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Mass Association of Patient Account Management (MAPAM)
Government Payer Meeting

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenter

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Agenda

- Staying Informed
- Important Modifiers
- 2022 Medicare Physician Fee Schedule Final Proposed Rule
- Telehealth Services – Public Health Emergency
- Provider Enrollment

Staying Informed

- During the COVID-19 Public Health Emergency, information and instructions may change and will turn to prior instructions following the PHE
  - U.S. Department of HHS Public Health Emergency
- It is vital to ensure that you receive the latest information as soon as it becomes available
- Therefore, please take the following steps to ensure you have access to the latest updates
  - Sign up for listserv messaging from both
    - CMS Listserv and
    - National Government Services Email Updates
- Routinely check
  - CMS Current Emergencies webpage and
  - NGS COVID-19 News page


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We're putting patients first.
We pledge to put patients first in all of our programs – Medicaid, Medicare, and the Health Insurance Exchanges. To do this, we must empower patients to work with their doctors and make health care decisions that are best for them.
This means giving them meaningful information about quality and costs to be active health care consumers. It also includes supporting innovative approaches to improving quality, accessibility, and affordability, while finding the best ways to use innovative technology to support patient-centered care.
But we can't and we don't do all of this alone. Learn more about how we are working together to ensure all patients get the very best health care.
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Stay Updated on the COVID-19 Vaccine

COVID-19 Vaccines and Monoclonal Antibodies

Medicare Part B Payment for COVID-19 Vaccines and Certain Monoclonal Antibodies during the Public Health Emergency

CMS has released a set of toolkits for providers, states and insurers to help the health care system prepare and assist in swiftly administering these products once they become available. These resources are designed to increase the number of providers that can administer the products and ensure adequate reimbursement for administration in Medicare, while making it clear to private insurers and Medicaid programs their responsibility to cover these products at no charge to beneficiaries. This webpage provides the payment allowances and other related information for these products. For more information, review the COVID-19 provider toolkit.

Payment Allowances and Effective Dates for COVID-19 Vaccines and their Administration During the Public Health Emergency:(DOS = Date of Service, TBD = To Be Determined)

CPT Code or HCPCS Code	CPT or HCPCS Short Descriptor	Labeler Name	Vaccine/Procedure Name	National Payment Allowance Effective for Claims with DOS on or after 03/15/2021	National Payment Allowance Effective for Claims with DOS through 03/14/2021	Effective Dates
91300	SARSCOV2 VAC 30MCG/0.3ML IM	Pfizer	Pfizer-Biontech Covid-19 Vaccine	$0.010[1]	$0.010[1]	12/11/2020 – TBD
0001A	ADM SARSCOV2 30MCG/0.3ML 1ST	Pfizer	Pfizer-Biontech Covid-19 Vaccine Administration – First Dose	$40.000[2]	$16.940[2]	12/11/2020 – TBD

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Medicare Advantage Plan Changes Starting January 1, 2022

- If you vaccinate or administer monoclonal antibody treatment to patients enrolled in Medicare Advantage (MA) plans on or after January 1, 2022, submit claims to the MA Plan.
- Original Medicare (NGS) won't pay these claims.
  - COVID-19 vaccine claims with dates of service for 2020 & 2021 for MA plan will be submitted to Original Fee-For-Service Medicare (NGS)

Important Modifiers

Modifier CR

- Modifier CR (catastrophe/disaster related)
  - Used on professional and outpatient institutional claims
  - **CR modifier is not required on telehealth services**

✓ Mandatory coding for any claim for which Medicare payment is conditioned on the presence of a “formal waiver” including the Section 1135 waiver

✓ Used to identify claims that are/may be impacted by specific payer/health plan policies related to a national or regional disaster

CS Modifier

- CS modifier waives cost sharing requirements
- MLN Matters® *SE20011 Revised: Medicare FFS Response to the PHE on COVID-19*
- DOS on/after 3/18/2020: Cost-sharing does not apply for COVID-19 testing-related services, which are medical visits
  - Append CS modifier to EM service performed
    - When E/M service leads to COVID-19 testing
    - Allows E/M to be paid at 100% of the fee schedule

2022 Medicare Physician Fee Schedule Final Rule

2022 Medicare Physician Fee Schedule Final (MPFS) Rule

- CMS issued a final rule 11/2/2021
- Includes updates on policy changes for Medicare payments under MPFS & other Medicare Part B issues, on or after January 1, 2022.
  - 2022 Medicare Physician Fee Schedule Final Rule
- The 2022 PFS final rule is one of several proposed rules that reflect a broader Administration-wide strategy to create a health care system that results in better accessibility, quality, affordability, empowerment, and innovation.

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2022 Medicare Physician Fee Schedule Final (MPFS) Rule

- Payment provisions to focus on but not limited to:
  - CY 2022 PFS Ratesetting and Conversion Factor
  - Evaluation and Management (E/M) Visits
    - Split (or shared) E/M visits
    - Critical Care Services
    - Teaching Physician Services
  - Telehealth Services under the PFS
  - Therapy Services
  - Billing for Physician Assistant (PA) Services

2022 Physician Fee Schedule (PFS) Ratesetting and Conversion Factor

- 2022 PFS conversion factor is $33.59
- A decrease of $1.30 from the 2021 PFS conversion factor of $34.89

Evaluation and Management (E/M) Visits

- CMS is making a number of refinements to current policies for:
  - Split (or shared) E/M visits
  - Critical care services
  - Services furnished by teaching physicians involving residents

Split (or shared) E/M visits

- CMS is refining the longstanding policies for split (or shared) E/M visits
  - To better reflect the current practice of medicine with the evolving role of non-physician practitioners (NPPs)
- In the CY 2022 PFS final rule, CMS is establishing the following:
  - Definition of split (or shared) E/M visits as E/M visits provided in the facility setting by a physician and an NPP in the same group
  - The visit is billed by the physician or practitioner who provides the substantive portion of the visit

Split (or shared) E/M visits

- By 2023, the substantive portion of the visit will be defined as more than half of the total time spent
- For 2022, the substantive portion can be history, physical exam, medical decision-making, or more than half of the total time
  - Except for critical care, which can only be more than half of the total time
- Can be reported for new as well as established patients, and initial and subsequent visits, as well as prolonged services
- A modifier is required on the claim to identify these services to inform policy and help ensure program integrity.
- Documentation in the medical record must identify the two individuals who performed the visit. **The individual providing the substantive portion must sign and date the medical record.**

Critical Care Services

- Critical care services are defined in the CPT Codebook
- CPT Codebook listing of bundled services are not separately payable
- When medically necessary, critical care services can be furnished concurrently to the same patient on the same day by more than one practitioner representing more than one specialty, and critical care services can be furnished as split (or shared) visits.
- Critical care services may be paid on the same day as other E/M visits by the same practitioner or another practitioner in the same group of the same specialty
  - The practitioner documents that the E/M visit was provided prior to the critical care service at a time when the patient did not require critical care
  - The visit was medically necessary
  - The services are separate and distinct, with no duplicative elements from the critical care service provided later in the day
  - Practitioners must report modifier -25 on the claim when reporting these critical care services

Critical Care Services

- Critical care services may be paid separately in addition to a procedure with a global surgical period if the critical care is unrelated to the surgical procedure
- Preoperative and/or postoperative critical care may be paid in addition to the procedure if the patient is critically ill and requires the full attention of the physician, and the critical care is above and beyond and unrelated to the specific anatomic injury or general surgical procedure performed (e.g., trauma, burn cases)
- CMS is creating a new modifier for use on such claims to identify that the critical care is unrelated to the procedure
  - If care is fully transferred from the surgeon to an intensivist (and the critical care is unrelated), the appropriate modifiers must also be reported to indicate the transfer of care.
- Medical record documentation must support the claims.

Teaching Physicians Involving Residents

- For CY 2021, practitioners can select the office/outpatient E/M visit level to bill based on either the total time personally spent by the reporting practitioner or medical decision making (MDM)
- CMS has now finalized and clarified that when time is used to select the office/outpatient E/M visit level, **only the time spent by the teaching physician in qualifying activities, including time that the teaching physician was present with the resident performing those activities, can be included for purposes of visit level selection**
  - Under the primary care exception, time cannot be used to select visit level. Only MDM may be used to select the E/M visit level
    - This is to to guard against the possibility of inappropriate coding that reflects residents' inefficiencies rather than a measure of the total medically necessary time required to furnish the E/M services

Telehealth Services under the PFS

- Certain services added to the Medicare telehealth services list will remain on the list through 12/31/23
  - This will allow CMS additional time to evaluate whether the services should be permanently added
- Extended inclusion of certain cardiac and intensive cardiac rehabilitation codes through the end of CY 2023
- Removed the geographic restrictions & added home as a permissible originating site for telehealth services furnished for the purposes of diagnosis, evaluation, or treatment of a mental health disorder
  - Must be an in-person, non-telehealth service with the physician or practitioner

Telehealth Services under the PFS

- CMS is amending the current definition of interactive telecommunications system for telehealth services
  - CMS will now include audio-only communications technology when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients in their homes under certain circumstances
- CMS is limiting the use of an audio-only for mental health
  - Practitioners who have the capability to furnish two-way, audio/video communications, but where the beneficiary is not capable of, or does not consent to, the use of two-way, audio/video technology will require the use of a new modifier
  - CMS is also clarifying that mental health services can include services for treatment of substance use disorders (SUDs)

Therapy Services

- New modifiers (CQ and CO)
  - Identify and make payment at 85 percent of the otherwise applicable Part B payment amount for physical therapy and occupational therapy services furnished in whole or in part by physical therapist assistants (PTAs) and occupational therapy assistants (OTAs) when they are appropriately supervised by a physical therapist (PT) or occupational therapist (OT), respectively for dates of service on and after January 1, 2022
  - CMS' revised policy would allow a 15-minute timed service to be billed without the CQ/CO modifier in cases when a PTA/OTA participates in providing care to a patient, independent from the PT/OT, but the PT/OT meets the Medicare billing requirements for the timed service on their own, without the minutes furnished by the PTA/OTA, by providing more than the 15-minute midpoint
    - That is, 8 minutes or more also known as the 8-minute rule

Billing for Physician Assistant (PA) Services

- Medicare to make direct payment to PAs for professional services that they furnish under Part B beginning January 1, 2022
- Medicare currently can only make payment to the employer or independent contractor of a PA.

Telehealth Services – Public Health Emergency

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Telehealth

- Submitting a Request
- Request for Addition
- CMS Criteria for Submitted Requests
- Review
- Deletion of Services
- Changes
- Adding Telehealth Services
- List of Telehealth Services

List of Telehealth Services

List of services payable under the Medicare Physician Fee Schedule when furnished via telehealth.

List of Telehealth Services for Calendar Year 2022 (ZIP)

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Help with File Formats and Plug-Ins

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		LIST OF MEDICARE TELEHEALTH SERVICES effective January 1, 2022-updated November 1, 2021		
Code	Short Descriptor	Status	Can Audio-only Interaction Meet th	Medicare Payment Limitation
90875	Psychophysiological therapy	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		Non-covered
90951	Esrd serv 4 visits p mo <2yr			
90952	Esrd serv 2-3 vsts p mo <2yr			
90953	Esrd serv 1 visit p mo <2yrs	Available up Through December 31, 2023		
90954	Esrd serv 4 vsts p mo 2-11			
90955	Esrd srv 2-3 vsts p mo 2-11			
90956	Esrd srv 1 visit p mo 2-11	Available up Through December 31, 2023		
90957	Esrd srv 4 vsts p mo 12-19			
90958	Esrd srv 2-3 vsts p mo 12-19			
90959	Esrd serv 1 vst p mo 12-19	Available up Through December 31, 2023		
90960	Esrd srv 4 visits p mo 20+			
90961	Esrd srv 2-3 vsts p mo 20+			
90962	Esrd serv 1 visit p mo 20+	Available up Through December 31, 2023		
90963	Esrd home pt serv p mo <2yrs			
90964	Esrd home pt serv p mo 2-11			
90965	Esrd home pt serv p mo 12-19			
90966	Esrd home pt serv p mo 20+			
90967	Esrd svc pr day pt <2			
90968	Esrd svc pr day pt 2-11			

Telehealth_Updated_01Nov2021

Medicare Telehealth Services

- Categories
  - Category 1
    - Services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services
  - Category 2
    - Services that are not similar to the current list of telehealth services
  - Category 3 (temporary category)
    - Services added to the list during the PHE for the COVID -19 pandemic
    - Services will remain on the list through the calendar year in which the PHE ends

Services Added to the Medicare Telehealth List on a Category 1 Basis

- For CY 2021, CMS is finalizing the addition of the following list of services to the Medicare telehealth list
  - Group Psychotherapy – 90853
  - Psychological and Neuropsychological Testing – 96121
  - Domiciliary, Rest Home, or Custodial Care services – 99334–99335
  - Home Visits – 99347–99348
  - Cognitive Assessment and Care Planning Services – 99483
  - Visit Complexity Inherent to Certain Office/Outpatient E/M – G2211
  - Prolonged Services – G2212
- Category 1 means permanent telehealth services

Addition of Services to the Medicare Telehealth List on a Category 3 Basis

- Category 3 - services added to the Medicare telehealth list during the public health emergency for the COVID-19 pandemic that will remain on the list through the calendar year in which the PHE ends
  - Domiciliary, Rest Home, or Custodial Care services – 99336–99337
  - Home Visits – 99349–99350
  - Emergency Department Visits – 99281–99285
  - Nursing facilities discharge day management – 99315–99316
  - Psychological & Neuropsychological Testing – 96130–96133; 96136–96139

Addition of Services to the Medicare Telehealth list on a Category 3 Basis

- Therapy Services, Physical and Occupational Therapy - 97161-97168; 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507
- Hospital Discharge Day Management – 99238–99239
- Inpatient Neonatal and Pediatric Critical Care – 99469, 99472, 99476
- Continuing Neonatal Intensive Care Services – 99478–99480
- Critical Care Services – 99291–99292
- End-Stage Renal Disease Monthly Capitation Payment – 90952, 90953, 90956, 90959, 90962
- Subsequent Observation and Observation Discharge Day Management – 99217; 99224–99226

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Reminders for Telehealth Services

- On/after 3/1/2020 and for duration of PHE
  - Bill audio or audio/video telehealth service with modifier 95 (professional telehealth service from a distant site)
  - POS equal to what it would have been (if were performed FTF) in the absence of a PHE
  - **CR modifier not required on telehealth services**
  - Telehealth services are professional services billed as distant site
  - Teaching physician may use audio/video telecommunications during key portions of service

Telehealth Documentation

- Same as any face-to-face patient encounter, except a statement needed indicating service was telehealth, along with
  - Patient location
  - Provider location
  - Names of all persons participating in the telemedicine service and their role in the encounter
- Time-based services, document start/stop time or total time
- Teaching physician may use audio/video telecommunications during key portions of service

Telephone Services

- 99441-99443
  - Telephone E/M service by a practitioner or qualified health care professional
  - **4/30/2020 added to telehealth services; use modifier 95**
  - Physicians (including Osteopaths, Podiatrists, and Optometrists), Dentists, Non-Physician Practitioners (including Nurse Practitioner, Clinical Nurse Specialist, Physician Assistant, Certified Nurse Midwife) and Maxillofacial Surgeon
- 98966-98968
  - Telephone assessment and management service
  - **Not on the CMS list of telehealth codes**
  - Clinical Psychologists, PT/OT/SLP, Optometrists, Non-Physician practitioners (including Nurse Practitioner, Clinical Nurse Specialist, Physician Assistant, Certified Nurse Midwife), LCSWs, Registered Dietitians (RDs) and Nutrition Professionals (NPs)

Provider Enrollment

Provider Enrollment Updates

- PE COVID 19 Emergency
- Provider Enrollment Application Process Timeline
- PECOS: Verify and Manage E-signature
  - After submission of an application
  - Return for corrections
- Submitting Claims Before Effective Date
  - Listserv April 2021
- Reminders to Prevent Development on Application Submissions
  - See handout provided

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Thank You!

- Questions?

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