Welcome to the Joint ATS/CHEST Webinar on the Medicare 2022 Final Rule

The webinar will begin shortly…

All participants will be on mute during the webinar.

The webinar will be recorded and posted on the ATS and CHEST websites for future reference.

The webinar will begin shortly...

Please use the webinar chat function to submit questions.

The Q/A session will happen at the end of the webinar.

Everything You Need to Know About the CMS 2022 Final Payment Rule

Thursday, January 20, 2022

Speakers

Omar Hussain, DO
Partner, Pulmonary Medicine Associates
Clinical Assistant Professor of Medicine
Loyola Stritch School of Medicine

Scott Manaker, MD, PhD
Professor of Medicine
Pulmonary and Critical Care
Division Penn Medicine

Amy M. Ahasic, MD, MPH
Chief, Pulmonary & Critical Care
Norwalk Hospital, Nuvance Health

Speaker Disclosures

Omar Hussain, DO
Has no affiliation with, or financial interest in, any commercial interest that may have direct interest in the subject matter of his presentation.

Amy M. Ahasic, MD, MPH
Has no affiliation with, or financial interest in, any commercial interest that may have direct interest in the subject matter of his presentation.

Scott Manaker, M.D., Ph.D.
Professor of Medicine

Pulmonary and Critical Care Division

Penn Medicine

Physician Advisor, Office of Billing Compliance, Penn Medicine

Novitas (J-12: PA,NJ,MD,DE,DC**) Medicare,** Contractor Advisory Committee (CAC)
Hospital Outpatient Panel, CMS

American College of Chest Physicians (ACCP)/American Thoracic Society (ATS)
Joint Clinical Practice Committee

American College of Physicians (ACP)
Coding & Payment Policy Subcommittee
Advisory Group: Improving Documentation To Enhance EHR Technology and Usability

American Medical Association (AMA)
AMA Relative Value Update Committee (RUC)
Chair, Practice Expense Subcommittee
Member, CPT/RUC Workgroup on E/M

National Board for Respiratory Care (NBRC)
Trustee

Conversion Factor

Amy M. Ahasic, MD, MPH, FCCP, ATSF
Co-Chair, ATS/CHEST Joint Clinical Practice Committee

ATS American Thoracic Society

CHEST

Conversion Factor

- The Medicare Physician Fee Schedule relies on national relative values established for work, practice expense, and malpractice with geographic cost adjustments
  - Values are then multiplied by a conversion factor (CF) to convert RVUs into payment rates
  - A temporary 3.75% increase in CF provided under the CY21 Consolidated Appropriations Act expired
- Final Medicare conversion factor for 2022 is $34.61
  - Decrease from $34.89 (-0.82%) for CY21
  - Initial expected CF for CY22 was $33.60 (-3.7%) but Congress intervened with a variety of actions

Pulmonary Rehabilitation

Amy M. Ahasic, MD, MPH, FCCP, ATSF

Co-Chair, ATS/CHEST Joint Clinical Practice Committee

ATS American Thoracic Society

CHEST

Direct Supervision and Virtual Services

- Virtual direct supervision is currently scheduled to expire December 31, 2022
  - Currently the definition of “direct supervision” is expanded to allow the supervision professional to be immediately available through virtual presence using real-time audio/video technology, instead of requiring their physical presence.
- Virtual delivery of hospital-based pulmonary rehabilitation using real-time audio-visual communications technology are scheduled to no longer be allowed when the PHE expires
- Pulmonary rehabilitation no longer requires “direct physician-patient contact” every 30 days by the medical director
  - A physician is still required to, in consultation with staff, review patient ITPs every 30 days

Aligning Regulations for PR and CR

- Revisions made to the PR and CR/ICR regulations to emphasize that though one program treats respiratory disease and one program treats cardiac conditions, both types of programs aim to improve QoL for their participants using similar methods.
- Consistency added to definitions of:
  - Individualized treatment plan (ITP)
  - Medical director
  - Outcomes assessment
  - Physician-prescribed exercise
  - Psychosocial assessment
  - Supervising physician

Pulmonary Rehabilitation and COVID

- Pulmonary rehabilitation will be covered for beneficiaries with confirmed or suspected COVID-19 with persistent symptoms that include respiratory dysfunction for at least 4 weeks
  - COPD eligibility requirements including PFTs do not apply
  - Does not require patient to have been hospitalized with COVID

Medicare Final Rule: January 1, 2022
Teaching Physician Services

"…when total time is used to determine the office/outpatient E/M visit level, only the time that the teaching physician was present can be included." ***can still use MDM***

"During the PHE, the time of the teaching physician when they are present through audio/video real-time communications technology may also be included in the total time considered for visit level selection." ***time with patient, not the resident***

"…outside the circumstances of the COVID-19 PHE, the teaching physician presence requirement can be met virtually, through audio/video, real-time communications technology, only in residency training sites that are located outside of a metropolitan statistical area." ***when PHE ends, telemedicine for Medicare FFS only in HPSAs***

MPFS: proposed on p. 468, finalized p. 472

Office Visit Total Calendar Day Times

	CPT Code	2021 (minutes)
New	99202	15-29
	99203	30-44
	99204	45-59
	99205	60-74
Established	99211	N/A
	99212	10-19
	99213	20-29
	99214	30-39
	99215	40-54

No longer face-to-face time

No longer >50% counseling & coordinating

NOT CMS times used for rate setting

Write the ***exact*** number (not range!) of minutes

When exceeding 89 (for new) or 69 (for established) minutes, start reporting G2212 (Prolonged services)(***not*** 99417)

Peters S. New billing rules for outpatient office visits. CHEST 158: 298-302, 2020

Moderate Complexity MDM: 2 of 3
99204/99214

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

*You didn't bill

Independent interpretation:

- your review of a study* (eg, image, tracing, data)
- unique by encompassing CPT code
- can combine 3 notes (or results or orders or 1 of each!)

Discussion - ***management*** or test interpretation

Decision – can be deciding ***not***!

Risk factors – (eg, age, weight, anticoagulation, you decide!)

Social determinants – economic, social, adherence, you state!

High Complexity MDM: 2 of 3

99205/99215

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

Severe – you determine!

Monitoring for toxicity – CPT (lab, imaging, EKG, echo, PFT) test, at least every 3 months

Medicare Final Rule: January 1, 2022
Telehealth Services List

CPT Code	Short Descriptor	Status	Audio Only
94002-94004	Vent mgmt inpat subq day	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20	
94664	Evaluate pt use of inhaler	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20	
99202-99205	Office/outpatient visit new		
99212-99215	Office/outpatient visit est		
99221-99223	Initial hospital care	Temporary Addition for the PHE for the COVID-19 Pandemic	
9923199233	Subsequent hospital care		
99238-99239	Hospital discharge day	Available up Through December 31, 2023	
99291-99292	Critical care, 1st hr and subq 1/2	Available up Through December 31, 2023	
99441	Phone e/m phys/qhp 5-10 min	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20	Yes
99442	Phone e/m phys/qhp 11-20 min	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20	Yes
99443	Phone e/m phys/qhp 21-30 min	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20	Yes
99468-99469	Neonate crit care initial and subq	Temporary Addition for the PHE for the COVID-19 Pandemic	
99471-99472	Ped critical care initial and subq	Temporary Addition for the PHE for the COVID-19 Pandemic	
99475-99476	Ped crit care age 2-5 init and subq	Temporary Addition for the PHE for the COVID-19 Pandemic	
99495-99496	Trans care mgmt 14 or 7 day		
99497-99498	Advncd care plan 30 min		Yes

Full list available at:
https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html

Other Payers: Parity or Pandemonium?

March 2020

Payer	Phone Parity	Video Parity
Traditional Medicare	Phone rate raised to $41-$100 via use of new telephone E/M codes	Yes
IBC	Yes	Yes
Aetna	Lower phone rate	Yes
Horizon	Yes	Yes
Cigna Commercial	Yes	Yes
Cigna Medicare	Lower phone rate	Yes
Keystone First (Medicaid/CHC/Medicare)	Lower phone rate	Yes
Health Partners Plans (Medicaid/CHC/Medicare)	Yes	Yes
United Health Care (Commercial/Medicare/Medicaid)	Yes	Yes

Telephone Visits

Not payable prior to COVID Public Health Emergency (PHE)
Couldn't be a new patient
Billing provider telephone time only:
- ***NO*** time for review of chart, records, images, completing note
- ***Only*** communication with pt via telephone

No E/M for 7 calendar days before/after patient initiation
- Exception: portal inquiry for a problem new from recent encounter

2020 COVID PHE: Medicare increased RVUs/$ to create equivalency with 99212-99214; and can be a new patient

		COVID PHE	
CPT Code	Time (min)	RVU	2022 Medicare $
99441	5-10	0.70	57
99442	11-20	1.30	92
99443	>20	1.92	130

Effective January 1, 2022

New Medicare Modifier -93

-93 Audio only

-95 Video and audio

Other payers ?

Changes to Critical Care Billing
Split Shared Billing
Modifier 93 and New Modifiers

Omar Hussain, DO

Co-Chair, ATS/CHEST Joint Clinical Practice Committee

ATS American Thoracic Society

CHEST

Critical Care

- Policy Change by CMS
- When medically necessary critical care services can be furnished concurrently to the same patient
  - 2 or more practitioners
  - Different specialties
- Critical Care Services can furnished as split (or shared) visits

American Thoracic Society Coding and Billing Quarterly January 2022, in press

Critical Care and E/M Visits

- Critical Care Services may be paid on the same day as other E/M visits
  - By the same physician or qualified health professional
  - By 2 different practitioners in the same specialty and same group
  - Practitioner documents that the E/M visit was provided prior to the critical care service
  - The E/M visit occurred when the patient did not require critical care
  - The E/M visit was necessary
  - The E/M service and the critical care service are distinct without duplicative elements.
  - Report modifier -25 with the critical care code

American Thoracic Society Coding and Billing Quarterly January 2022, in press

ATS American Thoracic Society

CHEST

Critical Care and Surgical Global Periods

- CMS confirmed critical care may be paid separately, in addition to a procedure with a global surgical period
  - The Critical Care is unrelated to the surgical procedure
  - Pre op and/or post op critical care may be paid in addition to the procedure if the patient is critically ill
  - The critical care is above and beyond and unrelated to the specific injury or surgical procedure
- New modifier FT should be reported with critical care services performed during the global surgical period of another unrelated procedure
- Modifier -55 should be reported if care is fully transferred from the surgeon to the intensivist and the critical care is unrelated to the surgery

Split (or shared) Evaluation and Management Visits

- In the facility setting, if a physician and an advanced practice provider in the same group see the same patient on the same day, then the visit is billed by the person who provides the substantive portion of the visit
- By 2023, “substantive portion” will be defined as more than half the total time caring for that patient
- For 2022, “substantive portion” can be history, exam, medical decision making or more than half the time. Critical care can only be more than half of the total time

Split (or shared) Evaluation and Management Visits

- Spit (or shared) visits can be reported for new as well as established patients, initial visits or subsequent visits, and well as prolonged services
- Modifier FS 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

American Thoracic Society Coding and Billing Quarterly January 2022, in press

Modifier 93

- Audio Only Technology
- Synchronous Telemedicine service Rendered via Telephone or Other Real Time Interactive Audio Only Telecommunication System
- Between physician/Qualified Healthcare Professional and patient who is located away at a distant site
- The synchronous telemedicine service must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service during a face to face visit

American Thoracic Society Coding and Billing Quarterly January 2022, in press

New Modifiers

New in 2022 HCPCS Level II Modifiers		
HCPCS Modifier	**Short Description**	**Long Description**
FT	Separate unrelated e/m	Unrelated evaluation and management [E/M] visit during a postoperative period, or on the same day as a procedure or another E/M visit. [Report 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]
FS	Split or shared e/m visit	Split [or shared] evaluation and management visit). - Append to claims for split/shared encounters in a *facility* setting.
FQ	Audio-only service	The service was furnished using audio-only communication technology
FR	Two-way a/v dir supervision	The supervising practitioner was present through two-way, audio/video communication technology

American Thoracic Society Coding and Billing Quarterly January 2022, in press

ATS American Thoracic Society

CHEST

ICD-10 Updates

Amy M. Ahasic, MD, MPH, FCCP, ATSF

Co-Chair, ATS/CHEST Joint Clinical Practice Committee

ATS American Thoracic Society

CHEST

Post-Acute Sequelae of COVID-19

- New ICD-10 code **U09.9 Post COVID-19 condition, unspecified** is used to document post-acute sequelae of COVID-19, or “long COVID” conditions, after the active illness has resolved
  - Replaces B94.8 Sequelae of other specified infectious and parasitic diseases which was used as a temporary alternative
  - First, code any specific condition such as dyspnea, unspecified (R06.0), pulmonary fibrosis (J84.10), chronic hypoxemic respiratory failure (J96.11), etc.

Cough

- Cough diagnoses codes have been expanded:
  - R05.1 Acute cough
  - R05.2 Subacute cough
  - R05.3 Chronic cough
  - R05.4 Cough syncope
  - R05.8 Other specified cough
  - R05.9 Cough, unspecified
- Always code the most specific diagnosis applicable

Thank you for your participation

Please check out the CBQ available at the ATS website *thoracic.org*

Send questions to *codingquestions@thoracic.org*