Coastal Carolinas Health Alliance
Medicare Update: Day 2

CY2022 OPPS Updates and Developments to Outpatient Services

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Presented By

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Learning Objectives

At the completion of this educational activity, the learner will be able to:

- Identify CMS rate setting changes for 2022 and how they affected pass-throughs
- Explain CMS changes to their planned elimination the inpatient only list
- List three significant COVID related updates

Resources link:

https://revenuecycleadvisor.com/helpful-links

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Agenda

- Payment system updates, including significant APC, C-APC updates
- Reimplementation of the inpatient only (IPO) list (or finalized policy)
  - Related ASC list additions and changes
- Devices
  - Pass through devices and policy to continue expiring devices
  - CG modifier for device to procedure edits, including retroactive changes
- Updates on the Prior Authorization Program
  - Updated Operation Guide Language
  - Exemptions
- Revisions to ABN Instructions
  - ABNs beyond one year
  - Recommendation for cosmetic and other non-covered services

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Agenda

- Selected MPFS Updates
  - Update to split/shared and critical care guidance
  - Revision of guidance on PTA/OTA modifiers CQ/CO, including time counting examples
- Appropriate Use Criteria (AUC) billing clarifications
- RHC Update
  - Per-visit-limit changes
  - Coding and coverage changes
- COVID PHE Update
  - Vaccine and monoclonal antibody billing
    - Home administration
    - Inpatient only monoclonal antibody
  - Billing expanded and relocated departments during COVID PHE
  - Proper use of CS modifier and other COVID related codes
  - Sorting out telehealth and correct billing during PHE
- Laboratory update, including COVID code updates

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Protecting Medicare and American Farmers from Sequester Cuts Act

- Signed into law December 10, 2021
  - Medicare sequestration suspended through March 21, 2022, 1% through June 30, 2022, full 2% starting July 1, 2022
    - Then 2.25% first six months of 2030, 3% later six months of 2030
  - MPFS
    - Mandatory 3% increased to conversion factor
  - PAMA transition for laboratory fee schedule
    - 0% reduction continued for 2022, and 15% phase in reduction extended to CY2023-CY2025 (originally scheduled for CY2021-CY2023)
    - Reporting requirements for lab payment data also postponed until 2023
  - Radiation Oncology Model
    - Delayed implementation until at least January 1, 2023

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CY2022 OPPS Payment Updates

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Information On the CY 2022 OPPS Final Rule and Addenda

- Download the rule and tables at: https://www.cms.gov/medicaremedicare-fee-service-paymenthospitaloutpatientpps/cms-1753-fc

- *Scroll down to download the rule and the Addenda:*
  - *Addendum A – lists APCs, rates, etc.*
  - *Addendum B – lists CPT codes, APCs, rates, etc.*
  - *Addendum C – lists APC by CPT, etc.*
  - *Addendum D – definitions of status indicators*
  - *Addendum E – inpatient-only list*
  - *Addendum J – related to C-APCs*
  - *Other files also available for download*

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CY 2022 Conversion Factor and Outlier Payment Updates

- **2.0%*** overall update comprised of:
  - Inpatient Prospective Payment System (IPPS) market basket percentage increase of 2.7%
  - -0.7% reduction due to the multifactor productivity adjustment
  - This results in an overall update of 2.0%
- CMS will increase the fixed-dollar threshold for outliers to $6,175 (an increase of $875 over CY 2021)

TABLE 84: Estimated Impact of the CY 2022 Changes for the Hospital Outpatient Prospective Payment System

		(1)	(2)	(3)	(4)	(5)
		Number of Hospitals	APC Recalibration (all changes)	New Wage Index and Provider Adjustments	All Budget Neutral Changes (combined cols 2 and 3) with Market Basket Update	All Changes
ALL PROVIDERS *		3,659	0.0	0.1	2.1	1.6
ALL HOSPITALS		3,552	0.0	0.1	2.1	1.6
	(excludes hospitals held harmless and CMHCs)					
URBAN HOSPITALS		2,803	0.0	0.1	2.1	1.6

* This is reported without sequestration being in effect; if it goes back into effect each payment is 2% less

CY2022 Payment Updates

- CMS finalized their proposal to use CY2019 claims data (from prior to the PHE) for rate setting purposes for CY2022 to more closely approximate the expected CY2022 outpatient hospital utilization
  - Ordinarily CMS would have used claims data from FY2020 for rate setting purposes in CY2022
  - The CY2020 data reflects changes in hospital utilization driven by the PHE, prompting CMS to use CY2019 data instead
  - This affected calculation of the relative weights and length of time pass through drugs, biologicals, and devices receive additional payment
    - CMS will pay up to 4 additional quarters of separate payment for 27 drugs/biologics and 1 device that otherwise would have expired in 2022
    - Similar to extension of New Technology Add-On Payment (NTAP) products for IPPS that were set to expire in 2022

Final HCPCS/CPT Code Status Indicator and/or APC Assignment Changes for 2022

Comparison of Final SI/APC Assignments Compared to October 2021 Addendum B																				
Row Labels	A	B	C	D	E1	E2	G	J1	K	L	M	N	Q1	Q2	Q4	S	T	V	H	Grand Total
New Codes w/no Prior Assignment in 2021	28	3	9	33	40	1	8	20	2		##	24	8	1	25	13	4	1	2	325
A				2																2
C				16																16
G				3					5			1								9
J1			257	16				7												280
K				1								12								13
M				40	23															63
N			32	10		10		1	2											55
Q1			2	6	1								2							11
Q2				2																2
S				6												5				11
T			2	3	1															6
E1			1	7						3	6					5				22
Grand Total	28	3	303	145	65	11	8	28	9	3	##	37	10	1	25	23	4	1	2	815

No new C-APCs for CY 2022

OPPS Topics With No Policy Changes

- Evaluation and Management
- Methodology for paying for drugs and biologicals
- Drug administration payment policy
- C-APCs, no new APCs
- Partial hospitalization payment policy
- Therapeutic radiopharmaceuticals (status indicator K)
  - APC rates based on manufacturer data or CMS' usual rate-setting method
  - CY 2022 payment final to continue to be ASP + 6%
- Brachytherapy sources (status indicator U)
  - Payment rates based on usual rate-setting (charges reduced to costs)
  - Some payment rate fluctuations exist
- Blood and blood products (status indicator R)
  - CMS continues to apply its special cost-to-charge calculation methodology, and continues to package blood and blood products when they are part of a C-APC claim

Off-campus Clinic Visit Payments

- CY2019: CMS applied a 60% reduction to OPPS payment for G0463-PO (grandfathered off-campus provider-based departments)
  - Court cases where originally decided in provider's favor, but court eventually sided with CMS and appeals have been exhausted through the Supreme Court Level
    - CMS originally processed 2019 claims with the payment reduction, then refunded the reduction based on initial court decision and has now reclaimed the reduction based on latest court action
    - CMS applied the reduction to 2020 and 2021 claims and will continue to do so

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Drugs and Biologicals Update Including 340B

- For CY 2022 CMS finalized extending 2021 policies with no changes
  - For example, the drug packaging threshold remains at $130
  - Average Sales Price (ASP) +6% remains as the basis for separately payable drugs for non-340B purchasing providers (and for all passthrough status drugs regardless of 340B status of the provider)
  - ASP -22.5% remains as the payment basis for non pass-through separately payable drugs that are acquired through the 340B drug program
  - Rural sole community hospitals (SCHs), children's hospitals, and PPS-exempt cancer hospitals continue to be exempt from the 340B payment reductions
    - CMS says it plans to review this exemption for rural hospitals in the future
  - New drugs & biologicals without ASP data are paid at Wholesale Acquisition Cost (WAC) plus 3%

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340B Payment Legal Saga

- In 2019, the court sided with hospitals in the lawsuit indicating that the Secretary had exceeded his authority and required CMS to cease and remedy harm to hospitals; CMS appealed the case but continued with the 340B payment reduction in CY 2020
- On July 31, 2020, a higher court ruled that CMS' 340B payment reduction is legal, striking down the lower court's decision
- AHA appealed, and on July 2nd, 2021, the US Supreme Court agreed to review the circuit court's decision; oral arguments were heard November 30th
- Recall in the CY 2021 rule, as a result of a survey sent to hospitals, CMS considered an even larger reduction in 340B payments (-28.7%) but in the end finalized staying with -22.5%
  - What this means is that CMS could increase the payment reduction in 2023 or beyond and could consider whether the 340B payment reduction should apply to rural hospitals in future.

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Reimplementation of the Inpatient Only list

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Inpatient Only List Reversal

The Inpatient Only (IPO) List has been used for ***two purposes***

- ***Payment prohibition***, payment not allowed for procedures designated inpatient only if provided to outpatients
  - With elimination of the IPO list, all procedures will be payable under Part B (OPPS) if no inpatient order is written
    - I.e., there will no longer be denials for inpatient only procedures provided on an outpatient basis
- Option for appropriate ***inpatient admission*** and Part A payment
  - With elimination of the IPO list, all procedure must meet the 2-midnight benchmark or case-by-case option
    - I.e., there will no longer be a "safe harbor" for cases on the IPO list, although if removed in 2021 or later special audit instructions prevent denials

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Inpatient Only List Reversal

- In the CY2021 OPPS Final Rule CMS finalized the elimination of the IPO list over the course of 3 years
  - 298 procedures were removed from the list for 2021
    - Proposed **266 musculoskeletal** procedures
    - Finalized additional **16 related anesthesia codes** and **16 additional procedures** recommended by the Hospital Outpatient Payment panel
  - Remaining procedures will be removed in 2022 and 2023 – the list will be fully eliminated by 2024

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Inpatient Only List Reversal

- In CY2021, CMS also made accompanying changes to the ASC List
  - CMS finalized adding 11 procedures to the ASC covered procedure list (CPL) using its normal process, including hip arthroplasty (Table 59 of the OPPS)
    - Required the procedures not be on the IPO List
  - CMS finalized two additional approaches to add to the CPL:
    - Removed general criteria for exclusion and instead excluded procedures on the IPO list as of December 31, 2020
      - General criteria were move to section title Physician Considerations beginning January 1, 2021
    - Process for stakeholders to request/notify CMS to add procedures meeting requirements to the CPL
- Resulted in additional 258 procedures added to the ASC CPL, as displayed in Table 60 of the final rule

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Inpatient Only List Reversal

- In CY2022, CMS reversed the policy they finalized for CY 2021 due to feedback from commenters requesting the list be reinstated for the following reasons:
  - Patient safety
  - Program integrity at risk
  - Increased burden during the PHE
  - Additional time needed to adjust to the changes
  - Unintended impact on MA and commercial payers that impose OP when procedure is not on IPO despite clinician order or patient care concerns

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Inpatient Only List Reversal

In the CY2022 OPPS Final Rule, CMS reversed their policy change from CY2021

- No longer eliminating the IPO list over the next 2 years
- Reinstated 295 of the 298 procedures removed from the list in 2021
  - Procedures that continue to be outpatient (i.e., not reinstated on the IPO list)
    - Lumbar spine fusion (CPT code 22630)
    - Reconstruct shoulder joint (23472)
    - Reconstruct ankle joint (27702)

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Inpatient Only List Reversal

In the CY2022 OPPS Final Rule, CMS reversed their policy change from CY2021

- Codified criteria used on a sub-regulatory basis prior to CY2021 to remove procedures from the inpatient only list:
  1. Most outpatient departments are equipped to provide the services to the Medicare population
  2. The ***simplest procedure described by the code*** may be furnished in most outpatient departments
  3. The procedure is related to codes that we have already removed from the IPO list
  4. A determination is made that the procedure is being furnished in numerous hospitals on an outpatient basis
  5. A determination is made that the procedure can be appropriately and safely furnished in an ASC and is on the list of approved ASC services or has been final by us for addition to the ASC list

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Inpatient Only List Reimplementation

In the CY2022 OPPS Final Rule, CMS reversed their policy change from CY2021

- Replaced regulatory provisions in place prior to 2021 containing long standing safety criteria historically used to add procedure to the ASC Covered Procedure List (CPL)
- Removed 255 procedures from the ASC CPL
  - Procedure added to the CPL in 2021 and remaining on the list:
    - 0499T – Cystourethroscopy w/ drug delivery for urethral stricture or stenosis
    - 54650 – Orchiopexy, abdominal approach for intra-abdominal testis
    - 60512 – Parathyroid autotransplantation, separate procedure

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IPO List Further Thoughts

Approach for procedures removed from the IPO List

> …It is a ***misinterpretation*** of CMS payment policy for providers to create policies or guidelines that establish the ***outpatient setting as the baseline or default site of service*** for a procedure based on…the elimination of the IPO list. (CY2021 OPPS Final Rule, 85 Fed. Reg. 86087)
>
> … we would expect that Medicare beneficiaries who are identified as appropriate candidates to receive a surgical procedure in the ***outpatient setting*** instead of being admitted as an inpatient, ***would not be expected to require SNF care*** following surgery. Instead, we expect that many of these beneficiaries would be ***appropriate for discharge to home*** (with outpatient therapy) or ***home health care.*** (CY2021 OPPS Final Rule, 85 Fed. Reg. 86089)

Important – do not apply an outpatient presumption, admit patients with expectation of two midnight stay

- To prevent impact on three-night stay SNF requirement
- For application of 2-Midnight Presumption

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Pass-through Devices

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Pass-through Devices

- Pass through devices are paid separately from procedure payments, rather than packaged like other devices, because CMS does not have cost data due to their newness
  - Because CMS used claims data from 2019, rather than 2020, for rate setting in CY2022 they did not have 2 years of complete data on pass through devices set to expire 12/31/21
    - C1823 (generator, neurostimulator (implantable), non-rechargeable, with transvenous sensing and stimulation leads), set to expire 12/31/21
      - Separate payment extended for one year through 12/31/22 under CMS's equitable authority – not pass-through provisions which would not allow an additional year
  - Large number of devices are currently approved for pass-through status

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Device Pass-Through Payments Update

HCPCS Code	Short Descriptor	SI	New	2022 APC
C1052	Hemostatic agent, gi, topic	H		2031
C1062	Intravertebral fx aug impl	H		2032
C1734	Orth/devic/drug bn/bn,tis/bn	H		2026
C1748	Endoscope, single, ugi	H		2029
C1761	Cath, trans intra litho/coro	H	Y	2033
C1823	Gen, neuro, trans sen/stim	H		2993
C1824	Generator, ccm, implant	H		2024
C1825	Gen, neuro, carot sinus baro	H		2030
C1831	Personalized interbody cage	H	Y	2034
C1832	Auto cell process sys	H	Y	2035
C1833	Cardiac monitor sys	H	Y	2036
C1839	Iris prosthesis	H		2028
C1982	Cath, pressure,valve-occlu	H		2025
C2596	Probe, robotic, water-jet	H		2027

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Pass-through Devices

- Pass-through devices must be reported with specific identified procedure codes to ensure correct off-set application (IOCE edit 98)
  - Each procedure code has an association offset amount used to calculate payment for the pass-through device
  - Device to procedure pairings and offsets are available:
    - As they are approved in the OPPS quarterly update transmittals; OR
    - As a full list in the IOCE Quarterly Data File – see the Report Tables folder, “OFFSET_CODEPAIR” file

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Pass-through Devices

- Example of pass-through payment
  - An offset is made from the pass-through device to account for the amount already included in the procedure payment for packaged devices

Percutaneous vertebral augmentation of 1 thoracic vertebral body (22513) using intravertebral body fracture augmentation with polymer implant (C1062)			
Item HCPCS	Total Charge	Procedure Payment Amount	Payment for Implantable Device CCR .45
22513	$14,000	$6,397	N/A
C1062	$5700	N/A	$2,565
Offset applicable for 22513			-$1,336
Pass-through payment			$1,229
Procedure Payment			+$6,397
Total Payment			$7,626

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Device Intensive Procedures

- Device intensive procedures must be reported with ***a device code***
  - Unlike pass-through devices no match is required
  - If a device is implanted that has no code, generic code C1889 (Implantable/insertable device for device intensive procedure, not otherwise classified) can be used to satisfy this edit
- Exceptions:
  - Terminated and discontinued procedures reported with modifiers -52, -73, -74
  - Specified procedures reported with modifier –CG if no device was used (e.g., a revision)
    - Implemented 1/1/2019
    - The list of specified procedures is available in the IOCE Quarterly Data files, Report Table Folder, “DATA_HCPCS” column DC labeled “BYPASS_E92_MODIFIER”

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Device Intensive Procedures

- Retroactive changes to the –CG Modifier procedure list
  - April 2021 added CPT Code 28300 (Incision of heel bone) retroactive to 1/1/2019
    - Note in January 2021 CPT code 28300 was added effective 1/1/21
  - July 2021 added CPT codes
    - 19281 (Perq device breast 1st imag) – retroactive to 1/1/21
    - 19283 (Perq dev breast 1st strtctc) – retroactive to 1/1/21
    - 19285 (Perq dev breast 1st us imag) – retroactive to 1/1/21
    - 21461 (Treat lower jaw fracture) – retroactive to 1/1/19
  - October 2021 added CPT codes
    - 22612 (lumbar spine fusion) – retroactive to 1/1/20
    - 27696 (Repair of ankle ligaments) – retroactive to 1/1/21
    - 27700 (Revision of ankle joint) – retroactive to 1/1/21
    - 27705 (Incision of tibia) – retroactive to 1/1/20
    - 28302 (Incisions of ankle bone) – retroactive to 1/1/20

Prior Authorization Updates

Prior Authorization

- No new procedures added for CY2022
- CMS made significant updates to the Operations Guide and other guidance in May and December 2021
  - ABNs related to prior authorization services
  - Removal of codes and guidance on trials for implantable spinal neurostimulators
  - Exemption timeline
  - To add a list of associated code, presumably for denial when the prior authorization service is denied
  - Removal of a code from the blepharoplasty list (67911 – correction of lid retraction)
- See Operational Guide on CMS website: https://www.cms.gov/files/document/opd-operational-guide.pdf

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Prior Authorization

Effective July 1, 2020, a prior authorization is a condition of payment for certain outpatient procedures

- Applies only to services provided in hospital outpatient departments, and related professional services (although CMS has not issued denials for physician services)
  - Does not apply to CAHs
  - Does not include procedures performed at ASCs or freestanding physician offices
  - Does not apply to MA plans – they are responsible for their own utilization plan for these procedures (i.e., prior authorization or other process)
- Although the process is called prior authorization – the hospital is actually granted a preliminary affirmation

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Prior Authorization

Procedures requiring prior authorization as of July 1, 2020:

- Blepharoplasty
- Rhinoplasty
- Panniculectomy
- Vein Ablation
- Botulinum toxin injections
  - Limited to two codes related to injections in the face and neck only

Procedures requiring prior authorization as of July 1, 2021:

- Cervical fusion with disc removal
- Implantable Spinal Neurostimulators
  - Codes 63685 and 63688 were originally included and then excluded from the requirement
  - The same PAR may be used for both the trial and permanent implantation

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Prior Authorization

Prior Authorization Process

- Responsibility for obtaining prior authorization
  - Hospitals ultimately responsible, although performing physician may also obtain authorization
- A Prior Authorization Request (PAR) is submitted to MAC
  - MACs all have portal for submission of requests
  - MAC must respond in 10 days, or 2 days if beneficiary's life, health, or ability to regain function is jeopardized
  - Include all necessary documentation – see Operational Guide and applicable NCDs and LCDs for documentation requirements

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Prior Authorization

Prior Authorization Process

- If provider receives provisional affirmation
  - MAC issues a Unique Tracking Number (UTN) and a decision letter to provider and beneficiary
  - Good for 120 days
  - Claims may still be denied based on technical requirements or information not available at the time of the PAR
- If provider receives provisional non-affirmation
  - MAC provides detailed information about missing or non-compliant information
  - Provider may resubmit PAR with additional information an unlimited number of times
  - A non-affirmation may not be appealed

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Prior Authorization

Prior Authorization Process

- Claims submitted without UTN (or UTN for non-affirmation) for HCPCS codes on the list ***are automatically denied***
  - Any claims associated with the service will (should) also be denied
  - CMS currently has no system edits that will cause this denial automatically
- Denials submitted without UTN are appealable denials
  - *CMS has instructed contractors to only determine if a prior authorization was obtained, and if not deny the claim,* ***even if the services would otherwise be covered and payable***
- Denial can also be used to bill secondary insurance

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Prior Authorization Exemption

Exemption from the prior authorization process

- In December, CMS announced the exemption process would transition from a six-month review to an annual process corresponding with the calendar year
  - Provider must have 10 claims submitted by June 30th to be considered for exemption
- Providers must maintain a 90% affirmation rate
  - The affirmation rate is calculated across all seven categories of services combined
- Notice of exemption or withdrawal of exemption will be provided at least 60 days prior to the effective date
  - Starting in 2022, this will be approximately November 1 of each year, with exemption starting January 1 of each year
  - If a provider with an exemption submits a PAR during the exemption period it will be rejected
- CMS offers providers the opportunity to opt out and continue to submit PARs

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Prior Authorization

ABNs related to services on the Prior Authorization list

- An ABN must be issued for services believed to be not medically necessary for which a non-affirmation was received to transfer liability to the patient
  - Billed with modifier –GA
- ABNs “should” be issued, but is technically voluntary, for services expected to be denied under the statutory exclusion for purely cosmetic services
  - “CMS encourages” providers to issue ABNs in these circumstances
  - Billed with modifier -GX
- CMS directed contractors to stop claims submitted with ABN modifiers for an additional documentation request to review the ABN for validity

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ABN Manual Update

- CMS issued updated ABN instructions in Claims Processing Manual Transmittal 10862, published July 14, 2021, effective October 14, 2021
  - Significant reorganization, in addition to some new content
- CMS added a comment “strongly encouraging” providers to issue ABNs for services that are statutorily excluded or that fail to meet technical benefit requirements
  - Acknowledges the ABN is voluntary and a courtesy to the beneficiary
  - First “encouraged” providers in May update of the prior authorization Operations Guide
- Length is still specified as one page, however, the official large print version is 5 pages long – presumably this is still accceptable

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ABN Manual Update

- New section: Period of Effectiveness for Repetitive or Continuous Non-covered Care
  - Clarified that an ABN remains effective as long as there has been no change in:
    - Care from what is described on the ABN
    - The beneficiary’s health status which would require a change in treatment
    - Medicare coverage guidelines for the item or service on the ABN
  - Clarified issuance of ABN for repetitive or continuous services beyond a year is voluntary as long as there are none of the changes above

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Medicare Physician Fee Schedule Update

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Information on the CY 2022 MPFS Final Rule and Addenda

- Download the rule and tables at: https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1751-f
- *Scroll down to downloads for the final rule and the Addenda*

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MPFS Conversion Factor Update

- CY2021 – CMS adopted a conversion factor of $32.41 (a decrease of $3.68 from CY2020)
- Congress required a 3.75% increase for CY2021 – resulting in a conversion factor of $34.89
- CY2022 – CMS adopted a conversion factor of $33.60 (3.85% less than CY2021 – subtracting the 3.75% congressional addition for 2021 and .10% budget neutrality factor
- Congress required a 3% increase for CY2022 – resulting in a conversion factor of 34.6062

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Split/Shared Services and Critical Care Guidance

- January 2021 – HHS Good Guidance request related to Claims Processing Manual, Chapter 12 (related to physician services):
  - Section 30.6.1 on level selection for split/shared services
  - Section 30.6.12 on critical care services
  - Section 30.6.13 on nursing facility split/shared
- May 26, 2021 – CMS withdrew these manual sections pending notice-and-comment rulemaking to address conflicts with AMA changes to guidance on E/M visit codes
  - Manuals had conflicting definitions of “substantive portion” used to determine which clinician billed
  - CMS published a press release with guidance until the 2022 MPFS Rule could be published referring to general SSA and regulatory guidance on incident to coverage and indicating they generally adopted the AMA prefatory language and interpretive framework for E/M codes

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Split/Shared Services

CY2022 MPFS guidance on split/shared services

- New regulation at 42 *CFR* 415.140
- Split/shard services defined as E/M visits provided in the facility setting by a physician and an NPP in the same group
  - "incident to" billing does not apply in facility settings so split/shared has been used to bill services provided by both MD/DO and NPP under the MD/DO number for full payment
  - Facility defined as settings where "incident to" billing is prohibited
- New required modifier –FS (Split (or shared) evaluation and management visit)

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Split/Shared Services

CY2022 MPFS guidance on split/shared services

- Billing clinician is based on the clinician that furnishes the "substantive" portion
  - If the billing clinician is an NPP, the 15% payment reduction to the MPFS payment applies
  - Likely to result in some reimbursement loss for providers billing split/shared under the physician
- Phased in definition of the "substantive portion" for reporting purposes
  - For 2022, except critical care, substantive portion is based on the key component (history/exam/decision making) used to select the E/M level OR time
    - The billing clinician must have performed the key component in its entirety
  - For 2023, the substantive portion will be defined by time and the billing clinician is the clinician providing 50% or more of the visit time
  - Split/shared may be reported for critical care services based on time only

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Split/Shared Services

CY2022 MPFS guidance on split/shared services

- Documentation
  - Must identify the two individuals who performed the visit
  - The individual providing the substantive portion (and billing) must sign and date the record
- Clarified split/shared may be reported for new and established patients and initial and subsequent visits
- Changed policy to allow split/shared to be reported for prolonged services
  - NPP and MD/DO would sum their time for both the E/M and prolonged services – whoever provided more time would report both the E/M and prolonged services code

Critical Care Services

CY2022 MPFS guidance critical care services

- CMS adopted the AMA CPT definition of critical care, including the bundling of services
- Clarified critical care services can be billed on the same day as another E/M visit by the same practitioner or practitioner in same group/specialty if
  - The E/M was provided prior to the critical care services – conflicts with CPT language
  - The patient did not need critical care at the time of the other E/M service
  - The visit was medically necessary
  - The E/M services are separate and distinct with no duplicative elements
  - Reported with modifier -25
    - Normally modifier -25 is used for E/M and procedures – why not modifier 27?

Critical Care Services

CY2022 MPFS guidance critical care services

- Critical care can be billed in addition to a procedure with a global surgical period if it is unrelated to the surgical procedure
  - Must be above and beyond and unrelated to the specific anatomic injury or general surgical procedure performed (e.g., trauma and burn cases)
  - Must report modifier –FT (Unrelated evaluation and management (E/M) visit during a postoperative period, or on the same day as a procedure or another E/M visit. (reported when an E/M visit is furnished within the global period but is unrelated, or when one or more additional E/M visits furnished on the same day are unrelated)
    - Modifier –FT appears to have a broad application – CMS confirmed to Part B News (a Decision Health publication, a sister entity to HCPro) that it is not used in the when critical care is reported with another E/M – even though it appears to apply – modifier -25 was adopted to report this situation in the CY2022 MPFS Final Rule

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Critical Care Services

CY2022 MPFS guidance critical care services

- Continuous critical care services crossing midnight are reported as a continuous services with the initial date of service
  - A new initial services is not reported for continuous critical care services that span midnight
  - CMS language is ambiguous for situations where time would be added for non-continuous critical care services – CMS defers to CPT: "…a continuous services does not reset and create a first hour. However, any disruption in the service does create a new initial service"

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Reporting Teaching Physician Services

CY 2022 teaching physician documentation and billing clarifications

- General rule: the teaching physician must be present for the key or critical portion of the service in order to bill for the service
  - In rural areas, “virtual presence” through audio-visual real-time communication can be used
    - During PHE may also be counted in other settings
  - For E/M services, the teaching physician must be present for the portion of the service that determines the level billed
- Where total time is used to determine office/outpatient E/M visit level, only the time the teaching physician is present can be included
  - Do not count time spent by the resident without the presence of the teaching physician

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Reporting Teaching Physician Services

CY 2022 teaching physician documentation and billing clarifications

- Primary Care Exception Policy
  - Allows payment for low and mid-level complexity services furnished by the resident without the physical presences of the teaching physician in certain primary care teaching settings
  - Services falling under this exception were expanded during the PHE
  - Teaching physician can direct the care of up to four residents as long as they are immediately available and review the care during or immediately after the visit
  - For services billed under this exception only medical decision making (MDM) may be used to determine the level billed
    - Time may not be used as it may be extended due to the inexperience of the resident

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Telehealth for Mental Health Treatment

- The SUPPORT for Patients and Communities Act expanded the use of telehealth for patients with diagnosed substance abuse disorder (SUD) or a co-occurring mental health disorder; and
- The Consolidated Appropriations Act of 2021 further expanded the use of telehealth for services furnished for the purpose of diagnosis, evaluation, or treatment of a mental health disorder
- CMS implementation these provisions:
  - The patient's home is a permissible originating site for mental health telehealth services (beyond the end of the PHE)
  - Geographic restrictions do not apply to mental health telehealth services
  - Under the CAA only there must be an in-person, non-telehealth services within six months prior to the initiation of telehealth and at least every 12 months
    - Exception to 12 month visit if patient and practitioner agree the risks and burden of the in-person service outweighs the benefit of an in-person visit, as documented in the patient's medical record
    - The subsequent visits can be furnished by a colleague in the same subspecialty in the same group
  - Practitioners must have the ability to provide audio/visual two-way real-time interactive communication
    - Audio only communication may be used if the patient is not capable of, or does not consent to, the use of two-way audio-visual technology
    - Modifier –FQ (The service was furnished using audio-only communication technology) must be applied

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Therapy Assistant Reduction

- Payment reduction for therapy assistants is effective January 1, 2022
  - CQ/CO modifiers trigger payment at 85% of MPFS
  - CMS previously adopted a "de minimis" policy for application of the modifiers – if at least 10% of a service is provided by the assistant the modifier would apply
  - Time spent concurrently with therapist does not count as assistant time

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Therapy Assistant Reduction

- For untimed codes like evaluations, “de minimis” policy applies to total minutes provided and if more than 10% is provided by assistant – modifiers CQ/CO apply
- For timed code, CMS made significant updates in CY2022 MPFS Final Rule
  - Continued: The therapist and assistant minutes are each rounded to the closest 15-minute increment and full 15-minute increments are reported with or without the modifier as appropraite
  - New: For remaining or “left-over” minutes, CMS will apply the “mid-point” or “8-minute” rule to any “left over” minutes
    - Meaning if the therapist provided at least 8 minutes without regard to any minutes provided by the assistant, they may report the code without a modifier
    - Fewer instances where modifier is required
    - 2 years with old guidance, new guidance adopted on the eve of the payment reduction – make sure therapists are using the new guidance and not reporting assistant modifiers when not necessary

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Therapy Assistant Reduction

- Example
  - PTA – 97110 – 22 minutes
  - PT – 97110 – 23 minutes
  - Total 45 minutes – 3 billable units
- Old guidance: 2 units 97110-CQ, 1 unit 97110
  - 1 unit with CQ because PTA provided 15 minutes (7 minutes remaining)
  - 1 unit without CQ because PT provided 15 minutes (8 minutes remaining)
  - “De minimis” rule apples to remaining 15 minutes – 7/15 – 46% so the remaining unit is billed with modifier CQ
- New guidance: 2 units 97110, 1 unit 97110-CQ
  - 1 unit with CQ because PTA provided 15 minutes (7 minutes remaining)
  - 1 unit without CQ because PT provided 15 minutes (8 minutes remaining)
  - 1 unit without CQ because PT provided at least 8 minutes of 97110

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Therapy Assistant Reduction

- Example
  - PTA – 97110 –10 minutes
  - PT – 97110 – 12 minutes
  - PT – 97140 – 20 minutes
  - Total 42 minutes – 3 billable units
- Old guidance: unclear
- New guidance: 97110, 97110-CQ, 97140
  - 1 unit of 97140 because PT provided 15 minutes (5 minutes remaining)
  - 1 unit of 97110 with CQ because PTA provided at least 8 minutes (2 minutes remaining)
  - 1 unit of 97110 without CQ because PT provided at least 8 minutes (4 minutes remaining)

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Therapy Assistant Reduction

- Tie-breaker policy (if equal minutes provided – provider choose the code to assign) still applies
  - For example:
    - 10 minutes of one code by PT
    - 10 minutes of another code by PTA
    - Total 20 minutes – 1 billable unit
    - Provider may bill service provided by PT without modifier or service by PTA with modifier

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Phase out of Coinsurance for Colorectal Cancer Screening

- The Consolidated Appropriate Act of 2021 required phase out of coinsurance for
  - Planned colorectal cancer screening tests that
  - Become diagnostic due to provider identified need for additional services (e.g., polyp removal)
- Coinsurance will be zero by 2030
  - CY2022 – 20%
  - CY2022 – CY2026 – 15%
  - CY2027 – CY2029 – 10%
  - CY2030 and later – 0%

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Appropriate Use Criteria

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Appropriate Use Criteria

- Ordering provider must
  - consult Clinical Decision Support Mechanism (CDSM) and provide result to furnishing provider
    - Reported with modifiers –ME, -MF, or -MG – and G-code representing the CDSM consulted

  OR
  - Self-attest to exception (emergency or hardship) and report that to the furnishing provider
    - Reported with modifiers –MA, -MB, -MC, or –MD
- MLN SE20002 reflecting policies finalized effective January 1, 2020
  - HCPCS G codes for CDSMs
  - Discusses how to report multiple tests and NPI numbers of providers
  - Detailed claims examples are included

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Appropriate Use Criteria

- In CY2021, CMS extended the educational and operations testing period for another year through CY2021
  - During education and operations testing period, reporting AUC criteria is required, claims will not be returned and no payment penalty applies
- In CY2022 CMS extended the education and operations testing period until January 1, 2023, or January 1 of the year following the year the PHE ends
  - CMS refers to the period after the education and operations testing period as the Payment Penalty phase – even though the penalty is applying to the rendering provider rather than the ordering physician, seemingly contrary to the intent of the statute

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Appropriate Use Criteria

- Currently, if no information is provided by ordering provider modifier –MH is reported
  - CY2022: CMS adopted a policy of no longer accepting the –MH modifier once the AUC program edits are implemented (the Payment Penalty phase)
    - Effectively makes the furnishing provider the enforcer – or face a payment penalty – hence the "Payment Penalty" phase
      - CMS will not implement denial immediately during the Payment Penalty phase, rather they will return the claim to the provider for correction
    - Intention on statute was to require ordering professionals to use AUC and implement quality measures, provisions and prior authorization for outlier physicians
    - CMS indicates statutory provisions that require reporting of AUC information on the claim justify not paying rendering providers when ordering providers do not provide needed information

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Appropriate Use Criteria

- CY2022 MPFS Final Rule
  - If the furnishing professional modifies an order with a replacement or additional test, and is unable to reach the ordering professional for a new order, the AUC information reported should be for the original order
    - CMS cites limitation in the BPM regarding amending diagnostic orders only when the ordering practitioner can not be reach – however, the BPM specifically states these requirements generally do not apply to hospital settings and one section specifically states it doesn't apply to hospital inpatients or outpatients
    - CMS repeatedly states providers must comply with the BPM when applying the AUC from the original order if unable to reach the ordering provider
      - But if the provisions don't apply to hospitals, does the requirement regarding being unable to reach the ordering provider apply to tests provided in hospital outpatient departments? Can hospital/radiologist just report the AUC from the original order without attempting to reach the ordering physician?

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Appropriate Use Criteria

- CY2022 MPFS Final Rule
  - Processing edits will only apply to
    - 13X TOB for institutional claims
    - 11 (office), 15 (mobile), 19 (off-campus outpatient hospital), 22 (on-campus outpatient hospital), 23 (emergency room), and 24 (ASC)
  - Processing edits will be bypassed for:
    - Claims with condition code 44
      - Edits do not apply to 12X inpatient Part B claims (i.e., condition code W2 claims)
    - Claims with Medicare as a secondary payer
  - Establishing a new modifier for situations where the ordering physician is not required to consult AUC
    - Professional claims (interpretations) for services not rendered in an applicable setting (i.e., CAH)
    - Services ordered before the penalty phase but rendered/billed after penalty phase

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Rural Health Clinic Update

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RHC Mental Health Services

- In the CY2022 MPFS Final Rule, CMS finalized regulations allowing RHC mental health visits to be furnished through interactive, real-time telecommunication
  - Mental health visit by interactive, real-time communication are billed similar to in-person visits
  - Audio-only visits are allowed if the beneficiary is not capable of or does not consent to the use of video technology
    - It's unclear if modifier TQ applies to these services
  - There must be an in-person, mental health services within six months prior to the initiation of telehealth and at least every 12 months
    - Exception to 12 month visit if patient and practitioner agree the risks and burden of the in-person service outweighs the benefit of an in-person visit, as documented in the patient's medical record

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RHC Hospice Attending Physician Services

- Effective January 1, 2022, RHCs can bill and by paid for hospice attending services under their AIR
  - When a patient elects hospice they also elect an attending physician
  - Prior to 1/1/22, RHC employed physicians and NPP could act as hospice attending physicians, but had to provider services outside their employment with the RHC and bill separately to Part B
  - Starting 1/1/22, an RHC employed physician or NPP can bill the hospice attending services as an RHC AIR visit service
  - RHCs report the –GV modifier in addition to the –CG modifier on the claim line for payment each day a hospice attending physician service is furnished
    - GV – attending physician not employed or paid under arrangement by the patient's hospice provider
  - Any technical component services remain the responsibility of the hospice
- See MLN Matters MM12357, revised 1/13/22

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Transitional Care Management

- In the CY2022 MPFS, CMS finalized concurrent billing of Transitional Care Management (TCM) and other care management services
  - RHCs report General Care Management (G0511) for either Chronic Care Management (CCM), Principal Care Management (PCM) or General Behavioral Health Integration (BHI)
    - RHC cannot bill if another practitioner/facility has billed care management services that month
    - Prior to 1/1/22 GCM could not be billed for the same timeframe as TCM
    - Describes at least 20 minutes of care coordination billed per calendar month
  - RHCs report Psychiatric Collaborative Care Model (CoCM) with G0512 per calendar month
  - TCM may be billed with GCM or CoCM for the same beneficiary for the same period as long as all requirements for billing each code are met
    - Time and effort can not be counted toward more than one code

RHC National Payment Limitation

- RHCs are paid per visit, based on their per visit costs, subject to a per visit payment limit
  - The limit applies to independent RHCs and provider based RHCs in hospitals with 50 or more beds
  - The limit for CY2021 was set at $87.52
  - Other RHCs are paid their costs, which may be significantly higher than the per visit limit amount
- The Consolidated Appropriations Act of 2021 restructured the RHC visit payment limit provisions, effective April 1, 2021
  - The per visit payment limit increases from $100 starting 4/1/21 to $190 in CY2028 ($113 - CY2022)
  - For grandfathered provider-based RHCs, the per visit payment amount is the greater of their per visit amount in CY2020, increased annual by the Medicare Economic Index, or the standard visit amount
    - As of December 31, 2020, the RHC was in a hospital with less than 50 beds and continues to have less than 50 beds, and is enrolled or submitted an application to enroll in Medicare

COVID PHE Update

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Home Administration of Vaccine

- CMS pays $40 for vaccine administration and effective June 8, 2021, an additional $35 for administration in the patient's home, including booster doses
- Requirements for home administration
  - The patient has difficult leaving the home to get the vaccine
    - Due to illness or injury that restricts their ability to leave home without supportive device or help from a paid or unpaid caregiver
    - They have a condition that makes them more susceptible to contracting a pandemic disease
    - They are generally unable to leave the home, it requires a considerable and taxing effort
  - The patient is hard-to-reach because of a disability or they face clinical, socioeconomic or geographical barriers to getting the vaccine in another setting.
    - They face challenges such as transportation, communication or caregiving
  - Provider doesn't need to certify the patient is homebound, but must document the clinical status or barrier they face to getting the vaccine outside the home

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Home Administration of Vaccine

- Settings that qualify
  - Private residence, including the patient's home that's been made a PBD by a hospital
    - No need to "relocate" an on-campus department, not paid under OPPS
  - Temporary lodging (hotel, motel, campground, homeless shelter)
  - Apartment in an apartment complex or unit in an assisted living facility or group home
  - Effective 8/24/21 - communal spaces of multi-unit or communal living arrangements
  - Effective 8/24/21 – assist living facilities participating in CDCs Pharmacy Partnership for Long Term Care Program with residents vaccinated through the program
- Settings that don't qualify
  - Hospitals
  - SNFs and Medicaid nursing facilities, regardless of whether they are the patient's residence

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Home Administration of Vaccine

- Other Restrictions
  - Has to be the sole purpose for the visit, if other services are rendered, only $40 administration fee applies
  - More than one patient
    - 6/8/21- 8/24/21 – only one $35 home administration add on fee
    - 8/24/21 – up to five $35 home administration add on fees, if fewer then 10 administrations to MCR patients at a single location
      - If more then 10 MCR patients receive administration, only one $35 home administration fee applies

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Monoclonal Antibodies

- Monoclonal Antibodies
  - In most cases, they are treated as a preventative, even though the EUA for some products requires the patient to have been diagnosed with COVID-19
    - Outpatient (watch for updates on the CMS website https://www.cms.gov/medicare/covid-19/monoclonal-antibody-covid-19-infusion):
      - Casirivimab and imdevimab – per EUA, latest 11/17/21
      - Bamlanivimab and etesevimab – per EUA, latest 12/3/21
      - Sotrovimab – per EUA, latest 12/16/21
    - Inpatient
      - Tocilizumab – per EUA, latest 6/24/21
        - » Only for use in the inpatient setting for patients with severe COVID
        - » Billed on 12X bill type – inpatient Part B preventative service

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Monoclonal Antibodies

- Monoclonal Antibodies
  - In most cases, they are treated as a preventative, even though the EUA for each product requires the patient to have been diagnosed with COVID-19
    - Preventative (pre-exposure prophylaxis for immunocompromised patients, unable to vaccinate)
      - Tixagevimab with cilgavimab, as 2 separate consecutive IM injections – per EUA, latest 12/20/21
    - Preventative (post exposure prophylaxis for patients exposed or at high risk of exposure
      - Casirivmab and imdevimab – per EUA, effective 7/30/21
      - Bamlanivimab and etesevimab – per EUA, effective 9/16/21

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Monoclonal Antibodies

- Payment for administration of monoclonal antibodies
  - Separate codes are established for each drug for infusion in the home or health care facility
  - Payments are geographically adjusted and do not apply if the provider is paid on a reasonable cost basis
    - Payment for infusion in health care setting – approximately $450
    - Payment for infusion in the home – approximately $750 – to applicable to tocilizumab
    - Payment for injection in health care setting – approximately $150.50
    - Payment for injection in the home – approximately $250.50
  - Unlike vaccines, nursing facilities and SNFs can qualify as the patient's home if it is considered the patient's permanent residence (i.e. they do not have a separate permanent residence they intend to discharge to)
- Medicare Advantage Plans pay for vaccines and monoclonal antibodies and administration beginning January 1, 2022

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Expanded and Relocated Departments

Provider-Based Department Services

- Hospitals do not need to report surge locations and expansion sites to the MAC or CMS, however, it may benefit them to do so for certain outpatient locations
  - If the expansion site is an outpatient department located off the campus of an OPPS hospital, it will be considered off-campus, reported with modifier –PN, paid at the MPFS hospital rate (i.e. 40% of the OPPS rate)
  - The hospital may apply to CMS to "relocate" all or part of an on-campus or "excepted" off-campus department to the new expansion location and bill with modifier –PO for full OPPS rate
    - HOW: hospital makes a "relocation" request under a modified "extraordinary circumstances" policy adopted by CMS for the PHE
    - Note - Relocation normally applies to off-campus "excepted" departments (i.e. billed with –PO) but during PHE on-campus departments may also relocate under the PHE relocation policy

Interim Final Rule with Comment Period, CMS-5531-IFC;
CMS Office Hours Calls May 5 and May 8; COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-For-Service Billing, Section E Q5, Section G Q5

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Expanded and Relocated Departments

- Reporting Modifiers for relocated departments

Dept	Mod before PHE	Payment	Mod after relocation	Payment
Excepted off-campus PBD relocated off-campus	-PO	OPPS (40% for G0463)	-PO	OPPS (40% for G0463)
On-campus PBD relocated off-campus	N/A	OPPS	-PO	OPPS (40% for G0463)
New off-campus expansion location	N/A	N/A	-PN	40% of OPPS or MPFS/CLFS*
Non-excepted off-campus department relocated off-campus	-PN	40% of OPPS or MPFS/CLFS*	-PN	40% of OPPS or MPFS/CLFS*

* Status indicator A services are paid under their normal fee schedule if billed with modifier -PN

Interim Final Rule with Comment Period, CMS-5531-IFC; COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-For-Service Billing, Section G Q6

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Expanded and Relocated Departments

Provider-Based Department Services

- What services can be billed from an expansion PBD location or a relocated PBD location – more information in next section
  - Category 1: Virtual service via telecommunication technology
  - Category 2: In-person service in the expansion department by hospital staff or under arrangement
  - Category 3: Telehealth originating site fees when practitioner is in a distant site (i.e. not a PBD of the same provider)
- Note: CMS has expanded the ability of certain practitioner, such as PT/OT/ST, employed by hospitals to provide telehealth service billed by the hospital – these are not provided in expansion/relocated PBDs but rather are provided as distant site telehealth services billed with modifier -95 as discussed below

Interim Final Rule with Comment Period, CMS-5531-IFC; CMS Office Hours Calls May 5 and May 8, COVID-10 Frequently Asked Questions (FAQs) on Medicare Fee-For-Service Billing Section G

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Expanded and Relocated Departments

Provider-Based Department Services

- Billing care at expansion sites
  - Billed under existing CCN
  - Outpatient care is billed with 13X or 85X
    - Patient must be “registered as a hospital outpatient”
  - Main hospitals address and NPI
  - Condition code DR or modifier CR as appropriate
  - Modifier –PO or PN as appropriate, see chart on next slide

Interim Final Rule with Comment Period, CMS-5531-IFC;
NUBC Guidance: Claims for COVID-19 Treatment (Updated),
COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service Billing

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Category 1 – Remote or Virtual Services

- Hospital Outpatient Therapy (including behavioral health, PT and OT), Education and Training services (Category 1 services) are covered when provided by hospital staff remotely by telecommunications technology under the following conditions:
  - The service does not require in-person delivery
    - CMS has provided an ***example*** list of services (located on waivers and flexibilities page) that may not require in-person delivery - indicated could apply to other services not requiring in-person presence (see zipped file on Coronavirus Waivers and Flexibilities page)
  - The patient is in the hospital, including expansion locations such as a patient’s home that has been designated a relocated PBD
  - The patient is registered as an outpatient of the hospital

Interim Final Rule with Comment Period, CMS-5531-IFC, on display April 30; COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-For-Service Billing, Section H

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Category 1 – Remote or Virtual Services

- Hospital Outpatient Therapy Education and Training provided remotely must meet normal order and supervision requirements

- Billed as normally bill if provided in the department (because the patient's home is now a relocated PBD)
  - Includes use of modifier PO or PN as appropriate
  - Therapy and education services generally have a status indicator A and are not affected by the –PN modifier reduction
  - Behavioral health and assessment visit services with other status indicators are paid at 40% of the OPPS rate if billed with modifier –PN or full OPPS if billed with modifier –PO (relocated on- or off-campus excepted PBD)

Interim Final Rule with Comment Period, CMS-5531-IFC, on display April 30; COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-For-Service Billing, Sections G, H

Category 1 – Remote or Virtual Services

Outpatient Therapy: telehealth vs. remote service

- Both telehealth and remote services by hospital therapists are billed on the UB-04 claim

Service	May be billed as telehealth (Modifier -95)	May be billed as hospital remote service (Modifier –PO or –PN)
Service on the telehealth list – status indicator ***other than*** A	Yes	No
Service is on the telehealth list – status indicator A	Yes	Yes
Service is on list of examples of remote services or hospital determines can be safely and effectively delivered remotely via telecommunication but not on the telehealth list	No	Yes

Interim Final Rule with Comment Period, CMS-5531-IFC, on display April 30; COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-For-Service Billing, Sections MM

Category 2 – In person services

Service not appropriate for remote delivery (Category 2)

- Services such as wound care and drug administration may be performed in-person by hospital staff in the patient's home
  - Home must be a relocated PBD
  - Patient should be registered as an outpatient
  - Must meet normal order and general supervision requirements
  - Billed as normally bill if provided in department (because the patient's home is now a relocated PBD)
    - Report –PO and –PN as discussed above
- Cannot overlap with HHA services because the patient's home is temporarily a hospital department and not their "home" while hospital is delivering services
  - If patient is under HH plan of care, hospital may not provide services that could be provided by the HHA

Interim Final Rule, CMS-5531-IFC, on display April 30

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Category 3 – Telehealth Originating Site Services

Telehealth Originating Site Services

- Originating site (where the patient is located) is normally limited to rural and HPSA locations
  - During the PHE, telehealth originating site is not limited to rural areas – can be anywhere within the PHE
- Originating site fee may be billed by
  - A hospital, SNF or CAH, including an inpatient unit
  - A provider department, including patient's home that is a relocated provider-based department
  - A physician office or RHC

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Category 3 – Telehealth Originating Site Services

Originating Site Services

- Includes a hospital department relocated to a patient's home, if:
  - The distant site provider normally practices in the hospital's PBD
  - The hospital staff provide administrative and clinical support
  - The hospital has "relocated" a PBD to the patient's home
  - The patient is registered as an outpatient of the hospital

- Does not apply if the provider is located in the PBD and patient is located in a "relocated" PBD (i.e., their home) – considered in the same facility – not billed as telehealth – use G0463

COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-For-Service Billing, Section LL

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Category 3 – Telehealth Originating Site Services

- Approved Technology
  - Requires two-way, real-time interactive communication
    - Except for certain services that may be audio only – noted on telehealth list
  - The Office of Civil Rights announced discretion in enforcement of HIPAA requirements during the PHE for good faith provision of telehealth even if the provider does not have a BA with the vendor
  - Approved non-public facing technology such as: Apple FaceTime, Facebook Messenger, Google Hangouts, Zoom, or Skype
    - Not allowed: Facebook Live, Twitch, TikTok because they are "public facing"
    - They also provided a list of HIPAA compliant vendors with BA agreements available

https://www.hhs.gov/hipaa/for-professionals/special-topics/hipaa-covid19/index.html;

COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-For-Service Billing, Section P

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Category 3 – Telehealth Originating Site Services

Originating Site Services

- Q3014 is billed for originating site fee
  - Q3014 is a Part B service
  - For outpatients, submit 013X claim
  - For inpatients, submit separate 012X claim (in addition to 011X), DOS for Q3014 = discharge date
  - Q3014 has a facility MUE of 2 and practitioner MUE of 1
  - Status indicator A – policy set rate/allowable of $27.59
    - Note that G0463 billed with either –PO or –PN for these "relocated" departments will pay $48.54 un-wage adjusted (i.e. 40% of the OPPS rate of $121.35)

COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-For-Service Billing, Section P FAQ 47

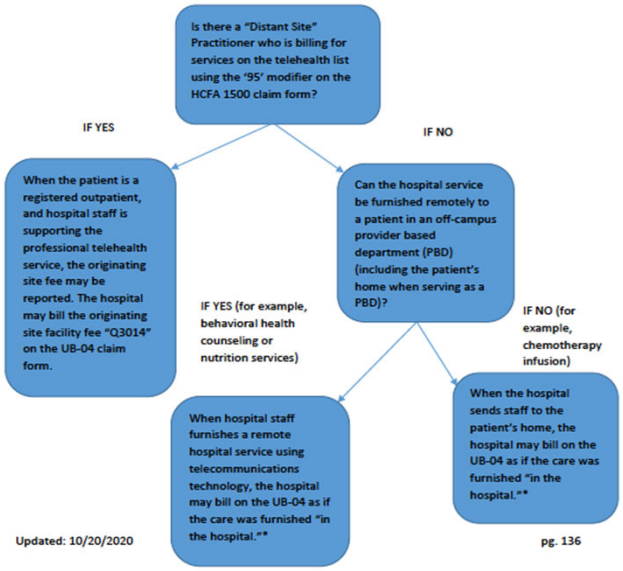
Category 3 – Telehealth Originating Site Services

Use of Q3014 vs. G0463

From COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-For-Service Billing

- Section LL, Q3: …Typically, the hospital would bill G0463 when a professional is located in the hospital and furnishes an evaluation and management outpatient service to a hospital outpatient who is also in the hospital. *If a physician is practicing from a hospital that has registered the patient as a hospital outpatient in the patient's home, which is serving as a provider-based department of the hospital,* ***we consider the physician and patient to be "in the hospital"*** *and usual hospital outpatient billing rules would apply in terms of billing for the service(s) furnished*. In this situation, there is no distant site practitioner and no telehealth service being furnished. New: 7/28/20 (*emphasis added)*
- Section P, Q9: If the beneficiary and the physician or practitioner furnishing the service ***are in the same institutional setting*** but are utilizing telecommunications technology to furnish the service due to exposure risks, the practitioner would not need to report this service as telehealth and should instead report whatever code described the in-person service furnished.

Category 3 – Telehealth Originating Site Services



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Telehealth Distant Site Services

Distant Site Services (Practitioner not in same facility as patient)

- Billed by designated professionals, including physicians, NPs, PAs, Nurse-midwives, CNS, CRNAs, clinical psychologists, LCSW, RDs
  - During the PHE, therapists (PT/OT/ST) employed by hospitals may provide services on the telehealth list
- Billed with face-to-face HCPCS codes describing the service provided by telehealth, as appropriate for their scope of practice
  - CMS publishes a list of codes eligible for telehealth billing, updated as recently as October 14
  - The list identifies codes approved during the PHE only and codes that can be provided by audio only technology

    https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

SE20011; Medicare Telehealth Frequently Asked Questions (FAQs) March 17, 2020; CARES Act; COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-For-Service Billing Section MM

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Telehealth Distant Site Services

For CY2022, no additions to the list of telehealth services

- CMS finalized extending the timeframe for approval of added telehealth services until December 31, 2023
  - CMS want to provide a glide path to evaluate whether the services should be permanently added to the telehealth list following the COVID-19 PHE
  - OIG is also studying the impact and risks of expanding the telehealth benefit
  - Does not extend the waiver allowing a patient's home to be an originating site during the PHE
    - Remember telehealth mental health services were statutorily expanded to be allowed in the patient's home and does not end with the PHE

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Telehealth Distant Site Services

Distant Site Services

- Billing practitioners must have NPI and be enrolled with Medicare (except those employed by hospitals and billed on UB-04 only)
  - Note that CMS implemented expedited enrollment (discussed below)
- Billed on UB-04 or CMS 1500 with Place of Service (POS) code where the service would be if it had been delivered in person or POS 02 for telehealth at the discretion of the provider
  - Payment may be at the facility rate (for POS 02 or other facility POS codes) or non-facility rate based on the POS reported
- Report with modifier -95 indicating telehealth, modifier –CR is not reported on telehealth
  - Professional services billing under Method II on the CAH claim continue to report telehealth modifier –GT, not -95 or –CR

SE20011; Medicare Telehealth Frequently Asked Questions (FAQs) March 17, 2020; CARES Act; COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-For-Service Billing, Section MM

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Laboratory and Testing Services

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COVID Testing Related Services

- Families First Coronavirus Response Act waives Medicare cost sharing for COVID-19 “testing related services”
  - Applies to visits furnished from 3/18/20 to end of PHE
  - Applies to E/M visits, including 99211 and C9803 for specimen collection, that
    - result in order for or administration of COVID-19 lab test
    - are related to furnishing or administering a COVID-19 test or the evaluation of an individual to determine the need for a COVID-19 test
  - Applicable services are submitted with modifier –CS to trigger 100% payment
    - Providers are prohibited from billing beneficiary’s deductible or coinsurance for services billed with modifier –CS
    - Facilities must submit adjustment claims adding –CS modifier if originally submitted without

MLN Connects Special Edition, April 7, 2020 and April 10, 2020

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COVID Testing Related Services

- Applicable E/M visit categories (presumably in person or via telehealth)
  - Office or other outpatient services
  - Hospital observation services
  - Emergency department services
  - Domicilliary, rest home or custodial care services
  - Home services
  - Online digital evaluation and management services
- 100% payment (i.e. cost share does not apply) to services paid to
  - Hospital outpatient departments paid under OPPS
  - Physician/NPPs paid under the MPFS
  - Critical Access Hospitals
  - Rural Health Clinics and Federally Qualified Health Centers

Orders for COVID Testing

- CMS revised regulatory requirements for laboratory testing during the PHE to remove the requirement for an order for COVID-19 testing, influenza testing and respiratory syncytial virus testing
  - There is a limit of one test each per beneficiary
- CMS published a list of laboratory tests not requiring an order during the PHE
  - For tests other than COVID-19, the order requirement is removed only when they are furnished in conjunction with COVID-19 testing
    - In the course of establishing or ruling out COVID-19; or
    - Identifying patients with an adaptive immune response indicating prior or recent infection
- If an order is obtained for testing, the NPI of the ordering physician or NPP should still be reported as normal

Interim Final Rule with Comment Period, on display April 30, 2020, Interim Final Rule with Comment Period, on display August 26

Specimen Collection Codes

- Specimen Collection by physician practices
  - CMS is allowing physician practices to bill 99211 for ***new and*** established patients for reporting assessment and specimen collection by clinical staff incident to a physician or NPPs' services
    - CMS clarified the physician may later bill a new patient code is they have never seen the patient before this COVID specimen collection visit
- Specimen collection by hospital outpatient departments
  - CMS recreated a ***new E/M code*** for specimen collection by hospitals: C9803 (Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2)(coronavirus disease [covid-19], any specimen source)
    - Assigned Status indicator Q1, packaged to other OPPS services if reported on same claim
    - Assigned APC 5731, payment rate $22.99

Interim Final Rule with Comment Period, on display April 30, 2020, COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-For-Service Billing, Section B, Q14

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Specimen Collection Codes

Specimen collection by independent laboratories

- CMS adopted 2 specimen collection codes for use by independent laboratories (i.e. not hospitals) effective 3/1/20
  - G2023 (Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)(Coronavirus disease [COVID-19]), any specimen source
  - G2024 (Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)(Coronavirus disease [COVID-19]), from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source
- These codes were published for use by independent laboratories, but have been assigned status indicator N in a "re-release" of the April IOCE
  - If hospitals incorrectly report them, they will be packaged.

Interim Final Rule with Comment Period, April 6, 2020,
Final Summary of Data Changes IOCE v21.1.0.R2 April 2020

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Laboratory diagnostic testing

- AMA CPT and HCPCS Level II codes for COVID testing continue to evolve
- See AMA CPT website for most current information concerning CPT codes for COVID-19 & influenza:
  https://www.ama-assn.org/practice-management/cpt/covid-19-cpt-coding-and-guidance
  - A special CPT Assistant can be accessed here:
    https://www.ama-assn.org/system/files/2020-10/cpt-assistant-guide-coronavirus-october-2020.pdf
- See updates published in quarterly OPPS Transmittals

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Laboratory billing

- COVID laboratory tests are billed by the hospital
  - if performed by the hospital on referred specimens
    - TOB 14X – unless patient in seen same day at hospital
    - Exception: lab tests for SNF Part A patients
  - if specimen is collected by the hospital during a hospital inpatient or outpatient encounters
    - TOB 11X or 13X
    - Performing lab, if not the hospital, furnishes the test “under arrangements” with the hospital
      - Bills hospital for the lab
      - Hospital must have a written agreement with the performing lab for the services furnished under arrangement

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Coverage of Respiratory Panel

- Palmetto has a policy of non-coverage of certain panels that include multiple respiratory DNA/RNA tests including for Coronavirus see – Article A56581/LCD L37713
  - Non-coverage is based on the number of targets – LCD L37713 specifies respiratory viral panels of 6 or more pathogens are non-covered
    - 87632 and 87633 (Infectious agent detection by nucleic acid (DNA/RNA); respiratory virus (eg, adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 6-11 targets (or 12-15 targets respectively)
    - 0115U - Respiratory infectious agent detection by nucleic acid (DNA/RNA), 18 viral types and subtypes and 2 bacterial targets, amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected
    - 0151U - Infectious disease (bacterial or viral respiratory tract infection), pathogen specific nucleic acid (DNA or RNA), 33 targets, real-time semi-quantitative PCR, bronchoalveolar lavage, sputum, or endotracheal aspirate, detection of 33 organismal and antibiotic resistance genes with limited semi-quantitative results
    - 0202U/0223U - Infectious Disease (Bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-COV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected
    - 0225U – Infectious disease (bacterial or viral respiratory tract infection) pathogen-specific DNA and RNA, 21 targets, including severe acute respiratory syndrome coronavirus 2 (SARS-COV-2), amplified probe technique, including multiplex reverse transcription for RNA targets each analyte reported as detected or not detected
  - 87631, 87636, 87637, 0240U, and 0241U are covered – directed at specific or fewer targets

Thank you!

Questions?

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