Medicare 2022 Proposed Physician Fee Schedule

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Richelle Marting is an attorney, registered health information administrator, and certified coder who focuses on healthcare coding, billing, and reimbursement issues. She has served as an outpatient multi-specialty surgery coder, hospital-based outpatient coder and a compliance coordinator for a large multi-specialty medical group. As an attorney she advises clients proactively on complex reimbursement questions and has guided multiple clients through extensive Medicare, OIG and private payor audits and investigations. She has served as an expert in litigation in matters involving health information management, reimbursement, and privacy.
OVERVIEW

Telehealth
Category 3
Interim telehealth
Consolidated Appropriations Act
Audio-only
Extended CTBS

Therapy Services
Therapy assistant payment
10% de minimis standard

RHC/FQHCs
Hospice attending providers
Transitional care management
Chronic care management
Mental health visit

Evaluation and Management Services
Split/shared
Teaching physicians
Primary care exception
Physician assistant services

Colorectal Cancer Screening
Closing the gap on patient financial responsibility

Supervision
Addresses virtual presence during PHE wind-down
When the PHE ends, CMS’s waiver authority to permit audio-only services as telehealth ends.
Telehealth

No new category 1 or category 2 services will be added. The distinction between category 3 and interim services is critical to end of coverage dates.

Categories 1 and 2
1: Services that are similar to professional consultations, office visits, and office psychiatry services; similar to those already on list
2: Services that are not similar to those on the current Medicare telehealth services list

Interim Telehealth Services
- Not all services added as telehealth were added as category 3 telehealth
- 106 codes’ coverage as telehealth will end when PHE ends
- Medicare seeking comment on whether to add as category 3

Category 3
- Adds telehealth services temporarily following the end of the PHE
- Added during the PHE
- Likely clinical benefit
- Insufficient evidence to add permanently as category 1 or 2
- Coverage would extend through 12/31/2023
Telehealth Categories 1 and 2 Requests, Denied

The following services were requested to be added as permanent, category 1 or category 2 telehealth services. Medicare finds none of the requests meet criteria and will not add this year.
<table>
<thead>
<tr>
<th>Service Type</th>
<th>HPCS</th>
<th>Long Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urodynamics</td>
<td>51741</td>
<td>Complex uroflowmetry (e.g., calibrated electronic equipment)</td>
</tr>
<tr>
<td>Biofeedback</td>
<td>90901</td>
<td>Biofeedback training by any modality</td>
</tr>
<tr>
<td></td>
<td>90912</td>
<td>Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient</td>
</tr>
<tr>
<td></td>
<td>90913</td>
<td>Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>Neurological &amp; Psychological Testing</td>
<td>96130</td>
<td>Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour</td>
</tr>
<tr>
<td></td>
<td>96131</td>
<td>Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td></td>
<td>96132</td>
<td>Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour</td>
</tr>
<tr>
<td></td>
<td>96133</td>
<td>Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure)</td>
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<tr>
<td></td>
<td>96136</td>
<td>Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes</td>
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<tr>
<td></td>
<td>96137</td>
<td>Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td></td>
<td>96138</td>
<td>Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes</td>
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<tr>
<td></td>
<td>96139</td>
<td>Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>Therapy Procedures</td>
<td>97110</td>
<td>Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility</td>
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<tr>
<td></td>
<td>97112</td>
<td>Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities</td>
</tr>
<tr>
<td></td>
<td>97116</td>
<td>Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)</td>
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<tr>
<td></td>
<td>97150</td>
<td>Therapeutic procedure(s), group (2 or more individuals)</td>
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<thead>
<tr>
<th>Physical Therapy Evaluations</th>
<th>97161</th>
<th>Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>97162</td>
<td>Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>Service Type</td>
<td>HCPCS</td>
<td>Long Descriptor</td>
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<tr>
<td></td>
<td>97163</td>
<td>Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.</td>
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<tr>
<td></td>
<td>97164</td>
<td>Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.</td>
</tr>
<tr>
<td>Therapy Procedures</td>
<td>97530</td>
<td>Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes.</td>
</tr>
<tr>
<td>Therapy Personal Care</td>
<td>97535</td>
<td>Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes.</td>
</tr>
<tr>
<td></td>
<td>97537</td>
<td>Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/ modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes.</td>
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<tr>
<td></td>
<td>97542</td>
<td>Wheelchair management (e.g., assessment, fitting, training), each 15 minutes.</td>
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<tr>
<td>Therapy Tests and Measurements</td>
<td>97750</td>
<td>Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes.</td>
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<tr>
<td></td>
<td>97755</td>
<td>Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes.</td>
</tr>
<tr>
<td></td>
<td>97763</td>
<td>Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes.</td>
</tr>
<tr>
<td>Personal Care</td>
<td>98960</td>
<td>Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient.</td>
</tr>
<tr>
<td></td>
<td>98961</td>
<td>Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients.</td>
</tr>
<tr>
<td></td>
<td>98962</td>
<td>Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients.</td>
</tr>
<tr>
<td>Evaluative and Therapeutic Services</td>
<td>92607</td>
<td>Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour.</td>
</tr>
<tr>
<td></td>
<td>92608</td>
<td>Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure).</td>
</tr>
<tr>
<td></td>
<td>92609</td>
<td>Therapeutic services for the use of speech-generating device, including programming and modification.</td>
</tr>
</tbody>
</table>
When the PHE ends, CMS’s waiver authority to permit audio-only services as telehealth ends

AUDIO-ONLY SERVICES

Medicare is considering permanently expanding coverage for audio-only services to certain mental health visits
The SUPPORT Act allows home to be used as an originating site for SUD treatment or co-occurring mental health disorders services delivered via telehealth, without geographic restrictions to rural areas.

Consolidated Appropriations Act

The SUPPORT Act allows home to be used as an originating site for SUD treatment or co-occurring mental health disorders services delivered via telehealth, without geographic restrictions to rural areas.

**Originating Site**
Home for diagnosis, evaluation, or treatment of mental health disorder for services on or after end of PHE

**Geographic Restrictions**
No rural area restriction for diagnosis, evaluation, or treatment of mental health disorder for services on or after end of PHE

**Eligible Patients**
In-person service within six (6) months
Periodic (q 6 month) in-person service

Exception:
Service is covered without CAA amendments

**Method of Delivery**
May include audio-only for
1) mental health conditions
2) In patient’s home
Considering frequency limits
Audio-Only Services

Medicare proposes to extend coverage of audio-only visits for certain mental health services

**Conditions**
- Diagnosis, evaluation, or treatment of mental health disorders
- Established patients
- Originating site is the patient’s home

**What to Watch for in the Final Rule**
- Documentation requirements
- Level of service limits
- Exclusions if psychotherapy add-on is used
- Exclusions if crisis code is reported

**Other Restrictions**
- Patient is unable to, does not want to use, or does not have access to two-way, audio/video technology
- Provider must have capacity for audio-visual, two-way real time communication
- Modifier to identify audio-only service and certify compliance likely
Extended Communication Technology Based Services

Added on an interim basis and Medicare proposes to make permanent

G2252

Brief communication technology-based service, e.g., virtual check-in service, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11–20 minutes of medical discussion
When the PHE ends, CMS’s waiver authority to permit audio-only services as telehealth ends.

Evaluation and Management Services
Split/Shared Visits

Mechanism to report services under physician's name when shared between physician and NPP

Established patients
Physician performs “substantive” portion

DHHS Petition Jan. 19, 2021
CMS Response
Transmittal 10742cp
Removal Effective May 9, 2021
Impact on Medical Review
Split/Shared Visits

Proposed regulatory definition and several changes to previous manual provisions that would apply to split/shared visits in a facility setting.

Proposed Definition

An E/M visit in the facility setting that is performed in part by both a physician and an NPP who are in the same group, in accordance with applicable laws and regulations.

Changes

- New and established patients
- Initial and subsequent visits
- SNF/NF setting permitted
- Allowed for critical care
- Substantive portion > 50%
- Prolonged services could be split/shared

Other Provisions

- Level of service based on MDM or time
- Only distinct time counts towards level
- ED visit activities?
- Watch for modifier in final rule
Critical Care

Proposed adopting CPT rules, including definition and bundled services, with certain exceptions

**Changes**
- Allow as concurrent care regardless of group affiliation
- All providers in the same group, same day, same patient combine time to determine 99291, 99292 units
- 99291 once per day, per patient, per group
- Provider reporting more than 50% of time bills
- No other E/M visit for the same patient, same day as critical care by provider in same specialty and group
- Bundled into post-op for 10-, 90-day procedures

**Other Provisions**
- Start/stop times not required
- Sufficiently document to allow reviewer to determine role each professional played
Teaching Physicians

Level selection and physician’s presence for billing purposes are addressed

Changes
If E/M is selected based on time, only the teaching physician’s time determines level
Teaching physician’s presence via audio/visual, real-time communications counts (during PHE)

Key or Critical Portion
“In the case of E/M services, the teaching physician must be present during the portion of the service that determines the level of service billed.”
Physician Assistants

As proposed, could bill and be paid directly, reassign payment benefit

<table>
<thead>
<tr>
<th>Changes</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regulations requiring payment for PA services go to PA employer and not to PA directly changed under CAA</td>
<td>Group practice of all PAs can now bill and be paid for PA services</td>
</tr>
<tr>
<td>Places PAs in parity with NPs, CNS for these purposes</td>
<td>PAs can reassign payment benefit</td>
</tr>
<tr>
<td></td>
<td>PA could bill and be paid directly, without an employer or group practice</td>
</tr>
<tr>
<td></td>
<td>Physician supervision, 85% payment rate unchanged</td>
</tr>
</tbody>
</table>
When the PHE ends, CMS’s waiver authority to permit audio-only services as telehealth ends.
Assistant Therapists’ Payments

Therapy assistants are paid a reduced rate, and services provided “in part by” therapy assistants subject to the reduced rate are defined.

- **Therapist Provides Visit Exclusively**
  - Therapist Bills
    - Paid full rate
    - Report GP, GO therapy plan of care modifiers

- **Assistant Provides Visit Exclusively**
  - Assistant Bills
    - -CQ or –CO
    - Report GP, GO therapy plan of care modifiers
    - Paid at 85%

- **Assistant Provides Part of Visit**
  - 10% or more?
  - >10% of time for service
  - Applies to timed, untimed codes
  - Applied to each 15-min unit (not total service)
Colorectal Cancer Screening
Colorectal Cancer Screening

Proposal would finally close loopholes causing patient financial responsibility when a screen sigmoidoscopy or colonoscopy lead to a therapeutic procedure based on findings.

Finally Eliminating Cost Sharing
Consolidated Appropriations Act: Colorectal cancer sigmoidoscopy and colonoscopy screening procedures will be covered at 100%, regardless of the code used.

Problem
- Screening colorectal services covered at 100%
- Anesthesia only recently added as covered at 100%
- Screening-turned-diagnostic/therapeutic only recently clarified as covered, but coinsurance applies

Timeline of Changes
- 80% Effective 1/1/2022
- 85% Effective 2023-2026
- 90% Effective 2027-2029
- 100% Effective 2030
When the PHE ends, CMS’s waiver authority to permit audio-only services as telehealth ends RHCs, FQHCs
The Consolidated Appropriations Act allows RHCs/FQHCs to receive payment for hospice attending physician services.

HOSPICE ATTENDING PHYSICIAN

Proposal would change longstanding policy that prevents RHCs, FQHCs from billing for providers’ hospice attending physician services. Instead of requiring providers be working outside their RHC/FQHC duties and separately bill their professional fees for hospice attending physician services, RHCs and FQHCs could directly bill and be paid for their providers’ hospice attending physician services.
Medicare would also allow TCM, CCM to be billed by RHCs, FQHCs for the same patient during the same date range.

TRANSITIONAL, CHRONIC CARE MANAGEMENT

RHCs, FQHCs placed in parity with fee for service billers which are permitted to report TCM, CCM provided in the same service period since 2020.

Policy would include G0511 General Care Management for RHCs and FQHCs and G0512 Psychiatric CoCM (RHC/FQHC-only codes)
Supervision
Direct Supervision

- Medicare is seeking comment on whether to extend and/or make supervision rules permanent
- Whether to allow only for a subset of services
- Whether modifier would be needed

Immediate Availability

Provider must be immediately available to engage via interactive technology

Real-time presence throughout the service is not required

Virtual Presence

Permitted through end of calendar year when PHE ends

Interactive Technology

Interactive, audio/video, real-time communications technology

Audio-only excluded
Questions?

Available Through Heartland Telehealth Resource Center for Technical Assistance
Richelle Marting, JD, MHSA, RHIA, CPC, CEMC, CPMA, CPC-I