January 4, 2021 | Volume 35, Issue 1

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In this issue

2021 predictions

Eyeing the future: E/M will disrupt, the PHE will end, telehealth will stay

Part B News editors scanned the health care landscape to come and interviewed experts to arrive at nine predictions of events and trends that will affect medical practices in 2021. (*Note: see www.partbnews.com for four bonus predictions.*)

Prediction: The E/M guideline revisions for office visit codes will sow confusion — with the use of time and with the "complexity of data" portion of medical decision-making (MDM).

The comprehensive updates to E/M office visit documentation guidelines, which go live Jan. 1, have been years in the making. After CMS fired a salvo in the 2018 rulemaking period, announcing it would wrap different levels of E/M codes into a single payment rate, the AMA responded in April 2019 with an alternate solution that included a new MDM table and revised time elements.

Since then, medical practices have awaited the new era of E/M office visit reporting, and its arrival marks the first significant change to the documentation and code level selection behind the series of codes — **99202-99215** — that accounts for roughly 20% of Part B spending annually in nearly 30 years.

Despite the lengthy lead time, some experts fear that many practices aren't ready to launch once the calendar flips to 2021. Given the amount of reimbursement dollars tied to the E/M codes, a lack of readiness could spell financial disaster.

"Not all coders [and] providers have sought out solid education on the upcoming changes," says Shannon McCall, CPC, director of HIM and coding for HCPro in Middleton, Mass. "Some providers may have relied on the brief educational

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content provided by the AMA when there are certainly more complexities to these changes than some may realize where application is necessary."

One of those potential challenges is the middle column of the revamped MDM table — the "amount and/or complexity of data to be reviewed and analyzed" element — which factors into code level selection and determines, in part, whether your patient encounter will meet a Level 2, 3, 4 or 5 service.

Betsy Nicoletti, CPC, president of Medical Practice Consulting in Northampton, Mass., says that already she has seen "widespread confusion about 'ordering' and 'reviewing' [tests] if separately reported."

As practices grapple with the new MDM table in 2021, the challenge of navigating the middle "complexity of data" column is likely to become more pronounced.

"The E/M guidelines are quite clear that if a provider is reporting a separate CPT code for the test, it cannot be counted toward MDM (or counted toward time)," McCall says. "This will be problematic for providers who have their own imaging equipment as well as labs. Upon audit, these services may have been counted 'twice' and possibly contribute to a higher level of service."

Coders may need to quickly familiarize themselves with tests that have their own CPT codes, so they know which tests can be accurately applied to the amount of data portion of the MDM level. "For example, if a urinalysis via dipstick is done with a culture, this is two unique CPT codes and would be counted as two," McCall offers. "Also, for labs where panels are ordered, this is only one 'test' although there may seem to be multiple analytes in the results."

The use of time as a controlling factor, which is allowed under 2021 guidelines to determine the level of E/M office visit codes, is another likely source of confusion — although perhaps more from a practice management than a counting standpoint. Any E/M office visit encounter can rely on time for code level selection in 2021, eschewing the previous "counseling" mandate, but that doesn't mean simply adding up the minutes of the encounter with pre- and post-work will make the most sense for your practice.

Ultimately, you will have to crunch some numbers and discern whether time or MDM is the best way to go for your typical patient population. Let's say, for instance, you're accustomed to seeing 30 patients per day and you would normally report a 99213 for the majority of the encounters. Under 2021 rules, 99213 has a minimum of 20 minutes per patient. "That's three patients an hour," McCall says. "So unless the provider is working from 8:00 a.m. to 6:00 p.m. with no breaks at all, then it may not be feasible."

It bears watching what private payers do with the E/M office visit guidelines, too, because that could be an added challenge. "CMS had not meaningfully updated documentation guidelines for E/M since the late 1990s, so recent policies to modernize, streamline and simplify requirements is appreciated," says Mollie Gelburd,

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JD, associate director of government affairs with the Medical Group Management Association (MGMA) in Washington, D.C. However, "to the extent that there are inconsistencies across payers with respect to documentation or payment policies, that will mitigate any positive effect and create 'pain points' by creating a patchwork of rules. Our hope is private payers quickly adapt to new Medicare rules."

Prediction: The public health emergency (PHE) will end in 2021. We should probably say, "almost certainly," but let's go big. From a public health point of view, anyway, our experts are optimistic. "

"We have the vaccines, and all of the data points to very robust responses across multiple patient types and ages — however, we haven't yet the data for the very young pediatric classes," says Jeremy Levin, M.D., chairman of the industry group Biotechnology Innovation Organization (BIO). "That will come. At the end of the day, we will have an effective barrier against COVID in 2021 but education of patients will be key."

The approvals of the Pfizer, BioNTech and Moderna COVID- 19 vaccines "offer the first real hope of an end to the coronavirus pandemic," says Lisa Doggett, M.D., senior medical director at HGS/AxisPoint Health, a global business process management company with population health management offerings. "With vaccine efficacy as high as 95%, we should be able to stop the spread of the virus as soon as we can get enough people vaccinated."

Not that there won't be bumps in the road. Levin is concerned with vaccine distribution in long-term care facilities, which were a hot spot in 2020. "The question for each of the state health departments will be, have they accounted for the budget that will be required to go and administer these vaccines onsite?" Levin says. "Because those patients won't be coming to their local doctor and there will need to be access."

Abe Malkin, M.D., founder and medical director of Concierge MD LA in Los Angeles, reckons that "there will likely continue to be infection surges in certain areas until we are able to vaccinate enough individuals to achieve herd immunity." But, he says, "the general consensus is that by the summer life will return to a semblance of normalcy as a large percentage of the population becomes vaccinated."

Daniel Cidon, CTO of NextGate, reminds you that this will be "the single largest vaccination rollout ever initiated" and will require "accurate and consistent patient identification," especially in the case of the Pfizer and Moderna vaccines, which require two doses. "The issue of patient identification becomes even more complex as a number of other vaccines, each with their own set of schedules, enter the market at the same time," Cidon says.

But the end of the PHE won't necessarily mean everything goes back to normal in Medicare rules. Christina M. Kuta, an attorney with Roetzel & Andress in Chicago, says that "even when the PHE ends, inevitably, I think it's reasonable to expect certain flexibilities afforded by it to continue through regulation." In fact, she notes, CMS already has "indicated a desire to extend some telehealth flexibilities beyond the PHE for certain rural areas" and in other cases (*PBN 12/17/20*). In fact, maybe the HHS Secretary, whose job it is to order PHEs, may "vamp" for some extra time to keep those flexibilities without changing the law (s*ee the telehealth prediction, below*). But we're betting on hope.

Prediction: Congress will finally loosen up on telehealth. Certainly, if it were up to physicians and patients, the telehealth flexibilities of the COVID-19 era would be extended indefinitely.

"I absolutely believe that flexible telehealth services are here to stay," Kuta says. "Even before the COVID-19 pandemic, state regulations and payer policies were changing in a way to allow for more telehealth services and increased payment for such services. Out of necessity, providers and patients have seen firsthand the convenience [that] telehealth services can provide for certain health concerns."

But do payers, federal or otherwise, agree strongly enough to keep up payments for services rendered under circumstances that were not previously payable?

Alexa B. Kimball, M.D., president and CEO of Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center (BIDMC) in Boston, thinks "payers should be aware that there is no going back — patients and health care providers alike will be more than unhappy if telehealth access is restricted or denied now that they have experienced its marked advantages."

It would take an act of Congress to make these services permanent, and Beth Halpern, a partner with Hogan Lovells in Washington, D.C., thinks for the first time the stars will align in 2021.

"I think almost every Congress for as long as I can remember has tried to expand telehealth for one population or another or for particular disease states," Halpern says. "And they chipped away at it even before the pandemic. But now it seems like a relatively easy thing for Congress to fix,

and the experience of the past year of using it more should help allay any concerns some people had about people's interest in actually using the service, which has always been the concern."

Also, "making the authority permanent isn't necessarily an expensive proposition," Halpern says. And what's not to love about a popular law that doesn't cost money?

That won't happen until it has to, though, so until the PHE gets called off, CMS will use the means at its disposal to provide as much telehealth-like services as possible — including communications technology-based services (CTBS), such as the **G2252** "brief communication technology-based service (e.g., virtual check-in)" service it recently instituted for established patients (*PBN 12/10/20*).

The agency will also try to pivot to remote patient monitoring (RPM) whenever possible, predicts Matthew Fisher, an attorney with Mirick O'Connell in Westborough, Mass. "CMS tipped its hand with the physician fee schedule that it has done all that it thinks can be done without legislative change," he says. "The underlying Medicare statutes only permit so much action to occur, which complicates matters. For RPM at least, Medicare has done a good job of expanding access and RPM can be used as a good gateway into both telehealth and value-based care."

Prediction: All E/M codes will get revised in 2021. This forecast speaks to the stated ambition of CMS to expand the 2021 E/M office visit guidelines across the full range of E/M services. Once again, CMS may be spurring other groups to action.

To that end, the "AMA will develop new descriptors for all E/M codes," predicts Maxine Lewis, president of Medical Coding and Reimbursement in Cincinnati. That assertion is supported by the AMA's early-year calendar of coding updates, which contains a number of E/M-related sessions. While *Part B News* is predicting an initial update to the E/M code set, it doesn't expect a rapid implementation. Given the lag time with the office visit codes, we would project the changes to occur across the spectrum no earlier than 2023.

Prediction: Value-based models — including the Trump ones — will thrive under Biden. Harry Nelson, co-managing partner of the Nelson Hardiman law firm in Los Angeles and author of *From ObamaCare to TrumpCare: Why You Should Care*, sees crossover potential for Democrats and Republicans in value-based care models — because Trump went big on those during his presidency (*PBN 1/23/20*). He especially sees potential in the Direct Contracting (DC) model of the Direct Primary Cares First initiative that rolled out in 2020. DC is a risk-sharing model with per-beneficiary, per-month (PBPM) payments for enrolled beneficiaries (*PBN 1/30/20*).

"I'm seeing in L.A. big health care players making a hard push [into Direct Contracting], particularly the Medicare Advantage plans," Nelson says. "CareMore, which was acquired by Anthem, is doubling down on it. And I'm hearing from health care lawyer colleagues on the East Coast that the same thing is happening in their markets. It's driven by big players."

While the Biden administration will probably throw out a lot of Trump health care initiatives, they'll "be more strategic" on value-based and bundled-payment initiatives, Nelson says. "Rather, they're going to leverage those to do more," he says. "Because now for the first time, you have value-based care initiatives that are Republican-led, and it's going to be a breakout success."

Prediction: Medicare for all is off the table — for now. Medicare for All — a single-payer alternative to the panoply of federal payment programs in the current health care system — enjoys strong support in surveys, but not so much among people who actually get nominated and elected to high office (*PBN 9/25/17*). During the 2020 primaries, then-candidate Joe Biden explicitly ruled out Medicare for All as too expensive, proposing instead a stronger ACA and lowering the Medicare enrollment age to 60 — which, Nelson notes, would bring 20 to 30 million more people into the program.

On the other hand, as Democratic nominee Biden picked Medicare-for-All fan Kamala Harris as his vice presidential running mate, and as the president-elect has proposed another M4A advocate, California attorney general Xavier Becerra, for Secretary of Health and Human Services (*see related prediction, online*).

With Congress closely divided, however, it appears that Biden couldn't get such an ambitious program off the ground even if he wanted to. "I think [public option/Medicare for All lite] is going to be on the shopping list, but not on the menu for 2021," Halpern says. "It will continue to be a hope and an aspiration."

Prediction: Biden will patiently, and successfully, build Obamacare back up. For the new HHS and CMS administrations, "the biggest potential action will be stabilization around the Affordable Care Act," Fisher says. A divided Congress would prove a stumbling block in terms of legislation, but legislation is not needed.

(*continued on p. 6*)

Benchmark of the week

Amid telehealth surge, experts wonder whether 2021 is the go-big year

While 2020 will always be remembered for the COVID-19 pandemic and the mass casualties and despair around the nation and the world, the lasting effects of the virus are also likely to reshape the delivery of health care in myriad ways. One of the lasting changes may be the vast expansion of telehealth services.

"Providers who did not previously offer telehealth embraced technology as a means to remotely maintain patient access to care and attempt to make up for revenue lost from substantial reductions of in-person visits," relays Mollie Gelburd, JD, associate director of government affairs with the Medical Group Management Association (MGMA) in Washington, D.C.

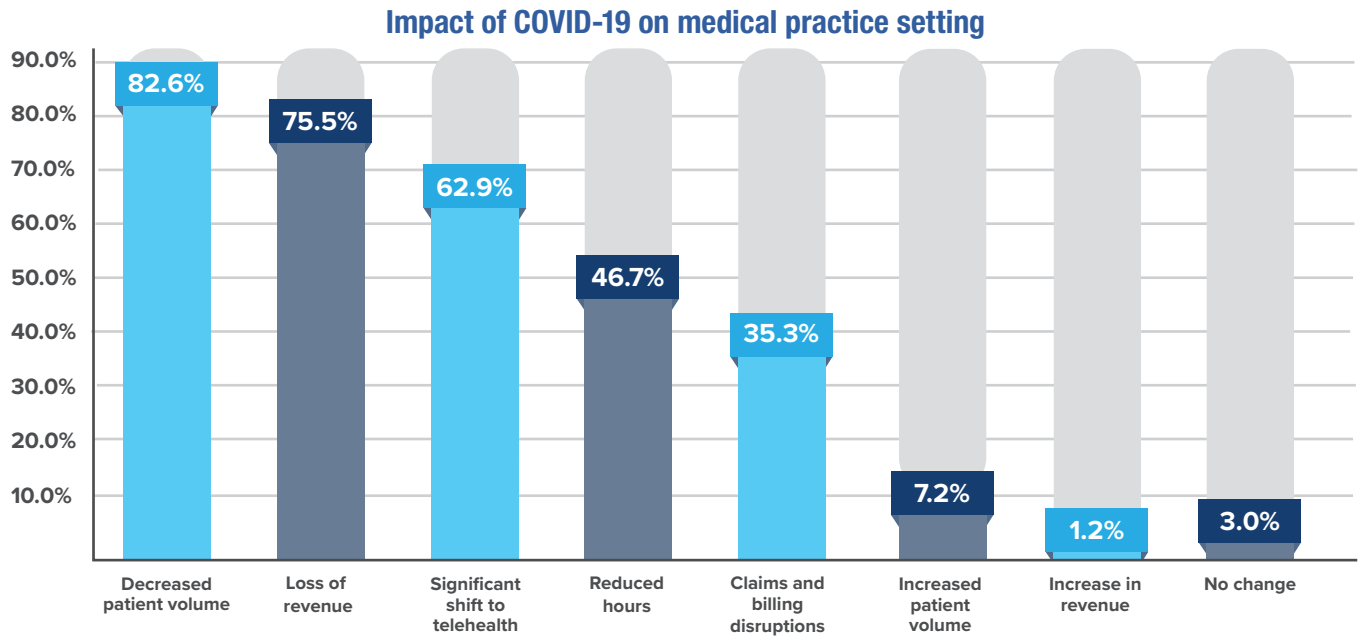
CMS, and perhaps lawmakers even more, are now facing "pressure to allow telemedicine," says Betsy Nicoletti, CPC, president of Medical. "Maybe the new administration will believe they have the statutory authority to allow it for office visits from anywhere," Nicoletti adds. It's "hard to put the genie back in the bottle."

CMS has long maintained that it does not have the statutory authority to free up the restrictive "distant" and "originating" site requirements that currently limit who can provide telehealth services and in what capacity.

"The lasting impact of telehealth adoption will depend in part on whether Congress removes barriers to telehealth reimbursement post-public health emergency, such as eliminating geographic and originating site restrictions, and whether CMS decides to cover audio-only technologies in the future," says Gelburd, who adds that preliminary MGMA data showed that almost all (97%) of providers delved into telehealth in the early days of the pandemic.

The chart below, taken from the 2020 DecisionHealth Medical Practice Staff and Salary Survey, administered in July 2020, reveals that almost two-thirds of medical practice respondents (63%) made a "significant" investment and pivot to telehealth.

For practices operating in the COVID-19 environment, freeing up telehealth and ensuring other PHE-related flexibilities has become a vital lifeline. "Amid COVID surges, practices will likely continue to face declining in-person patient volume, which creates cash flow issues, and increased expenses due to COVID response," Gelburd says. "This creates uncertainty, and could also lead to staffing issues as staff have to call out due to potential exposure." – *Richard Scott (rscott@decisionhealth.com)*



Source: *2020 DecisionHealth Medical Practice Staff Salary and Trends Survey*

(*continued from p. 4*)

Biden will do what he can in regulation and executive action to reverse the alterations Trump did to the law — and since most of those changes were done in regulation and executive action, that should be very doable. Take the short-term limited-duration plans that Trump's HHS allowed to serve as a virtual replacement for ACA-compliant plans by extending the time beneficiaries could use them (*PBN blog 8/8/18*). Biden's HHS can cut that right back to the Obama-era *status quo*.

Other possibilities for Biden that Rosemarie Day, founder and CEO of Day Health Strategies in Somerville, Mass., sees: "Restoring Navigator program funding, discouraging Medicaid work requirements, and potentially adding an Open Enrollment period through Healthcare.gov to help mitigate the COVID crisis." Day also notes that as California's Attorney General, Biden's HHS Secretary-designate, Xavier Becerra, "led the state opposition to the Republican's court-based attempts to overturn the ACA" in *California v. Texas*; his appointment, she thinks, "sends a strong signal about the importance of the ACA."

"It isn't big structural policy," Halpern says. "It's restoring previous policies on how we promote the exchanges and opportunities to provide health care."

Prediction: Expect more attention to fraud in Medicare Advantage and risk adjustment. *Part B News* has covered some prosecutions based on allegations of fraudulent risk adjustment (*PBN 12/3/20*). Sanket Shah, clinical assistant professor in the online master's degree in health informatics program at the University of Illinois-Chicago, says the attention is not likely to let up.

"Auditors have been paying closer attention to Medicare Advantage overbilling and fraudulent risk score submissions over the past couple of years," Shah says. "We're seeing more stories coming out revolving around whistleblower-generated investigations that provide a glimpse into how some organizations try and game the system."

CMS reported $16.27 billion in improper Medicare Advantage payments in 2020, and the recent suits — not to mention the continuing growth of Medicare Advantage as a piece of the Medicare payment pie — suggest increased auditor attention on the program.

"I see a lot of attention being driven by various actors and entities," Sanket says, including the Department of Justice and OIG. But he sees CMS auditors doing a lot of their own investigating "with the aid of machine learning and advanced analytics."

Prediction: Ransomware threat, and losses, will continue to grow. This pernicious cyberthreat has gotten worse every year since it emerged and there's no sign that anything can stop it except universal vigilance — and that's not close to happening. "Until health care can demonstrate that it can stop attacks and more comprehensively protect its data, the industry will remain under attack," Fisher says. "The reality in that regard should drive better investment in technology and resources to strengthen defenses. Along with the resource and monetary investment, it is also necessary to make to invest in education and awareness." — *Roy Edroso and Richard Scott (redroso@decisionhealth.com)* ■

2020 predictions

PBN's 2020 predictions: Missed on health reform, hit on E/M changes and most else

Part B News staff hold ourselves accountable for our predictions every year by sharing with our readers how we fared with last year's predictions. Here are 2020's results.

Prediction: Except for small changes around the edges, federal health care reform will stall in 2020.

Not true. Since a repeal of the ACA failed in 2017, President Trump has mostly stayed away from Congress and tried to influence federal health policy via rulemaking and executive actions (*PBN 10/2/17*). It looked in January 2020 as if the administration would continue to take random regulatory pot-shots at Obamacare and otherwise devote itself to trimming the federal bureaucracy per its Patients Over Paperwork initiative.

Two things changed that, however: the COVID-19 public health emergency (PHE) and the reworking of the E/M rules in Medicare. The former necessitated big changes in scope of practice, telehealth and other areas (*PBN 12/21/20*). The latter constitutes one of the most impactful changes in Medicare billing, coding and documentation in years — as well as a major blow to procedure payments (*PBN 12/10/20*).

And the PHE fallout will be felt for some time to come.

"We in the United States have always expected that all medicines will be available to everybody," as opposed to other nations that have to ration their care, says Jeremy Levin, M.D., chairman of the industry group Biotechnology Innovation Organization (BIO). "Now we're now going through a change... Given the lack of resources in the short term (in other words, vaccines) and the tremendous disparity

in mortality and mobility based on age and vulnerability, we are forced to triage."

The PHE put the kibosh on other big changes — for example, the planned major overhaul of the Merit-based Incentive Payment System (MIPS), the MIPS Value Pathways (MVP), got pushed back to 2022. But the COVID-19 and E/M changes more that outweigh that.

Prediction: The 2021 E/M office visit documentation revisions will proceed as planned, but CMS will face adamant pushback on the payment side — and the proposed E/M rates will get chopped.

Largely true. Let's consider this a piece at a time. Except for the creation of a HCPCS prolonged services code (**G2212**) to replace the CPT version (**99417**), you won't find any deviations from the expected 2021 E/M office visit documentation guidelines that medical practices were talking about heading into 2020. Starting Jan. 1, 2021, your code level selection for E/M codes **99202-99215** will be based on either medical decision-making (MDM) or time — exactly as drawn up.

On the payment side of the equation, CMS did indeed draw loud opposition to the proposed fee projections that a cumulative 30% increase to the most-reported E/M office visit codes would create as a consequence of budget neutrality. Many groups, from the AMA and MGMA to the American College of Surgeons and the American Association of Orthopaedic Surgeons, took issue with the rate cuts that were projected to impact specialty groups that didn't factor into the E/M bonus mix (*PBN 7/14/20*).

Where the prediction veers off track is in how CMS responded to the adamant pushback it received. Instead of chopping the E/M rates to lessen the fee losses elsewhere, CMS opted to take a scalpel to the entire Part B fee schedule by slashing the conversion factor by more than 10%. Ultimately, the letter of the prediction is true — "the proposed E/M pay rates will get chopped" — but we didn't envision the remainder of services to take the significant hit that they are projected to in 2021.

Prediction: The increase in malware, ransomware and phishing attacks against health care facilities will continue substantially in 2020.

True. As *Part B News* reported on Nov. 19, "Ransomware, a bane of health care providers for years, has gotten even worse" (*PBN 11/23/20*). It's gotten so bad that the FBI has started issuing advisories on "credible information of an increased and imminent cybercrime threat to U.S. hospitals and health care providers."

And as hackers get more sophisticated — sometimes burrowing into systems for months before being detected — the damage from a single exploit can be tremendous. Just last month, *Health IT Security* reported that a third-party vendor called Dental Care Alliance was "notifying hundreds of its clients that a near-monthlong system hack potentially breached the protected health information and payment card numbers of 1 million patients." And security experts have yet to develop a magic bullet.

Prediction: Medicare for All will not be the Democratic rallying cry.

True. Joe Biden may have a Vice-President-elect who championed Medicare for All and a nominee for HHS Secretary who championed Medicare for All, but the incoming president has never championed it. In fact, in March, running against the candidate most closely associated with Medicare for All, Vermont Senator Bernie Sanders, Biden suggested that if he were president and Congress passed a Medicare for All bill and sent it to his desk, he would probably veto it.

"How did they find $35 trillion?" Biden said at the time. "What is that doing? Is it going to significantly raise taxes on the middle class, which it will?"

Biden won the nomination with 52% of the vote to Sanders' 26%. Maybe Biden will change his mind in the future. But in 2020, this was not the Democratic message.

Prediction: Obamacare's biggest judicial challenge will fail in the Supreme Court.

Not yet. That challenge was *Texas v. U.S.*, which after some lower-court victories has mutated into California v. Texas, on which SCOTUS heard arguments in November (*PBN 10/22/20*). (*See our prediction in this issue.*)

Prediction: Medicare Advantage will continue to grow — and so will enforcement threats based on faulty risk adjustment coding.

True and true. In the 2020 predictions issue, *Part B News* said that Medicare Advantage penetration would not only continue to grow but that the growth that's taken place over the past 15 years would accelerate. And accelerate it did, capturing 24.1 million members in 2020, a 9.5% increase over 2019, according to data from Kaiser Family Foundation. The 9.5% year-to-year increase is a nearly two-point jump over the 7.8% growth in MA membership between 2018 and 2019. That's a 22% increase in growth rate.

As MA expands, so do the compliance threats. As *Part B News* reported in December, the Kaiser Foundation Health Plan settled with the Department of Justice to "resolve allegations that it submitted invalid diagnoses to Medicare for Medicare Advantage beneficiaries and received inflated payments from Medicare as a result" (*PBN 12/7/20*). Other suits targeting large health systems, involving billions of dollars in risk-adjustment payments, also came to light in 2020.

Prediction: Non-physician practitioner (NPP) utilization will rise in 2020.

True, as far as we can tell. We called this a "safe bet" in the 2020 predictions issue, and it usually is — the growth of NPPs in recent years has been unstoppable. The only reason for caution in answering with a resounding "true" is that the 2020 claims data is not yet available. However, the trends in 2019 show that nurse practitioner (NP) and physician assistant (PA) billing remains on a clear upward trajectory.

Consider claims associated with E/M code 99214, the most frequently reported E/M service. In 2019, NPs reported 11.2 million claims for the code. That's up 15% from the year before and a 100% increase in claims over the five-year period from 2015 to 2019. The growth among PAs has been strong, too. In 2019, PAs reported 5.5 million 99214 claims, up 15% year to year and 83% since 2015. We expect that the booming growth, shown in the chart below, continued in 2020.

NPs' 99214 claims, 2015-2019

Services	Payment	Year
5,613,870	$317,326,893.92	2015
6,908,243	$386,431,643.37	2016
8,331,290	$463,218,297.53	2017
9,704,490	$542,086,440.31	2018
11,235,190	$642,642,518.70	2019

Prediction: Tech solutions will be used to ease the pain of prior authorization.

Not yet. But CMS published a proposed rule that would do just that in 2021. (*See next week's issue of* Part B News *for coverage on a new prior authorization proposed rule.*)

Prediction: Telehealth initiatives and participation will continue to soar in 2020.

True. Here's another one you can attribute to the COVID-19 PHE. We'll never know how providers would have engaged with telehealth without the pandemic. But we do know that telehealth flexibilities led to a rise in telehealth encounters, reported by the Commonwealth Fund, from 1% of physician encounters at the start of the pandemic to 6% in October, and the majority of medical practices are expanding (*see benchmark, p. 5*). — *Roy Edroso and Richard Scott (redroso@decisionhealth.com)* ■