wednesday webinar

PRESENTED BY PALMETTO CARE CONNECTIONS

CMS Final Physician Fee Schedule CY 2022 Review

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This webinar is being recorded.

The webinar recording and presentation will be available after the webinar.

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MPFS Main Points

- Conversion Factor Reduction (and resulting payment cuts)
- Expanded list of telehealth services
- New coverage for tele-behavioral health services
- Evaluation and Management Visits changes
- Payment for Physician Assistant services
- Continued implementation of appropriate use criteria
- Changes to Medicare Diabetes Prevention Program
- New coverage for remote therapeutic monitoring (RTM) services
- Increased reimbursement for care management services
- Launch of MIPS Value Pathways and other Quality Payment Updates

With a focus on our favorites – telehealth and virtual care!

- 2022 Conversion Factor – what to watch out for
- Tele-behavioral Health Updates
- Split Shared Visits
- Teaching Physicians: Primary Care Exception
- Physician Assistants
- Remote Therapeutic Monitoring

Disclaimer

- The opinions expressed in this presentation and on the following slides are solely those of the presenter and not necessarily those of my employer nor the organization sponsoring this webinar. Any mistakes are my own.
- My dogs have their own opinions particularly about FedEx, UPS and the USPS delivery personnel and may contribute to the content of today's webinar.

Conversion Factor for 2022 and Sequestration (Reduction in Federal Pmt)

2022: $34.6062 per RVU

The suspension aligned with the current CARES Act legislation (H.R. 1868-117th Congress (2021-2022)) requiring all health plans to suspend the 2% sequestration reduction in payments from May 1, 2020 to March 31, 2022.

All claims that are based on Medicare payment (Medicare and Medicaid) with dates of service May 1, 2020 through March 31, 2022 will not apply the 2% reduction.

Effective April 1, 2022 through June 30, 2022, a 1% sequestration reduction will apply.

Effective July 1, 2022, the 2% reduction will automatically be applied and in line with the current CARES Act legislation

Tele-Behavioral Health – Permanent Changes!

- Eliminated geographic barriers and allows patients in their homes to access telehealth services for diagnosis, evaluation, and treatment of mental health disorders.
- Audio-only telephone calls. This means counseling and therapy services, including treatment of substance use disorders and services provided through Opioid Treatment Programs, will be more readily available to individuals, especially in areas with poor broadband infrastructure.
- Mental health visits furnished by Rural Health Clinics and Federally Qualified Health Centers via telecommunications technology, including audio-only telephone calls, expanding access for rural and other vulnerable populations.

Split/Shared Services

- CMS defined split/ visits as an E/M visit in the facility setting that is performed in part by both a physician and a NPP who are in the same group, in accordance with applicable law and regulations such that the service could be billed by either the physician or NPP if furnished independently by only one of them. Payment will be made to the practitioner who performs the substantive portion of the visit.
- Facility setting means an institutional setting in which payment for services and supplies furnished incident to a physician or practitioner's professional services is prohibited under CMS regulations.

Split/Shared: Adoption of AMA's Prefatory Language – MPFS 2022

- Critical care services were defined in the withdrawn [in May 2021] provisions of the Medicare Claims Processing Manual (IOM). The IOM definition tracked closely with the CPT Codebook prefatory language regarding critical care services. To improve transparency and clarity, we proposed to adopt the CPT prefatory language as the definition of critical care visits. The CPT prefatory language states that critical care is the direct delivery by a physician(s) or other qualified healthcare professional (QHP) of medical care for a critically ill/injured patient in which there is acute impairment of one or more vital organ systems, such that there is a probability of imminent or life-threatening deterioration of the patient's condition. It involves high complexity decision-making to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition.

Cont.

- Thus, we proposed that critical care visits may be furnished as concurrent care … to the same patient on the same date by more than one practitioner, in more than one specialty (for example, an internist and a surgeon, allergist and a cardiologist, neurosurgeon and NPP), regardless of group affiliation, if the service meets the definition of critical care and is not duplicative of other services. Additionally, as for most Medicare-covered services, these critical care visits would need to be medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Split/Shared Facts

- New modifier : FS - Split (or shared) evaluation and management service
- Allowed:
  - Facility settings including inpatient, outpatient including OBS, ED (POS 21, 19, 22, 23)
  - Nursing facility for visits not mandated to be done by a physician
- Not allowed:
  - in office setting (POS 11)
- Allowed: for critical care
- Clinicians sharing the E&M service must be in the same group practice, same specialty.
- Providers can report split/shared visits for new as well as established patients, and initial and subsequent visits as well as prolonged services.

Split/Shared: Substantive Portion

- CMS believes E/M services performed split shared should be reported by the clinician who does a “substantive portion” of the visit.
- In 2022, the substantive portion may be based upon more than half of the total time or one of the three key components(history, exam or MDM).
- In 2023, substantive portion will be based upon time. The substantive portion of the visit will be defined as more than half of the total time spent by the physician and NPP.

Telehealth CC consults

- Key word: consult
  - A request for opinion or advice, and a stated reason to substantiate the need for the service.
  - A report from the consulting provider back to the requesting provider. The consultant shall prepare a written report of his/her findings and recommendations, which shall be provided to the referring physician. The service is justified only if the consulting physician gives his opinion and/or advice to the requesting provider. Without a report back to the requesting provider, a consultation hasn't occurred.
- Additional Documentation
  - A statement that the service was provided using telemedicine;
  - The location of the patient;
  - The location of the provider; and
  - The names of all persons participating in the telemedicine service and their role in the encounter.
- https://providers.bluekc.com/Content/PDFs/paymentpolicies/Telehealth.pdf

Teaching Physician Rules

- If using time to select an E/M code, use only the time the attending is present; don’t use resident time.
- Primary care exception:
  - During the PHE, clinicians billing under the primary care exception can report level 4 and 5 services, but when the PHE ends, clinicians will no longer be able to report level 4 and 5 E/M services.
  - Under the primary care exception, time cannot be used to select the visit level. Only MDM can be used to select visit level. This will help ensure appropriate coding to reflect the total medically necessary time required to furnish E&M services.

Physician Assistant Services

- CMS is implementing section 403 of the Consolidated Appropriations Act, which authorizes Medicare to make direct payment to PAs for professional services that they furnish under Part B beginning January 1, 2022.
- PAs may bill Medicare directly for their professional services, reassign payment for their professional services, and incorporate with other PAs and bill Medicare for PA services.

Remote Therapeutic Monitoring: AMA Prefatory Language

- Remote therapeutic monitoring services (e.g., musculoskeletal system status, respiratory system status, therapy adherence, therapy response) represent the review and monitoring of data related to signs, symptoms, and functions of a therapeutic response. These data may represent objective device-generated integrated data or subjective inputs reported by a patient. These data are reflective of therapeutic responses that provide a functionally integrative representation of patient status.
- Codes 98975, 98976, 98977 are used to report remote therapeutic monitoring services during a 30-day period. To report 98975, 98976, 98977, the service(s) must be ordered by a physician or other qualified health care professional.
- Code 98975 may be used to report the setup and patient education on the use of any device(s) utilized for therapeutic data collection. Codes 98976, 98977 may be used to report supply of the device for scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmissions. To report 98975, 98976, 98977, the device used must be a medical device as defined by the FDA.
- Codes 98975, 98976, 98977 are not reported if monitoring is less than 16 days. Do not report 98975, 98976, 98977 with other physiologic monitoring services (e.g., 95250 for continuous glucose monitoring requiring a minimum of 72 hours of monitoring or 99453, 99454 for remote monitoring of physiologic parameter[s]).
- Code 98975 is reported for each episode of care. For reporting remote therapeutic monitoring parameters, an episode of care is defined as beginning when the remote therapeutic monitoring service is initiated and ends with attainment of targeted treatment goals.

Direct Supervision

“Thus, we are finalizing a policy that permits therapists and other qualified healthcare professionals to bill the RTM codes as described. However, where the practitioner’s Medicare benefit does not include services furnished incident to their professional services, the items and services described by these codes must be furnished directly by the billing practitioner or, in the case of a PT or OT, by a therapy assistant under the PT’s or OT’s supervision.”

Interpretation

- If performing provider doesn’t have an NPI, they need to meet the supervision guidelines to submit.
- For the set up and education codes, direct supervision is required if not performed by the person who is billing.

The Codes

98975	Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment
98976	device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days
98977	device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days
98980	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes
98981	each additional 20 minutes (List separately in addition to code for primary procedure)

Practice Expense Codes

CPT #	Description	Who	RVUs (Non-facility) 2022	Payment 2022
98975	Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment	Clinical staff	0.56	$19.38

Practice Expense Codes (cont.)

CPT #	Description	Who	RVUs (Non-facility) 2022	Payment 2022
98976	Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days)	Clinical Staff	1.61	$55.72
98977	Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days)	Clinical Staff	1.61	$55.72

Treatment Management Codes

CPT #	Description	Who	RVUs (Non-facility) 2022	Payment 2022
98980	Remote therapeutic monitoring treatment management services, physician/ other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes	MD, NP and PTs, OTs	1.45	$50.18
98981	each additional 20 minutes (List separately in addition to code for primary procedure)	MD, NP and PTs, OTs	1.18	$40.84

When Appropriate

We also note that the five RTM codes will be designated as “sometimes therapy” codes, which means that the services can be billed outside a therapy plan of care by a physician and certain NPPs, but only when appropriate. While therapists’ services must always be provided under therapy plans of care, RTM services that relate to devices specific to therapy services, such as the ARIA Physical Therapy device (CPT code 98977), should always be furnished under a therapy plan of care.

Billing

Not telehealth according to CMS	No modifiers required unless direct supervision of a PTA or OTA is done by a PT or OT	Place of Service
• Bill the code(s) only	• PTA = CQ modifier • OTA = CO modifier • Result = 15% reduction in reimb	• Where the service was provided (generally, POS 11, 19 or 22)

RPM	RTM as defined by the AMA	RTM as proposed by CMS
Monitored: Vitals type data	Monitored: Non-Vitals type data	Monitored: Non-Vitals type data
Not limited to body system	Limited to respiratory or musculoskeletal	Expand beyond two systems
Time-specified for collection in order to bill (16 days)	Time-specified for collection in order to bill (16 days)	Time-specified for collection in order to bill (16 days)
Device: FDA defined	Device: FDA defined	Device: seeking comments
Data: auto-uploaded	Data: auto-uploaded or self-reported	Data: auto-uploaded or self-reported
Who can order: MDs, NPs (codes are in “E&M Section” of AMA CPT code book)	Who can order: MDs, NPs (codes are in the “Medicine Section” of AMA CPT book	Who can order: MDs, NPs (codes are in the “Medicine Section” of AMA CPT book
Who can perform and bill: combined minutes of MDs, NPs, clinical staff (incident to, gen’l)	Who can perform and bill: combined minutes of MDs, NPs	Who can perform and bill: MDs, NPs, therapists: anyone who can bill Medicare

Wondering about POS 10?

- 02 - Place of Service for reporting Telehealth services rendered by a physician or practitioner from a Distant Site
- 10 - Place of Service for reporting Telehealth services provided in Patient's home
- Note: some payors are requiring providers to report if patient was at home or in another facility per the definitions
- (This code is effective January 1, 2022, and available to Medicare April 1, 2022.)
- Guidance has not yet been shared; keep with the PHE requirements about POS until further notice

Resources

- Federal Register, MPFS 2022: https://public-inspection.federalregister.gov/2021-23972.pdf
- MPFS Files: https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1751-f
- HIPAA Privacy Rule: https://www.hhs.gov/sites/default/files/privacysummary.pdf