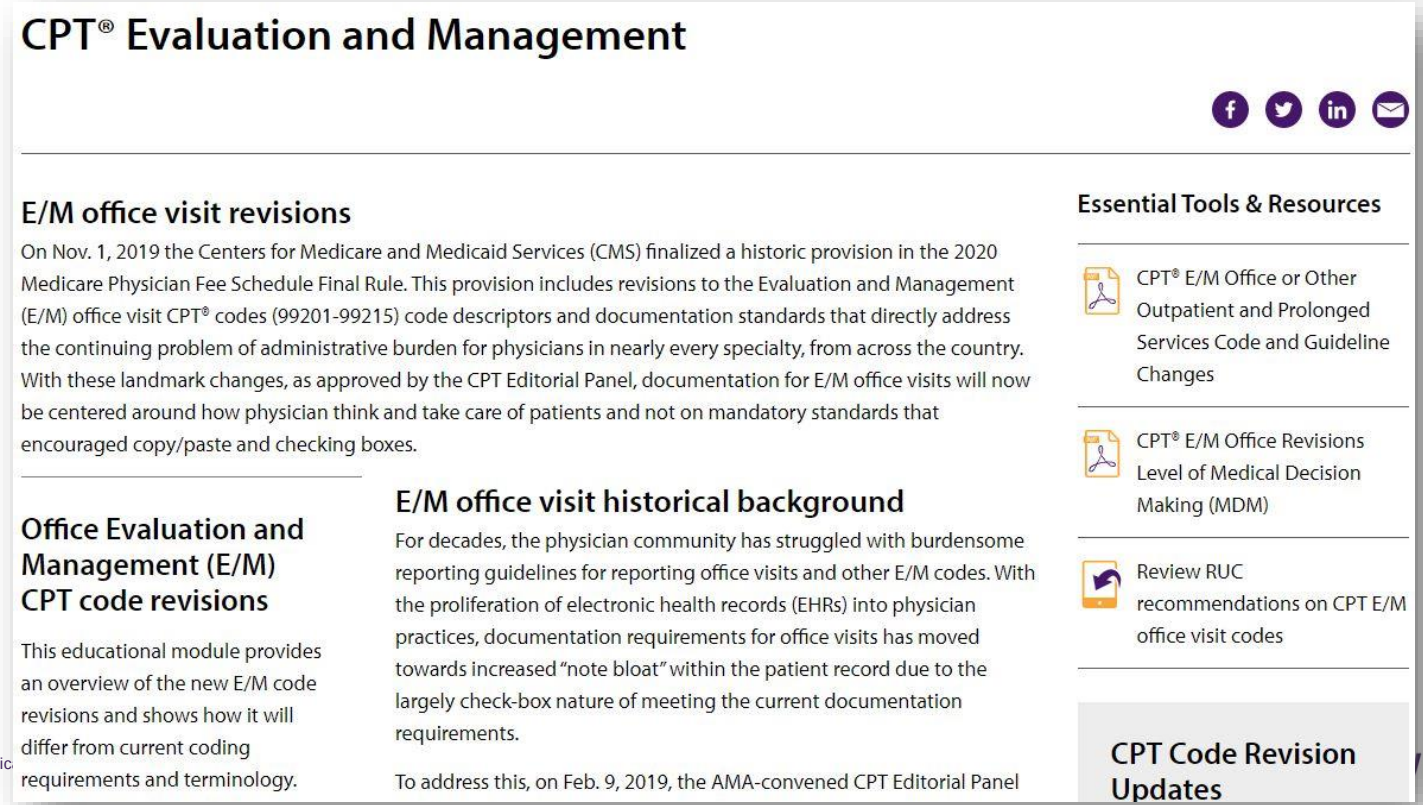
AMA CPT® E/M Education – AMA Microsite

ama-assn.org/cpt-office-visits



CPT® Evaluation and Management

E/M office visit revisions

On Nov. 1, 2019 the Centers for Medicare and Medicaid Services (CMS) finalized a historic provision in the 2020 Medicare Physician Fee Schedule Final Rule. This provision includes revisions to the Evaluation and Management (E/M) office visit CPT® codes (99201-99215) code descriptors and documentation standards that directly address the continuing problem of administrative burden for physicians in nearly every specialty, from across the country. With these landmark changes, as approved by the CPT Editorial Panel, documentation for E/M office visits will now be centered around how physician think and take care of patients and not on mandatory standards that encouraged copy/paste and checking boxes.

Office Evaluation and Management (E/M) CPT code revisions

This educational module provides an overview of the new E/M code revisions and shows how it will differ from current coding requirements and terminology.

E/M office visit historical background

For decades, the physician community has struggled with burdensome reporting guidelines for reporting office visits and other E/M codes. With the proliferation of electronic health records (EHRs) into physician practices, documentation requirements for office visits has moved towards increased "note bloat" within the patient record due to the largely check-box nature of meeting the current documentation requirements.

To address this, on Feb. 9, 2019, the AMA-convened CPT Editorial Panel

Essential Tools & Resources

- CPT® E/M Office or Other Outpatient and Prolonged Services Code and Guideline Changes
- CPT® E/M Office Revisions Level of Medical Decision Making (MDM)
- Review RUC recommendations on CPT E/M office visit codes

CPT Code Revision Updates

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AMA CPT® E/M Education – Full CPT Guidelines Language

CPT® Evaluation and Management (E/M) Office or Other Outpatient (99202-99215) and Prolonged Services (99354, 99355, 99356, 99XXX) Code and Guideline Changes

This document includes the following CPT E/M changes, effective January 1, 2021:

- E/M Introductory Guidelines related to Office or Other Outpatient Codes 99202-99215
- Revised Office or Other Outpatient E/M codes 99202-99215

For the complete version of E/M Introductory guideline changes, Office or Other Outpatient (99202-99215) code changes, Prolonged Services code (99354, 99355, 99356, 99XXX) and guideline changes, see *Complete E-M Guideline and Code Changes.doc.*

Note: this content will not be included in the CPT 2020 code set release

Category I

Evaluation and Management (E/M) Services Guidelines

Guidelines Common to All E/M Services

Time

The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of the CPT codebook. The inclusion of time as an explicit factor beginning in CPT *1992* is done to assist in selecting the most appropriate level of E/M services. Beginning with *CPT 2021* and except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is importan

Level of Medical Decision Making (MDM)

Note: this content will not be included in the CPT 2020 code set release

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Elements of Medical Decision Making: Amount and/or Complexity of Data to be Reviewed and Analyzed (*Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.)	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	Minimal • 1 self-limited or minor problem	Minimal or none	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low • 2 or more self-limited or minor problems; or • 1 stable chronic illness; or • 1 acute, uncomplicated illness or injury	Limited *(Must meet the requirements of at least 1 of the 2 categories)* **Category 1: Tests and documents** • **Any combination of 2 from the following:** ▪ Review of prior external note(s) from each unique source*; ▪ review of the result(s) of each unique test*; ▪ ordering of each unique test* or **Category 2: Assessment requiring an independent historian(s)** *(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)*	Low risk of morbidity from additional diagnostic testing or treatmer
99204 99214	Moderate	Moderate • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute complicated injury	Moderate *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** • **Any combination of 3 from the following:** ▪ Review of prior external note(s) from each unique source*; ▪ Review of the result(s) of each unique test*; ▪ Ordering of each unique test*; ▪ Assessment requiring an independent historian(s) or **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); or **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other qualified health care	Moderate risk of morbidity from additional diagnostic testing or treatment *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinan of health

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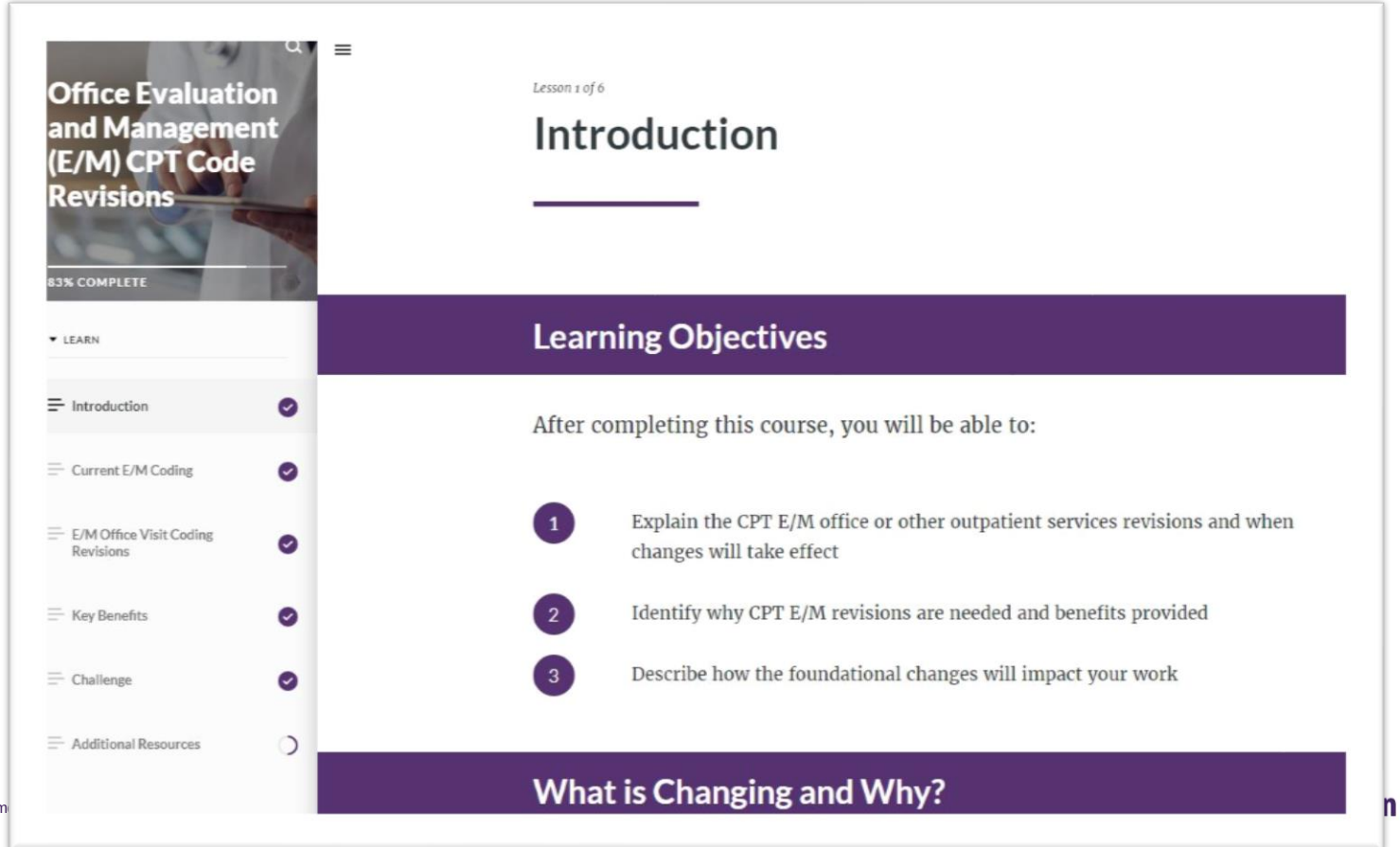
AMA CPT® E/M Education – Training Modules



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AMA CPT® E/M Education – Future Offerings

Two additional Training Modules

- Time and MDM-specific
- Timeline: February/March

App based education

- Stand alone E/M educational app
- Imbedded in current CPT QuickRef phone/tablet app
- Timeline: Later 2020

SMART of FHIR Integration

- Developing direct EMR integration
- Timeline: Later 2020

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Physicians' powerful ally in patient care

AMERICAN PSYCHIATRIC ASSOCIATION

PAYMENT FOR NON-FACE-TO-FACE SERVICES:
A Guide for the Psychiatric Consultant

Interprofessional Telephone/Internet/Electronic Health Record Consultations*
CPT Codes: 99446, 99447, 99448, 99449, 99451

* These codes should not be billed if your time spent consulting is part of a CoCM program and billed by the treating physician using the CoCM codes (99492-99494)

"Consult with Discussion" and "Consult without Discussion"

Medicare now pays for non-face-to-face limited consultation services where physicians and other qualified healthcare professionals are consulting about a patient without the patient present. These services include evaluation and management recommendations on patient care through the use of a secure platform (i.e., telephone, fax, or electronic health record (EHR). This document is intended to help consulting psychiatrists understand how they might use the new codes in the care of patients who are being treated by other physicians and are NOT seen or evaluated by the consulting psychiatrist.

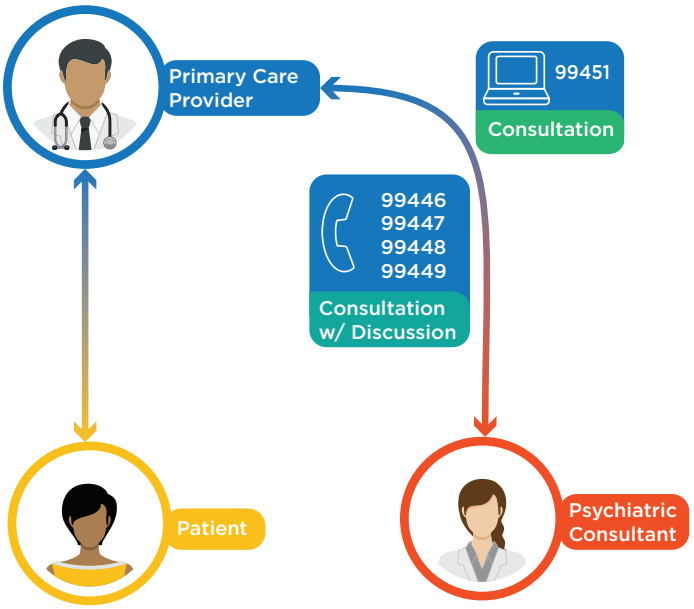
99446-99449 "Consult with Discussion" and 99451 "Consult without Discussion"

The patient's primary care provider (PCP) requests the opinion/treatment advice of a psychiatrist or psychiatric consultant and includes the following:

- Case review provided via telephone/EHR/fax/internet
- Assessment and management recommendations by a psychiatric consultant
- A brief report is provided to the treating/requesting PCP

There are two situations where these codes **cannot** be used:

1. If an in-person visit with the psychiatric consultant has occurred within the previous 14 days or will occur within the next 14 days.
2. If the sole purpose of the contact is to transfer care or arrange for an in-person consultation with the psychiatric consultant.



Differences between the two code sets:

99446-99449 "Consult with Discussion"
(Time guidelines listed on page 2)

- More than 50% of the time must be devoted to the consultative discussion with the requesting primary care provider either verbally or online.
- Requires both a verbal and written report to the treating/requesting PCP
- Does not include any time spent communicating with the patient and/or family

99451 "Consult without Discussion" (5 minutes or more)

- Health record assessment via EHR/Internet/Fax and time to create a report is included in billable time
- Only a written report to the treating/requesting PCP is required
- Do not bill 99451 for services that last less than 5 minutes

Billing for the treating/requesting PCP

99452 is to be used by the PCP requesting the consult if 16-30 min of time is used preparing the referral and/or communicating with the psychiatric consultant. Cannot be reported more than once in a 14-day period per patient.

Additional codes are available for time exceeding 30 minutes:

- If patient is onsite: appropriate E/M plus prolonged service codes 99354, 99355, 99356, 99357
- Patient not present: non-face-to face prolonged service codes 99358, 99359

Both code sets:
Both sets of codes can be used for a patient new to the psychiatric consultant or for an established patient with a new problem or problem exacerbation.

Other stipulations:
- If more than one contact is needed to complete the e-consult—report one code with cumulative time over a 7-day period
- These codes cannot be used with prolonged service codes 99358-9

Recommendations:
- Include the written or verbal request and specify the reason for the referral in the report and the patient's medical record.
  - Document as appropriate, including date and time spent.
  - Retain the record of request.
- Requesting PCP should inform the patient they are asking the advice of a psychiatric consultant and that there may be an associated co-pay/coinsurance for this service.

Time guidelines and approximate reimbursement under 2020 Medicare Physician Fee Schedule:

"Consult with Discussion"
(medical consultative discussion and written report):
- **99446:** 5-10 minutes $18
- **99447:** 11-20 minutes $37
- **99448:** 21-30 minutes $56
- **99449:** 31+ minutes $74

"Consult without Discussion"
(health record review and written report, no verbal discussion required):
- **99451:** 5 or more minutes $38

Coverage for these services and payment rates will vary.

Case Examples

Example 1:
This communication was sent via a secure electronic platform to a contracted psychiatric consultant from a primary care clinician.

Reason for consult:
"I wonder if it might not be beneficial to see if this patient can get by on fewer psychoactive medications."

Current Presentation:
64-year old man had first psychotic break and hospitalization 4 years ago and given first diagnosis of bipolar affective disorder. Has also had left arm dystonia since being a teenager and has been on psychoactive medication for that. Has not seen a psychiatrist in 3+ years, all psych meds filled in primary care. Overall, no current hallucinations, feels depression mostly controlled. His co-pay to see a psychiatrist is $45, which is prohibitive, so I'm doing this consult to save him money and because he is presently psychiatrically stable.

Medications:
Aripiprazole 2.5 mg/day; citalopram 20 mg/day; desipramine 25 mg/day; clonazepam 1 mg QID for dystonia; trihexyphenidyl 5 mg five times a day for dystonia. Also, losartan, tamsulosin

My Thoughts/Plans:
- Consider lowering aripiprazole to 1 mg/day; then consider weaning or d/c desipramine
- Neurology managing clonazepam and trihexyphenidyl related to dystonia and I was not going to consider reducing these

Time: 14 minutes total time
(chart review and documentation)

Billing: *99451*
(all communication was electronic, greater than 5 minutes)

This section is sent back to the PCP and put into the patient's EHR

Psychiatric Consultant Response:
Thank you for your request. I would be inclined not to change his medications much. He has been stable not that long, relatively speaking and if he doesn't have side effects and is not asking to be taken off meds, I would give him another year or two on this regimen. If you do decide to decrease his psychotropic medications, I would start with one of the antidepressants, not aripiprazole. Aripiprazole is already at a very low dose and is working as a mood stabilizer (in addition to antipsychotic effect), protecting him from going into depression or mania. Desipramine is stronger and more effective for depression of his two antidepressants, but also has more side effects and more likely to cause switch to manic episode. So it's hard to decide which antidepressant is safer to taper off. I would lean toward desipramine, probably because of potential cardiac side effects. It is recommended to check ECG for QTc prolongation on anyone over age 50 who is on desipramine. If you still feel that you would like to decrease aripiprazole, I would decrease it to 2 mg a day and see how he does. Hope this helps.

The above treatment considerations and suggestions are based on a review of a specific clinical question from the patient's primary care provider. I have not personally examined the patient. All recommendations should be implemented with consideration of the patient's relevant prior history and current clinical status. Please feel free to contact me with any questions about the care of this patient.

Dr. Johns, Psychiatric Consultant
402-381-6655
Dr.Johnsconsultant@apa.com

Example 2:

Reason for Consult:
I noticed that despite being diagnosed with bipolar disorder, patient's medications appear to be an antidepressant and a sleep med. I feel that I learned that antidepressants for someone with bipolar disorder can be risky in that it may potentially trigger manic episodes. Is this a risk to be concerned about? (I'd like to call you over my lunch break today to discuss.)

Primary care provider and psychiatric consultant then have a phone conversation summarized as the following:

Primary Care Provider:
Current Presentation:
45-year-old male currently reporting depressive symptoms and likely experiencing a depressive episode (bipolar disorder diagnosis). Patient has been diagnosed with bipolar disorder for many years and has had manic, mixed, and depressed episodes in the past. Patient recently had a family member pass away and depression has come on strongly over the last two weeks.

Medications:
Patient has had poor medication compliance. Medications include psych meds (Fluoxetine 20 mg 1x/day and trazadone 100 mg at bed for sleep) and other non-psychotropic or non-psychiatric meds.

My Thoughts/Plans:
We have been discussing the importance of adherence to medication, and particularly so now that patient is experiencing increased symptoms after the death of a family member. Therapy will be continued and grief work will likely be a part of it, however some med questions caught my eye. I saw he was not on a "bipolar med." I want to treat the depression, but I don't want to induce a mania.

Psychiatric Consultant Response:
You are correct about antidepressants having potential the risk of inducing a manic episode. But each case needs to be reviewed individually and risks vs. benefits should be carefully examined. The depression in Bipolar Disorder could be very severe and overall carries a higher risk of suicide. Whoever is prescribing his meds, should look

into the trajectory and the severity of his episodes and symptoms. One should look and answer the following questions: how long does average episode last; how much or percentage of time patient was in 'neutral' state; did he need hospitalization when manic; has he ever been suicidal when depressed; and so on. Having said all this—yes, I would be somewhat concerned that this patient is not on a mood stabilizer. Mood stabilizers have a protective effect from a switch to both depression and mania.

Further Conversation:
Primary care provider added that he did recall patient had a hospitalization 10 years previous but didn't know the details. He was pretty certain that the diagnosis of bipolar was correct and at times the ups had caused family problems. The psychiatric consultant then recommended adding the medication quetiapine to treat both the depression and prevent future manic episodes. Recommended holding trazadone for now as quetiapine will help with any insomnia.

Time: 7 minutes total time (10 minutes of time speaking to Dr. X by phone about the case and giving recommendations and 7 additional minutes of chart review and documentation)

Billing: 99447—Medical Consultative Discussion and review, 11-20 min
17 min of time (10 min of time speaking to Dr. X about the case and giving recommendations)

This section is sent back to the PCP and put into the patient's EHR

Documentation to chart:
Reason for consult:
As reported by Dr. Bell: "I noticed that despite being diagnosed with Bipolar, patient's meds appear to be an anti-depressant and an anti-anxiety medication as well as some sleep meds. I feel that I learned that anti-depressants for someone with bipolar disorder can be risky in that it may potentially triggering manic episodes. Is this a risk to be concerned about?"

Spoke with Dr. Bell about his concern for patient JD.
Psych meds: fluoxetine 20mg and trazadone 100mg

Assessment:
Bipolar-depressed

Plan:
- Continue fluoxetine 20mg/day
- Start quetiapine 50mg QHS and increase to 100mg at day 5. Re-evaluate and quetiapine can continue to be titrated up in 50mg doses to an average dose of 200-300mg QHS.
- Monitor for increased weight gain and metabolic syndrome
- Stop trazadone as many patients find quetiapine sedating.

The above treatment considerations and suggestions are based on a consultative discussion with the patient's primary care provider. I have not personally examined the patient. All recommendations should be implemented with consideration of the patient's relevant prior history and current clinical status. Please feel free to contact me with any questions about the care of this patient.

Dr. Johns, Psychiatric Consultant
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March 25, 2021

Kenneth Beagan, Deputy Commissioner
Division of Insurance
Commonwealth of Massachusetts

Jatin Dave, MD, MPH, Chief Medical Officer
MassHealth
Commonwealth of Massachusetts

Dear Mr. Beagan and Dr. Dave,

On behalf of the orthopaedic members of the MA Orthopaedic Association, thank you for conducting the helpful, productive and transparent listening sessions related to the implementation of Chapter 260 of Acts of 2020, provision for telehealth services.

Telehealth services are instrumental in allowing patients access to medical diagnosis and care in the safety of their homes and is a critical component in maintaining health care services for all. During the height of the pandemic, telehealth was a lifeline to patients and the physician community to ensure services to patient's needing and/or seeking care during the public health crises. This was a critical response and the physician community quickly pivoted to telemedicine in order to provide access to quality care for the thousands of patients that had their appointments and surgeries cancelled during the "stay at home" critical times of the pandemic.

We are pleased to participate in these important sessions and for the opportunity to provide comments concerning matters addressed and discussed in the sessions. To this end, we are submitting comments, feedback and suggestions related to the topics discussed during the first two sessions.

What Constitutes a Telehealth Visit

Telehealth or telemedicine are considered interchangeable by the American Telemedicine Association (ATA) and defines, "telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status."

The Massachusetts Orthopaedic Association (MOA) encourages the adoption of the ATA's extensive definition stated above to ensure that telecommunications equipment and interactive portals are not limited to patients by the regulations or insurers. In order for all patients to be allowed access telehealth visits, specific and/or narrow specifications of equipment and/or portals may inadvertently discriminate against patient populations creating undue hardships and potentially the inability for patients to utilize and access telehealth. Recognition and reimbursement of audio-only coverage serves the needs of patients who do not have access to services that support audio-video technology. This coverage also assists our elderly and mobility impaired patients

who have limited capability to conduct video telemedicine. The audio only technology allow us to continue to provide access to care for these patient population groups.

Definition of Services RE: Chronic Disease Management

The orthopaedic community treats and manages patients of all ages with chronic diseases related to orthopaedics. The proposed Center for Medicare Services (CMS) definition reviewed and discussed during the listening session unfortunately does not include other chronic orthopaedic conditions and excludes chronic conditions our pediatric patients battle.

We encourage and support the use of the Centers for Disease Control's definition of chronic diseases, "…defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both." This broader definition will help ensure the care and treatment of chronic diseases in orthopaedic care via telemedicine is accessible to all patients who suffer from chronic diseases.

Carrier Communication with Insureds

Communication from the carriers is a critical component for insureds to understand their plan's coverage and benefits, including telehealth coverage. While the MOA was not able to be in attendance for the first listening session, we appreciate the Division of Insurance making the discussion and chat notes available via their website and based on the information provided, the MOA shares the following feedback.

Once the final regulations are adopted, it will be imperative for insureds to understand their coverage, based on their plan, for telehealth services. Policy amendment language and future policy coverage should clearly outline the difference in coverage for in office visits and telehealth visits. The use of clear and comprehensive multi-mode communication by the carriers to the insured, with messaging that is appropriate to and represents the diversity of the carrier's insured population, will assist in the public's understanding of the differences.

In addition to a multi-mode communication plan by the insurers, telehealth coverage could be clearly marked on the patient's insurance identification cards, assisting both patients and physicians with the insured's level of coverage for telehealth visits, helping to minimize confusion regarding telehealth coverage.

Carrier Contracts and Communication with Physicians

The MOA shares the central tenet belief expressed by the tMed Coalition in their March 10, 2021, comment letter to DOI and MassHealth that telehealth services be treated on-par with in-office visits. By doing so, the need for separate contracting by the carrier with the physician community would not be necessary. If telehealth amendments to existing carrier contracts with physicians are required, we respectfully request adequate notification and time to review telehealth service contract amendments.

The MOA looks forward to providing information and comments on reimbursement and utilization review as they relate to telehealth services after the next listening session focusing on these two discussion topics is held on March 31, 2021.

Telecommunication Technology Platforms

The statutory definition of telehealth allows for existing and new technologies to be used and is vital for patient access to telehealth services, currently and in the future. This broad definition allows for greater flexibility in utilizing various platforms and modes of telecommunication. It is important to both patients and physicians that technology is not limited or specifically mandated as this may limit access to telehealth services.

We agree that the technology used must meet the clinical needs for the telehealth services we provide while maintaining patient privacy and informed consent. While there is a mandate in Chapter 260 that telehealth services conform to federal and state health information privacy and security standards, we ask that there be no additional specifications in the

regulations as to certain platforms and telecommunication modes as long as what is being used to facilitate telehealth services meet the clinical needs, conforms to patient privacy (federal and state), and allows for informed consent by the patient.

My colleagues and I would be happy to discuss any of these matters, answer any questions you may have and/or provide additional information. If we can be of assistance, please contact the MA Orthopaedic Association via email maorthoexec@gmail.com.

Thank you for your time and consideration. We look forward to continuing future discussions and commenting in the coming weeks.

All the best,

Walter Stanwood, MD
President
MA Orthopaedic Association

The *t*MED Coalition, representing more than 35 healthcare provider organizations, consumer advocates, technology organizations and telecommunication associations, would like to thank the Division of Insurance and MassHealth for the productive listening session held on March 12, 2021 relative to the implementation of telehealth provisions within Chapter 260 of Acts of 2020.

We appreciate the opportunity to provide written comments in follow up to the thoughtful discussion about what constitutes a telehealth visit and how the Division and MassHealth should outline definitions of behavioral health services, chronic disease management and primary care services for the purposes of reimbursement for these services.

A. What constitutes a telehealth visit?

At the outset, it's important to remember that we are not talking about "visits" in the traditional sense, but "encounters" with providers. This distinction is important because the *t*MED Coalition views the charge of Chapter 260 of the Acts of 2020 as to codify and direct the implementation of a now widely utilized healthcare delivery modality within an existing system of medical services. Put another way, it is our belief that telehealth and its related technologies offer new and significant modes of accessing healthcare that, while at times result in shorter or asynchronous "encounters", do not require a redefinition of the nature of a healthcare visit. For example, the Centers for Medicare and Medicaid Services' Medicare Physician Fee Schedule effective January 1, 2021 (updated January 24, 2021) enumerates services ranging from assessments, evaluation and management, observation care, critical care, annual screenings and follow-up services across behavioral health, chronic disease management and primary care that range in encounter length (from two minutes to over one hour). The length of time for covered services reflects the length of time required for a provider to offer said service without redefining the nature of the encounter. Furthermore, the utilization—and existing federal reimbursement of asynchronous telehealth technologies—such as communication technology-based services (CTBS) underscore the importance of valuing healthcare as a service regardless of physical presence or immediate two-way interaction. Limiting the notion of a visit to circumscribed periods of time, activities, mutual interaction, or modality would resultantly limit the promise of telemedicine to increase access to care for patients.

Generally speaking, when conducting evaluation and management (E/M) visits in-person, clinicians conduct a patient history, perform an examination, and undertake medical decision-making within an in-office setting. These same clinical tasks and use of medical expertise must be undertaken during a telehealth encounter. In addition, the overhead costs of electronic medical records, patient access

representatives and even malpractice insurance all remain fixed costs and fixed necessary resources needed to delivery services via telehealth.

The American Telemedicine Association (ATA), a national association consisting of over 400 organizations and the only of its kind charged with accelerating the adoption of telehealth nationally, in its Standardized Telehealth Terminology and Policy Language for States on Medical Practice, characterizes a "telehealth evaluation" as follows:

> Prior to diagnosing, providing treatment or making recommendations, including issuing a prescription, the practitioner must obtain an applicable history and physical evaluation of the patient adequate to establish diagnosis and identify underlying conditions and/or contraindications to any treatment or prescription recommended/provided. The history and clinical evaluation may be conducted via synchronous or asynchronous telehealth communication, provided the relevant standard of care is met.

Furthermore, when prescribing drugs via telehealth, ATA notes that:

> When prescribing based on a telehealth encounter, a practitioner may prescribe the patient a legend drug, including a controlled substance, if the practitioner is authorized to prescribe such legend drug under applicable state and federal laws. To be valid, a prescription must be issued for a legitimate medical purpose by a practitioner acting in the usual course of the practitioner's professional practice. All prescribing must comply with applicable state and federal requirements.

In addition, regarding standards for telehealth encounters, it is important to note that the policy adopted by the Massachusetts Board of Registration in Medicine (Policy 2020-01) on June 25, 2020 states that: "The practice of medicine shall not require a face-to-face encounter between the physician and the patient prior to health care delivery via telemedicine. <u>The standard of care applicable to the physician is the same whether the patient is seen in-person or through telemedicine.</u>" The *t*MED coalition strongly supports this policy.

Additionally, the ATA, in its previously referenced standardized terminology, states that:

> A practitioner utilizing telehealth shall be held to the same standards of professional practice as a practitioner practicing the same profession in an in-person setting, and nothing in this section is intended to create any new or different standards of care. However, it needs to be acknowledged that standards of care do vary based on site of care, time of day/night, location of the patient, and data available to the provider. It should be the responsibility of the provider to escalate to a higher level of care (or otherwise initiate appropriate recommendations) when medically indicated or necessary for patient safety.

We would like to note that Chapter 260 of the Acts of 2020 does not preclude a decision on behalf of a clinician who may deem that a patient would be best served within an in-office setting. Similarly, the

*t*MED Coalition has always supported the provisions that have been codified in the legislation that allow a patient to decline receiving services via telehealth in order to receive in-person services.

We would thus strongly discourage the development of different medical necessity criteria and standards by health plans. Providers and patients benefit from standardization across all plans and a patient's ability to access telehealth should not differ based on their health plan enrollment.

Regarding documentation for telehealth encounters, the *t*MED Coalition supports the language in Chapter 260 of the Acts of 2020 as follows:

> A health care provider shall not be required to document a barrier to an in-person visit nor shall the type of setting where telehealth services are provided be limited for health care services provided via telehealth;

Additionally, the *t*MED Coalition would like to note that, in response to the questions posed by DOI and MassHealth, any additional documentation, beyond what has been included in MassHealth All Provider Bulletin 289, is not necessary.

B. Definitions of Services – Behavioral Health Services

The *t*MED Coalition supports the definition of behavioral health services as provided in Chapter 260 of the Acts of 2020. The field of behavioral health has historically been underfunded as a result of limitations in covered services and lack of acceptance of the diverse care team required to treat behavioral health patients. Chapter 260 recognizes the importance of maintaining a broad definition of behavioral healthcare and intentionally does not dictate provider eligibility. This is in keeping with contemporary medical science and with statewide and national reforms which are moving the provision of behavioral healthcare towards integration with primary care and community-based services. Tele-behavioral health services must mirror these recent and important evolutions both by allowing treating clinicians to utilize the widest range of treatment interventions and by permitting the broadest possible number of clinicians to provide behavioral health services. Any effort to create an exclusive list of qualified providers limited to those licensed mental health professionals included under MGL Ch 176G, Section 4M (i) is not consistent with who provides behavioral health services in clinical practice and would negate the clear legislative intent, undermining the ability of many professionals, particularly those treating children and patients with developmental disabilities, to provide covered telehealth services.

B. Definitions of Services – Chronic Disease Management

In this section, DOI and MassHealth pose the question about whether the 2021 Centers for Medicare and Medicaid Services (CMS) list of chronic conditions should be adopted for compliance with section 56. While this list identifies the 15 of the most chronic conditions for Medicare patients in the CMS Chronic Condition Data Warehouse and may be considered a good start, the list does not sufficiently represent many of the chronic conditions in the adult under 65 population nor those that are prevalent in the pediatric population.

Additionally, the Chronic Care Management Program (CCM) that Medicare began paying separately under the Medicare Physician Fee Schedule in 2015 is for services provided to Medicare patients with multiple chronic conditions. Patient eligibility under this program presumes that this program only applies to "patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline." Clearly, this program is targeted solely for the Medicare population and has limited application for the commercially insured and Medicaid population in Massachusetts.

Given the limitations of this program, including the limited set of clinicians who are allowed to bill for such services under the CCM program (physicians, nurse midwives, clinical nurse specialists, nurse practitioners, and physician assistants), and the limited set of four current procedural terminology (CPT) codes (99490, 99491, 99487, 99449) that are permitted to be used in this program, the *t*MED Coalition recommends that DOI consider adopting broader definitions for chronic disease management akin to the definition utilized by the Centers for Disease Control and Prevention (CDC) which states: "Chronic diseases are defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both." We would acknowledge that there are additional definitions affecting pediatric populations (one out of five people in Massachusetts are children). The American Academy of Pediatrics defines chronic conditions as "a health condition that lasts anywhere from two months to a lifetime." Additionally, the Advancing Care for Exceptional (ACE) Kids Act, which was passed by Congress and was signed into law in April 2019, and is being implemented by CMS defines chronic conditions as "a serious, long-term physical, mental, or developmental disability or disease." Qualifying conditions listed in the statute includes: cerebral palsy, cystic fibrosis, HIV/AIDS, blood diseases (such as anemia or sickle cell disease), muscular dystrophy, spina bifida, epilepsy, severe autism spectrum disorder, and serious emotional disturbance or serious mental health illness. Finally, the *t*MED Coalition would note that, for purposes of comparison, one large commercial insurer in Massachusetts characterizes a chronic disease as "a condition that affects your health and can be controlled but not cured."

Utilizing a broad definition of chronic disease management ensures that the state's implementation of telehealth includes relevant and critical space to remain aligned with evolving medical evidence, precludes the need to establish a process by which we could revisit and update a pre-established list of conditions, and removes the potential for bottlenecks in the provision of accessible care that do not exist within in-office settings.

Additionally, we would encourage DOI and MassHealth, when considering reimbursement for chronic disease management care and services, to allow those clinicians who are providing care and treatment for in-person chronic disease management services to also provide telehealth care and services.

Most importantly, we would note that healthcare providers have been providing care and treatment to patients via telehealth throughout the pandemic – which has been reimbursed on-par with in-person visits. A reduction in reimbursement parity for telehealth services may create a barrier to access health care services, thereby compelling patients to seek in-person service or forgo necessary services. Many

patients face transportation challenges, the need to take time from work, child-care access issues, and/or are immunocompromised or at higher risk of COVID-19 infection, serious illness, or hospitalization. To compel in-person services for such patients could amplify existing systemic disparities in accessing healthcare, thereby undoing the significant equity benefits of telemedicine.

Furthermore, it is important to note that the chronic disease definition does not take into consideration the most compelling chronic disease of the last year: SARS-COV-2 or more commonly known as COVID-19. With more than 590,000 cases in Massachusetts (and more growing by the day), it is imperative that the providers utilizing telehealth to treat these patients, including the so-called "COVID long-haulers" be reimbursed on-par with in-person visits for these services. It is a moral imperative that COVID patients have access to telehealth services – given the need to quarantine and remain socially distanced.

B. Definitions of Services – Primary Care Services

The *t*MED Coalition strongly recommends that both the Division and MassHealth not seek to circumscribe the providers who may offer primary care services via telehealth. Chapter 260 does not define a primary care provider and it is important to note that many primary care services are not always provided by pediatricians, internists, and other "primary care" clinicians. Specialty care providers, particularly obstetrician/gynecologists and others, can and do provide forms of primary care for patients within, for example, visits regarding reproductive health and family planning. As such, we would encourage the Division and MassHealth to not limit the utilization of telehealth solely for those primary care providers as defined under section 1 of Chapter 176O. Instead, we urge a philosophy that is centered around the nature of care—a telehealth encounter which provides primary care services ought to be considered "primary care" regardless of the provider's ability to fulfill all three of the criteria in the definition of a primary care in section 1 of Chapter 176O.

As noted in the above section regarding chronic care management, the *t*MED Coalition would like to highlight that the provision of primary care services via telehealth has been reimbursed on par with in-office visits during the pandemic. We support an extension of reimbursement parity for primary care services beyond the public health emergency to support the provision of essential healthcare, especially for members of those communities challenged by COVID-19 (rural residents, those with disabilities, and low-income workers whose time, mobility, and access to care may be limited).

Thank you very much for your time and your consideration of these matters. We appreciate the opportunity to offer these comments as you craft and formulate policies to implement Ch. 260 of the Acts of 2020 to advance and expand access to telehealth services in Massachusetts. Should you have any questions or concerns, please do not hesitate to reach out to Adam Delmolino, Director, Virtual Care & Clinical Affairs at the Massachusetts Health & Hospital Association (MHA) at (617) 642-4968 or adelmolino@mhalink.org or Akriti Bhambi, Director, Policy and Government Advocacy at MHA at (661) 345-5036 or abhambi@mhalink.org or Leda Anderson, Legislative Counsel at the Massachusetts Medical Society at (781) 434-7668 or landerson@mms.org.

List of *t*MED Coalition Members

- Massachusetts Health & Hospital Association
- Massachusetts Medical Society
- Massachusetts League of Community Health Centers
- Conference of Boston Teaching Hospitals
- Massachusetts Council of Community Hospitals
- Hospice & Palliative Care Federation of Massachusetts
- American College of Physicians – Massachusetts Chapter
- Highland Healthcare Associates IPA
- Health Care For All
- Organization of Nurse Leaders
- HealthPoint Plus Foundation
- Massachusetts Association of Behavioral Health Systems
- Massachusetts Academy of Family Physicians
- Seven Hills Foundation & Affiliates
- Case Management Society of New England
- Massachusetts Association for Occupational Therapy
- Atrius Health
- New England Cable & Telecommunications Association
- Association for Behavioral Healthcare
- National Association of Social Workers – Massachusetts Chapter
- Massachusetts Psychiatric Society
- Massachusetts Early Intervention Consortium
- Digital Diagnostics
- Zipnosis
- Perspectives Health Services
- Bayada Pediatrics
- American Heart Association / American Stroke Association
- Planned Parenthood Advocacy Fund of Massachusetts
- Mass. Family Planning Association
- BL Healthcare
- Phillips
- Maven Project
- Upstream USA
- Cambridge Health Alliance
- Heywood Healthcare
- Franciscan Children's Hospital
- American Physical Therapy Association – Massachusetts
- Community Care Cooperative
- Fertility Within Reach
- Virtudent
- Resolve New England
- Massachusetts Association of Mental Health
- AMD Global Telemedicine
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April 16, 2021

Kevin Beagan, Commissioner
Division of Insurance
1000 Washington St #810
Boston, MA 02118

Dear Commissioner Beagan,

Thank you for your ongoing commitment to ensuring a smooth rollout of the regulations to implement Chapter 260 of the Acts of 2020. We thank you and your staff for a productive and informative hearing on March 12th to discuss the definitions within the law, and we appreciate this opportunity to provide written comments for your review.

Background - Telehealth at Boston Children's Hospital

For more than seven years, Boston Children's Hospital (BCH) has been providing telehealth services directly to patients in their homes for standard clinical care; to community hospitals across Massachusetts where pediatric specialties are needed but hard to recruit and retain; and to local pediatric offices to better triage and manage patients in their own community. Since January of 2020, we have worked extensively to support health care systems and patient families throughout New England to care for children as the COVID-19 grew into a local and global crisis.

When the Governor's Executive Orders closed all in-person, non-essential hospital services, our telehealth team stepped up and transitioned all clinically appropriate care to virtual visits, guiding patients and their families through the new telehealth landscape. Since March 2020, BCH has increased its telehealth visits from 1% of all outpatient visits to a steady 85% during the height of COVID-19. In recent months, outpatient visits continue to be 20-90% virtual depending on the clinical specialty, with an average of 40-45% across the hospital. This has allowed us to provide important and high-quality care for the children of Massachusetts, all while maintaining high patient satisfaction ratings of 9.4 out of 10.

While BCH has long supported increased access to telehealth, the pandemic has expanded our understanding of what telemedicine is capable of providing for our patients, and these virtual services are now offered in more than 45 clinical sub-specialties. Telehealth utilization has kept patients from missing school and learning time, resulting in better education outcomes; decreased caretaker burden for parents who would have had to take time off work; reduced time travelling long distances, saving resources on transportation; eased appointment compliance for patients with mobility challenges, including due to the difficulties associated with transporting cumbersome medical equipment; and has kept medically fragile children out of high-traffic areas, where they may be exposed to contagious infection.

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Examples of Telehealth at Boston Children's Hospital

We have seen and heard amazing stories from patients, families, and practitioners about new ways that telehealth is being used that we could not have imagined. For example:

- A medically complex physical therapy (PT) patient faced challenges coming to the hospital from Western Massachusetts with two caregivers, a wheelchair, medical equipment, and their PT equipment. During a virtual visit, our BCH therapist was not only able to provide regular care, but by seeing the patient in her home environment, was also able to modify her equipment and improve her quality of life in ways previously not possible.
- A patient with a congenital spinal cord deformity (spina bifida) reported to their care team that a change in foot positioning was affecting the ability to walk, do schoolwork and play. Through a multidisciplinary telehealth video visit, the entire care team --including a urologist, neurologist, physical therapist, and nurse-- was able to evaluate and assess the patient's condition in his own home, expediting a timely referral to a neurosurgeon and forging a greater bond between the patient and his care team.
- For patients with short-bowel syndrome, a condition afflicting the intestines that can require up to 12 hours of intravenous nutrition each day, the medical attention needed to ensure proper nutrition necessitates monthly, weekly, or even daily visits to the hospital. Offering telehealth to these patients has reduced number of times patients must transport themselves and their intravenous supplies to the hospital, reducing the risk of infection to the intravenous incision sites and providing these children greater sense of normalcy and overall wellness.
- At BCH, we have seen increased participation among adolescents in group substance use disorder treatment; for the first time, we have seen 100-percent attendance in these critically important group sessions. Due to the greater telehealth access, there have been lower "no-show" rates for patients who require frequent visits as part of their complex care plan. BCH will continue to utilize telehealth in the longer-term future even after the pandemic, given the rapid adoption of telehealth and the dramatic impact it has had on children.

All of these telehealth services have remained uninterrupted due to the Governor's swift action promoting payment parity and access throughout Massachusetts during the pandemic. The COVID-19 crisis has stimulated all of us to be creative and flexible in our solutions and has provided great opportunity to make improvements to our telehealth care system.

Patient Need and Value of Telehealth

In pediatrics, it is important to remember that the care depends on the child and not just the diagnosis. Parents of children with chronic, complex, or acute conditions have shared with us that telehealth provides their children flexibility, convenience, and a feeling of safety when treated in their own homes. It is not uncommon to have a family share the following experiences:

- Their child is managing 20-30 different or evolving diagnoses during their lives, due to the variable nature of a child's growth.

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- Though their child may have one diagnosis, the family is seeing different multiple subspecialty providers, all of whom are treating different aspects of their child's complex condition.
- Out of the 15-20 different specialists seen by an adolescent patient, only 1-2 may have known and cared for the patient since birth
- Appointments are mostly available during school hours, resulting in an average of 30 missed school days for a complex patient, resulting in difficulties keeping up with classwork or attending extracurricular activities.

Telehealth brings comfort into a patient's home or local hospital and pediatrician office. Patient families feel comfortable talking on their phone. Children learn to speak up and advocate in their own way. Live in-person visits are often more challenging for children, as they require visiting an unfamiliar, often intimidating place. Especially for children with autism and other developmental delays, the security of being able to stay in the comfort of their homes has improved wellness and care outcomes.

> "*Accessibility to Virtual Visits enables parents to be the parent that their children often need, in the sense that, when they are not at the hospital, they also play doctor, nurse, and social worker at home. The burden of decision making or assessment in the case of needing to go to the hospital or not, it's a lot. It is incredible to be able to access the consultation of clinical providers virtually to make the right decision in that moment - to monitor the child at home or to bring them into the hospital. Parents will always do what's best for their children. The partnership between families and care providers, Virtual elevates that immensely.*" – A Boston Children's parent with twin daughters born with multiple chronic conditions

DOI Request for Response - What constitutes a telehealth visit?

Telehealth visits, as described in BCH's background, occur for a wide variety of diagnoses and reasons. Visit appropriateness for telehealth must be determined by the clinician, as patients and diagnoses are not "one size fits all." Furthermore, regulations and eligibility should not create standards that lead to unnecessary administrative burden or limited access.

The clinical documentation should support the clinical care that was rendered. The factors below must be considered in determining what constitutes a visit:

1. **Clinical judgement and appropriateness is determined by each individual care provider.** For example, two patients with the same demographics and diagnosis may not follow the same evaluation or treatment plan and two providers specializing in same area and treating patients with same diagnosis may have different management plans.
2. **Clinical documentation to support care that was extended via telehealth. The same clinical documentation that is required for in-person should also be required for telehealth.** Other information to be considered in the documentation is the technology modality (e.g., audio-only telephone, audio-video, online interview) to distinguish between types of telehealth delivery.

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In addition, the Massachusetts Board of Registration in Medicine (Policy 2020-01) on June 25, 2020 states: "The practice of medicine shall not require a face-to-face encounter between the physician and the patient prior to health care delivery via telemedicine. The standard of care applicable to the physician is the same whether the patient is seen in-person or through telemedicine."

We have heard BCH providers share how telehealth has impacted care delivery for individual patient's condition:

"Prior to COVID, there was limited activity due to the lack of reimbursement. We see that reimbursement drives telehealth activity. In these past months, we've learned that telehealth is really effective care, as it allows our care team to see the patient's home life which can be more valuable than coming into a clinical exam room." – Norman Dean, Executive Director Otolaryngology

"Many of my patients can be seen through telehealth. This has been extremely helpful as my patients are often medically fragile and do not need to make frequent visits to the hospital when medical visits can be completed using technology. While some visits clearly need to be in person, not all need to be so. Telehealth allows the provider and patient's family to make these decisions in a way that is best for the patient's needs." – Dr. Christina Jacobsen, Attending Physician in Endocrinology and Genetics

DOI Request for Response - Definition of Behavioral health

An important component of the "behavioral health" definition includes language for the care and treatment of "developmental" disorders. Boston Children's Hospital Autism Spectrum Center is dually governed by the Department of Neurology and Department of Developmental Medicine. Any child can be seen by a provider in any of three specialty areas for diagnosis and ongoing care: developmental pediatrics, child neurology, or psychology. Children with autism spectrum disorder receive individualized care with autism specialists such as developmental behavioral pediatricians, child neurologists, psychologists, psychiatrists, nurse practitioners, geneticists and gastroenterologists, as well as physical, occupational, and speech and language therapists. All three types of providers are equally trained and follow the same clinical guidelines. Even through autism is known as a behavioral health condition, it is still critical that all trained and eligible licensed health professionals be able to help assess, treat and manage conditions like these.

Boston Children's Recommendation:

- Licensed mental health providers also need to **include physicians and advanced practice healthcare providers** who specialize in primary care, adolescent medicine, neurology, developmental medicine, and other areas **who treat behavioral health related conditions**.

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DOI Request for Response – Definition of Chronic Disease Management

In Massachusetts, 1 in 5 people in are children (US Census Bureau). According to the American Academy of Pediatrics, between ten and twenty million children and adolescents in the United States have some form of chronic illness or disability. Children may be born with a condition that affects them over a lifetime and needs continual monitoring and adaptations to care. Or a child may sustain an acute injury, like a broken bone, that needs to be followed longer-term but is not chronic in nature. The definition of chronic disease management used in the regulations must account for a child's diagnosis and needs.

Boston Children's Recommendations:

- Similar to the definition of behavioral health care, chronic disease management should include the care and services for the **evaluation, diagnosis, treatment** or management of patients with conditions over time, as determined by the individual licensed health professional.
- We recommend including the following definition, in parallel to the **Centers for Disease Control and Prevention's** definition of chronic disease, to guide your regulatory work to ensure care for children continues -
    - The **American Academy of Pediatrics** defines chronic conditions as "a health condition that lasts anywhere from 3 months to a lifetime."
    - The definition for children should also include language for conditions identified at birth expected to last greater than three months to include infants diagnosed with an anticipated chronic disease to avoid any potential delays in care at the time of birth to three months.

Chronic disease management is different in pediatrics than for adult care. Children are constantly growing and changing, and therefore the evaluation and treatment of any condition will change with the continual growth and development of child, as well as the natural history of the actual condition itself. Therefore, there are two fundamental categories of "chronic disease management" in the pediatric patient that need to be considered:

1. **The condition changes over time, but the patient is constant -**
    - Certain conditions are **chronic** because over time they can change and require serial examinations, imaging, non-operative care and surgical treatment. Examples of medical conditions that change over time include neoplasias (i.e. benign tumors and cancer), skeletal dysplasias, scoliosis, Perthes disease, and hip dysplasia.
2. **The condition is constant, but the patient is changing over time -**
    - The diagnosis of a congenital difference does not change, but its effect on a growing, developing child may change, requiring continual or "**chronic**" care. Examples of such conditions include clubfeet, genetic or metabolic disorders, or congenital limb differences.
    - The fundamental condition or diagnosis may not change, but it may have dynamic manifestations at different ages, stages of development and growth, and during different activities. Prime examples include neuromuscular conditions like chronic kidney disease, cerebral palsy and stroke.

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- While acute fractures and soft tissues can heal, there can great impact on chronic musculoskeletal health, particularly related to growth, joint function, and posttraumatic arthritis. For example, fractures of the growth plate in young children may result in skeletal deformities and thus need longer-term monitoring and possible future surgical care. Similarly, while an ACL tear may be treated with surgical reconstruction, there can be longer-term sequealae affecting the meniscus of the knee or articular cartilage.

At BCH, more than 45 specialties provide telehealth services for chronic and complex patients. Within these specialties, specialty care teams can consist of more than 10 providers; limiting this team to a subset of providers removes the value and impact telehealth can have on a patient family. Telehealth has afforded the opportunity for all team members to meet with a patient in one visit together. These care teams may include a Surgeon, Medical Physician, Physician Assistant, Nurse Practitioner, Nurse Educator, Physical Therapist, Occupational Therapist, Speech Pathologist, Nutritionist, or Pharmacist, among others. Regulations should not specify that certain specialties are ineligible for telehealth reimbursement, as it could create a system where patients may potentially only be able to meet with select care team members telehealth and others in-person.

"*Telehealth is a valuable tool for children and adults with chronic or complex medical needs. The ability to follow-up with one's specialists via telehealth is essential and needs to be covered as equivalent care. Telehealth allows patients and parents to not miss huge chunks of time off work for doctor's appointments and it allows children to not miss large chunks of school. By eliminating the travel and expense of travel/parking for families, people can be more compliant with their follow-up visits and health care in general. Telehealth has been a true blessing for myself and my patient population. It should be supported and maintained in the future.*" – Dr. Amy Kritzer Physician in Genetics

DOI Request for Response – Definition of Primary Care Management

Primary care management is broadly defined in the bill. We applaud this broad definition and believe this will allow many care providers in the patient primary care home to provide care to our patients.

Boston Children's Recommendation:

- Primary Care is the medical home for patient care and all provider types within the primary setting need to be included. This would include Physicians, Nurse Practitioners, Physician Assistants, Nurses, Nurse Educators, Nursing Assistants and other related allied healthcare providers.

Thank you again for the opportunity to comment on these important regulations. Should you have any questions, please do not hesitate to contact Director of State Government Affairs, Shannon Moore, at Shannon.Moore@childrens.harvard.edu.

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Respectfully,

Shannon Moore

Shannon Moore
Director of State Government Affairs
Boston Children's Hospital

MAHP Draft Feedback
March 12 DOI Session #2 to Discuss Implementation of Chapter 260 of Acts of 2020 Telehealth Provisions

What constitutes a telehealth visit?

Is there a way to define a "visit"? Are there certain features/items/criteria that need to be met for an encounter to be considered a "visit" whether in office or provided via telehealth?

What services should not be considered to be appropriately provided through telehealth?

MAHP Response:

- In accordance with the new statutory language, health care services delivered via telehealth will be covered if:
  1) the health care services are covered by way of in-person consultation or delivery, and
  2) the health care services may be appropriately provided through the use of telehealth.

- In order for a "visit" (for the purpose of evaluating, diagnosing, consulting, prescribing, treating or monitoring of a patient's physical health, oral health, mental health or substance use disorder condition) to be reimbursable as telehealth under Chapter 260:
  - **Services rendered must be clinically appropriate, medically necessary covered services and not require an in-person assessment and/or treatment.**
    - Health plans can utilize Medical Record Documentation policy and Practice Site Standards, included in the Provider Manual, to set out standards for a telehealth or in-person visit in order to ensure that a particular covered service is clinically appropriate for telehealth delivery and does not require an in-person assessment or treatment. Additionally, post-service audits can be used to ensure appropriate clinical care is being rendered via telehealth.
  - **Services rendered must be documented in the member's medical record in the same manner as a face-to-face visit.**
  - **Providers performing and billing telemedicine/telehealth services must be eligible to independently perform and bill the equivalent face-to-face service.**
  - The encounter must satisfy the elements of the patient-provider relationship, as determined by the relevant healthcare regulatory board of the state where the patient is physically located.
  - The service must be conducted and a permanent record of online communications relevant to the ongoing medical care and follow-up of the patient must be maintained as part of the patient's medical record to ensure continuity of care.
  - Services must be filed with the appropriate modifiers and place of service codes in accordance with a health plan's billing guidelines.
  - The components of any evaluation and management services provided via telehealth must include at least a problem focused history and straightforward medical decision making, as defined by the current version of the Current Procedural Terminology (CPT) manual.

- **The existing categorization and coding established and utilized within the Medicare system can serve as a uniform framework for the coverage of telehealth services in Massachusetts**. Providers have called for consistency among coverage by individual health plans in the state to reimburse in-network services delivered via telehealth modalities. More importantly, consumers must be

financially protected when they responsibly seek care with an in-network provider through telehealth. Based on the virtual service provided by to an individual patient, a comprehensive set of HCPCS and CPT codes have been developed over time and are already utilized by a majority of payers and providers participating in telehealth coverage arrangements throughout the national and state health care system. This coding structure used by Medicare can serve as a model to all providers and health plans in Massachusetts for how to categorize specific virtual services to support uniformity in coverage and billing.

Telehealth reimbursement in accordance with the Medicare framework differentiates a comprehensive "visit" requiring synchronous or interactive communications, including audio-only, between the patient and a distant physician or health care specialist who is performing the service reported from asynchronous telehealth. The patient must be present and participating throughout the communication.

Medicare Telehealth "Visits"

Medicare reimburses providers for telehealth visits in which synchronous telecommunication technology, live videoconferencing, is used to conduct office visits, hospital visits, and other services that generally occur in-person**.** Prior to the COVID-19 public health emergency, Medicare required the use of an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient at home. This coverage was extended to audio-only visits for the immediate future. This includes codes for office or other outpatient visits (99201-99205 for a new patient office or other outpatient visit for evaluation & management services; 99211-99215 for an established patient office or other outpatient visit for evaluation & management services).

Medicare Virtual Check-Ins (Not a "Visit")

Medicare reimburses doctors and certain practitioners for "**brief communication technology-based service**. These virtual check-ins are:

- Brief (**5-10 minutes of medical discussion**), requiring only a minimal time commitment on behalf of a provider
- **Patient-initiated**, to avoid opportunity for billing fraud or overutilization
- Require an established patient-provider relationship, and
- **For a provider to determine whether a full evaluation in an office visit or other service is needed**, therefore the communication is not reimbursable if related to a medical visit within the previous 7 days or leads to a medical visit within the next 24 hours (or soonest appointment available).

- Medicare Asynchronous Communications
  Referred to as "store-and-forward" electronic transmission of a patient's health information in the form of digital images or pre-recorded videos, these communications do not constitute a "visit".

- **Services that are not separately reimbursable as a telehealth visit under Chapter 260 include services incidental to covered E&M, counseling, or medical services**.
  - Examples include reporting of test results, provision of educational materials, administrative matters including scheduling, registration, updates to billing information, reminders, and requests for medication refills or referrals or ordering of diagnostic studies.
  - **CPT E/M codes include service descriptors that require a review of a patient's history, an examination of the patient, and medical decision-making regarding treatment**. Providers

select the appropriate code level for the E/M service based on either time or medical complexity. For 2021, time is defined as "total time spent on the day of the encounter", allowing providers to include "both the face-to-face and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter." Activities that a provider can count toward total time include: Prepare for the visit, for example, review test results; Obtain or review 'separately' obtained patient history; Perform a medically necessary examination and/or evaluation; Counsel and educate the patient, a family member or a caregiver; Orders for tests, medicine, additional services; Refer or communicate with other health care professionals; Enter clinical information in the patient's medical record; Interpret and share test results with the patient; Coordinate patient care.

Definition of Behavioral Health Services

Should any elements of the definition need further clarification? Does section 55 apply to any network provider who provides the noted services or only those providers that are identified as licensed mental health professionals?

MAHP Response:

- State law requires health plans in Massachusetts to cover behavioral health benefits: 1) as listed in Section 4M(g) of MGL Chapter 176G that 2) are rendered by a licensed mental health professional acting within the scope of his license. Therefore, Section 55 applies only to licensed mental health professionals (limited to a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist, a licensed alcohol and drug counselor I, or a licensed marriage and family therapist within the lawful scope of practice for such therapist) who provide behavioral health outpatient services provided by a licensed hospital, a mental health or substance abuse clinic licensed by DPH, a public community mental health center, a professional office, or home-based services delivered via telehealth.
- Additionally, providers performing and billing telehealth services must be eligible to independently perform and bill the equivalent face-to-face service.
- Only those behavioral health services reimbursed by CMS as covered codes for BH telehealth are reimbursable for coverage as behavioral health services delivered via telehealth.
- The categories of primary care services and behavioral health services were defined and addressed separately in the new law, demonstrating legislative intent that the two categories of health care services be mutually exclusive and distinct. Behavioral health services in Section 55 do not include services provided by a PCP, pediatrician, family practitioner, or general practitioner; behavioral health services provided by a PCP are included in primary care services.

Definition of Chronic Disease Management

Should the information listed in the booklet to describe chronic care management apply to "chronic disease management" as defined in Section 56? The CMS guide identifies practitioners who provide chronic disease management; should this list apply in Massachusetts as the appropriate list of practitioners to provide chronic disease management according to Section 56? The CMS guide identifies chronic disease management by CPT service codes; should these services and codes identify what is to be considered chronic disease management according to Section 56?

MAHP Response:

- MAHP supports defining chronic disease management in accordance with the CMS Chronic Care Management guide. Chronic care management is defined and understood as encompassing the oversight and education activities conducted by health care professionals to help patients with chronic diseases to understand their condition and live successfully with it. This term is equivalent to disease management for chronic conditions. The work involves motivating patients to persist in necessary therapies and interventions and helping them to achieve an ongoing, reasonable quality of life. Chronic disease management is NOT treatment of chronic illness.
- We support the use of the identified CPT service codes, which provide payment of care coordination and care management for a patient with multiple chronic conditions, for chronic disease management.

Definition of Primary Care Services

Who should be considered a primary care provider?

MAHP Response:

- Health plans consider the following providers PCPs: family practice, general practice, internal medicine, obstetrics & gynecology, pediatrics, adolescent medicine, geriatric medicine, nurse practitioner, physician assistant, adult nurse practitioner, family nurse practitioner, gerontological nurse practitioner, and pediatric nurse practitioner.
- Additionally, providers performing and billing telehealth services must be eligible to independently perform and bill the equivalent face-to-face service. Oftentimes, NPs and PAs can bill independently if enrolled in a health plan's claims system with their own provider ID or under a PCP or specialist physician.

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Joanne Sweeney, *Co-President, Riverside EI*

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Maggie Finnegan, *Region II, Criterion Valley EI*

Martha Levine, *Region III, Northeast Arc EI -Cape Ann*

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May 13, 2021

Kevin Beagan
Deputy Commissioner
Health Care Access Bureau Massachusetts
Division of Insurance
1000 Washington Street Boston, MA 02118

Dear Deputy Commissioner:

On behalf of the Massachusetts Early Intervention Consortium, thank you for hosting five listening sessions to solicit comments and promote dialogue regarding the critical implementation of telehealth provisions within Chapter 260 of Acts of 2020. We thank both the Division and MassHealth for the collaborative and thoughtful process used to guide the listening sessions. We respectfully submit the following comments for your consideration. The majority of our comments focus on the second listening session and the specific topicsof **Definitionof Services - Behavioral Health and What Constitutes a Telehealth Visit.**

When the Governor declared a Public Health Emergency, both Early Intervention and Specialty services were deemed essential services and programs remained open remotely providing critical telehealth and tele-intervention services to children and families. The 59 Early Intervention Programs and 15 Specialty Service Providers statewide provide medically necessary and essential services to over 54,000 children, birth to age three, who have or are at risk for developmental delays. EI Specialty Services include Autism Spectrum Disorder services and specialized services for children who are deaf and hard of hearing, blind or visually impaired. *(Note, all references to Early Intervention in this letter refer to both general Early Intervention Programs and Specialty Service Providers serving EI children and families).*

During the stay-at-home order, the ability for Early Intervention providers to quickly pivot and transition from a system of in-person, in-home or community-based services to telehealth and telephonic services was literally a lifeline for children and families. Early Intervention families desperately needed access to services but also the assurance that services could be delivered in a safe manner that would reduce the risk of exposure to and transmission of the virus. Telehealth has been the only way that EI programs can service children and families safely during COVID.

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Definition of Services - Behavioral Health

We join with our colleagues in the tMed Coalition in applauding the Chapter 260 definition of behavioral health services, which was expanded to include care and services for individuals with developmental disabilities. Chapter 260 recognizes the importance of maintaining a broad definition of behavioral healthcare and intentionally does not dictate provider eligibility. Telehealth behavioral services must allow providers and specialists to utilize the widest range of treatment interventions and permit the broadest possible number of clinicians to provide behavioral health services.

Coverage for telehealth behavioral health services should not be limited to an exclusive list of qualified providers such as licensed mental health professionals as defined in M.G.L. c. 176G, section 4M(i). The definition is too narrow and would exclude professionals currently providing developmental services to children and adults who have developmental delays or developmental conditions, including Early Intervention services, which are now covered under the behavioral health definition in Chapter 260.

Adopting such a narrow definition or an exclusive provider list could exclude Early Intervention and EI Specialty Service Providers who are currently covered under Massachusetts mandated benefits laws. Early Intervention services are designated as developmental services in Massachusetts General Law (Chapter 111G); Medically necessary Early Intervention services are further deemed mandated benefits under Massachusetts health insurance statutes including Mass Health Chapter 118E; Chapter 175 Section 47C; Chapter 176A Section 8B; and Chapter 176B, Section 4C.

Early Intervention services are provided by a multidisciplinary team of specialists that includes, but is not limited, to speech, occupational and physical therapists, social workers, mental health clinicians, developmental specialists, and nurses. Certification by the Massachusetts Department of Public Health (MDPH) is required for all EI programs and for all clinicians who provide direct services to children and families within the Massachusetts Early Intervention system. The MDPH has a rigorous certification process which includes the alignment of criteria for state certification and licensure with state personnel standards and national professional organization standards across all disciplines.

The EI multi-disciplinary team of specialists deliver child-specific and family-centered services that reflect the true integration of medical and behavioral health services designed to support the child and family's behavioral, social, emotional and developmental health.

Through the specific inclusion of the words "developmental services" in the behavioral health definition, the Legislature recognized the necessity for parents and their children with medically fragile/medically complex needs and/or developmental delays to retain remote access to services and supports via telehealth after the Public Health Emergency and as an ongoing service option and modality. The Legislature added the word “developmental” intentionally and specifically to include the pediatric population and the clinicians and specialists currently providing medically necessary and clinically appropriate services to children and their families/caregivers who support their care and treatment. This includes Early Intervention and EI Specialty Services.

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The Consortium's primary goal is to ensure that the broad legislative intent and inclusion of developmental services, including Early Intervention, is maintained and validated through any guidance and regulations that may be developed to implement the telehealth provisions of Chapter 260.

What Constitutes a Telehealth Visit:
For Early Intervention services, the guidance regarding what constitutes a visit is already clearly articulated in the DPH EI Operational Standards. This should continue to be the guidance for EI telehealth visits going forward.

We recommend that forthcoming guidance and regulations regarding the definition of telehealth visits and the billing and reimbursement for said visits should be consistent with existing and applicable billing regulations and operational standards for in-person visits. There is no need to create new and potentially conflicting rules for in-person and telehealth services. We further recommend that forthcoming regulations and rules are clear, consistent and easy for providers, insurers and patients to understand and follow going forward. It is critical to maintain and ensure reliable and consistent access to and reimbursement for Early Intervention Services, via all modalities of in-person and telehealth, including audio-only telephone services.

Audio-Only Access and Health Equity
Early Intervention providers are extremely concerned about our families and communities of color that are being disproportionately impacted by poverty and COVID-19 infection. The pandemic is impacting access to services for some of the most vulnerable children and families in urban and rural communities across the state. This is widening and exacerbating the health disparities and inequities gap that existed long before COVID-19. The use of audio-only telephone services has been essential for Early Intervention and Specialty Services Programs to reach struggling families who lack WIFI/internet access and computers/laptops. As noted above, it is essential to maintain telehealth, audio-only options for Early Intervention children and families.

Overall Recommendations and Comments: Modality Is Clinical Decision- Consistency for In-Person and Remote/Telehealth Care and Limiting Barriers to Access
The EI Consortium echoes the comments of the tMed Coalition and others in urging the Division and MassHealth to consider modality of care as a clinical decision and as such, all guidance and regulations should be consistent for in-person and remote/telehealth and should not differ based on modality. This consistency will reduce and avoid the unintended consequence of creating administrative burdens and barriers to timely and clinically appropriate care. We are concerned that establishing different regulations for in-person and telehealth could create confusion for consumers and create barriers to health care access, particularly for our low-income families and underserved populations already over-burdened and disproportionately impacted by COVID-19.

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Providing a Glide-Path to Facilitate Transition:
The EI Consortium strongly supports the tMed Coalition recommendation for the Administration to consider providing at least 90 days notice before lifting the declaration of emergency. Such notice would give providers an adequate timeline for a "glide-path" regarding changes in reimbursement for telehealth services that may require adjustments and modifications to billing systems and patient scheduling and to provide sufficient notice to patients with regards to any changes that providers may make regarding the continued ability to offer telehealth services. We believe that 90 days, as outlined in the legislation, is insufficient time and to the extent possible, additional time should be afforded to avoid disruption of patient care.

Thank you for the opportunity to offer these comments as the Division and MassHealth work to formulate guidance and policies to implement Chapter 260 of the Acts of 2020 to advance and expand access to vital telehealth services in Massachusetts.

We concur with the comments you shared at the last listening session on April 29, 2021 - "Telehealth works, it makes sense and we need to make sure it continues going forward."

If you have any questions, please contact Mary Ann Mulligan, Legislative Consultant to the Massachusetts Early Intervention Consortium at mamulligan@governmentalstrategies.com or (617) 447-5043.

Respectfully submitted,

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