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2022 CMS Evaluation and Management Updates

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

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Agenda

- 2022 Medicare Part B CMS updates and guidelines
  - PA enrollment and billing
  - Split/Shared
  - Telehealth
  - Critical Care
  - NGS E/M billing instructions for PAs and NPs

Objectives

- Provide information on Medicare guidelines and 2022 updates
- Provide information on specific rules
- Billing practices to reduce E/M claim denials and appeals for NPPs
- Encourage access to NGS website for valuable reference information

Physician Assistants

- CMS Final Rule quotes 2021 CPT Codebook, pg. 6, “When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialties as the physician.”
- As of 1/1/2022**, PAs may bill the Medicare program** and be paid directly for their services in the same way that NPs and CNSs currently do
- As of 1/1/2022, PAs may reassign their rights to payment for their services, and may choose to incorporate as a group comprised solely of practitioners in their specialty and bill the Medicare program, in the same way that NPs and CNSs may do

Physician Assistants

- What has stayed the same?
- CMS notes that **changes** for PA practice and billing rules **do not apply** to these previously established rules for PA services
  - the statutory benefit category for PA services, including the requirement that PA services are performed under **physician supervision** (see below)
  - the statutory payment percentage applicable to PA services

Physician Assistants

- PAs have flexibility to meet the statutory physician supervision requirement through collaborating with physicians and forming partnerships as long as this is in accordance with their state scope of practice laws
- In authorizing PAs to bill Medicare directly, CMS is encouraging PAs performance of more services under collaborative relationships with physicians. This is likely to enhance care opportunities for Medicare beneficiaries in rural and underserved communities where physician shortages impact access to care

PA Provider Enrollment

- PAs now planning to bill directly must update their enrollment status
- Must add: practice ownership details, practice address, medical record correspondence address, billing agency details if applicable
- Best reference: NGS website
  - Change Existing Provider Enrollment Information

Split/Shared E/M Visits

- 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
  - **Effective 1/1/2022, Modifier FS required on all E/M services that have been performed on a split/shared basis**
  - Modifier FS applies to split/shared E/M service codes used in the **inpatient** and **outpatient *facility*** setting

Split/Shared E/M Visits

- **For 2022**
  - The substantive portion can be history, physical exam, medical decision-making, or more than half of the total time
  - When using time to assess the substantive portion of the service, the provider who spent and documented the most time is considered the billing provider
- **By 2023**
  - The substantive portion of the visit will be defined only as more than half of the total time spent
  - As above, the provider who spent and documented the most time will be considered the billing provider

Split/Shared Options

- Split/shared rules in the **facility** setting (inpatient and outpatient) apply to
  - **New and established** care for outpatients and for initial and subsequent care for inpatients
  - **Observation** services
  - **Prolonged** services
  - **Consultative** services
  - **Admission and discharge** services
  - **Critical care** services (see later slides)

Split/Shared Documentation

- 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**
- Each provider must document his/her contribution to the service and, if applicable, the specific time that he/she spent on the service

Split/Shared Observation Services

- Observation occurs in an **outpatient facility** setting
- Observation codes (99218-99220, 99224-99226) are used **only** by the **primary physician** who is responsible for care
- Modifier AI is added to the above services to identify the provider as the attending of record
- During the observation period, **consultative providers** bill services using outpatient codes 99202-99205 and 99211-99215, without use of Modifier AI

Split/Shared Observation Services

- Attending physicians and consultants may perform split/shared services in the observation setting
- **For 2022**: split/shared observation services may be level-set based on service components (history, exam, MDM) or on cumulative time spent by both providers
- **For 2023**: split/shared observation services will be level-set based on cumulative time only

Critical Care Basics

- Critical care includes multiple other services that are not separately payable
  - These services are defined in the AMA 2022 CPT Manual, referenced in the CMS 2022 Final Rule
- When medically necessary, critical care may be furnished concurrently to the same patient on the same day by more than one practitioner representing more than one specialty

Critical Care Same Day as Other E/M

- 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
  - Both services are medically necessary and 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 Split/Shared

- **As of 1/1/2022, critical care services may be furnished as split (or shared) visits**
- **Physician and NPP** members of the same group may split/share critical care service over a full DOS
- Service may be billed based **only on cumulative time spent by both providers**
- Substantive (billing) provider = spent and documented >50% total time

Critical Care In the Global Period

- Critical care by the performing surgeon may be payable in the global period, only when it is **unrelated** to the surgery
- **Modifier FT**: appended to claims for critical care in the global period by the **performing surgeon**, for a clinical situation **unrelated** to the surgery

Telehealth

- **Services** originally added to the Medicare telehealth services list as a result of the PHE will be retained on a temporary Category 3 basis until the end of CY 2023
- This will allow stakeholders to analyze and consider permanent addition of these services

Telehealth

- Not changed: The **geographic limitations** for telehealth originating sites apply outside the circumstances of the PHE in most circumstances
- After the current PHE: Home will remain as an approved originating site **only for mental health services**

Telehealth

- After the PHE, mental health services will continue to be permissible with the patient's home as the originating site
- The mental health practitioner furnishing such telehealth services must have furnished both
  - an in-person, non-telehealth service to the beneficiary within the six-month period before the date of service of a telehealth service

  and

  - an in-person, non-telehealth service to the beneficiary must occur at 12-month intervals for subsequent care
- The practitioner must document any valid exception to this rule in the medical record

Telehealth

- The pre and post F2F visit for telehealth mental health services may be performed by a clinician's same-specialty, same-group colleague if the original practitioner is unavailable
- Telehealth mental health services must be furnished via interactive telecommunication that includes both audio and visual two-way, real-time communication, with two exceptions described below
- Two exceptions to audio-visual technology rule have been made for mental health services furnished by practitioners who have the capability to furnish two-way, audio/video communications, but where
  - the beneficiary is not capable of two-way audio/video technology
  - the beneficiary does not consent to the use of two-way, audio/video technology

Medicare Telehealth Modifiers

- CMS has approved two service-level modifiers to identify mental health telehealth services furnished to a beneficiary at home to describe specific communications technology
- **Modifier FQ** = A telehealth service was furnished using real-time audio-only communication technology
- **Modifier FR** = A supervising practitioner was present through a real-time two-way, audio/video communication technology
- Modifiers are optional as of 1/1/2022 and required as of 4/1/2022

CMS MLN MM12519

- MLN Matters® *MM12519 Revised:Summary of Policies in the Calendar Year (CY) 2022 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List*

NGS Initiative

- NGS goal: reduce unnecessary provider burden
- Claim data analysis demonstrates high rate of denials and appeals for
  - **Multiple same date of service** E/M claims submitted by group NPPs
  - **Multiple new patient visit** E/M claims by group NPPs within a three-year period

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E/M Golden Rule and Facts

- CMS permits one E/M service per beneficiary per date of service for each provider specialty
- NPs (Specialty 50) and PAs (Specialty 97) are only assigned a single specialty, but they work in full scope of sub-specialty groups
- NPPs working in a physician group: considered as working in exact same specialty or subspecialty as physicians in the group

NPP E/M Billing Issue

- Issue
  - NPP E/M claims are denied when more than one same-specialty NPP service is billed by a group on a single DOS
  - NPP “new patient” claims are denied when a second new visit is submitted by a group NPP within a three-year period
  - High rate of denial, frequently overturned with documentation of both services on appeal
  - Denials and appeal process is burdensome and costly to both the providers and NGS

Solution

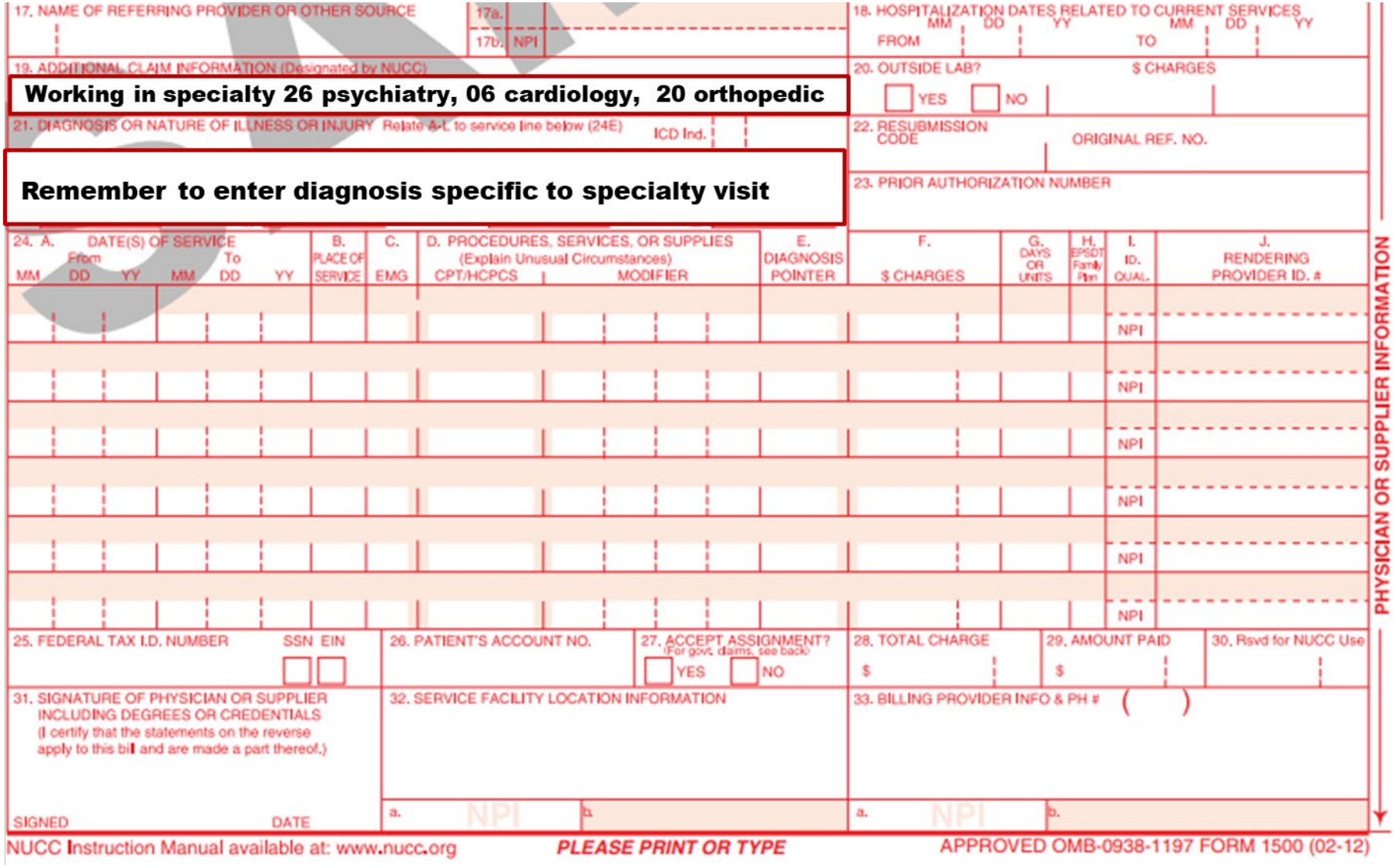
- Applies to **all** NPP E/M claims
- NPP is still the **rendering** provider
- NPPs add specialty of the group in which the service was rendered (e.g., Cardiology Spec 06, Psychiatry Spec 26) – info added to loop 2400 NTE segment (or Box 19 paper)
- Repeat claims for same day and new patient services will suspend for comparison with paid claims in history
- NGS claim examiners compare specialty information with paid history claim(s); claims may be allowed when both **specialty information and diagnoses are different**

Important Claim Facts

- NPP E/M claims submitted without specialty information in loop 2400 NTE segment will continue to deny when an E/M claim has been paid to another group member NPP
  - on the same date of service or
  - a new patient visit has been paid to an NPP within three years
- **Primary diagnoses** on claims must vary, supporting care for two different clinical conditions

Anticipated Outcomes

- **Significant decrease** in rate of denial on E/M claims submitted by NPPs
- **Significant decrease** in rate of appeals, correlative to the lower denial rate
- **Significant increase** in provider revenue



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Medicare Part B CMS-1500 Crosswalk for 5010 Electronic Claims

- Working in specialty
  - 26 psychiatry, 06 cardiology, 20 orthopedic

Claim Notes	2300	NTE02	S	Claim Notes description field
	2400		S	

- Remember to enter the diagnosis specific to specialty visit

Diagnosis or nature of illness or injury	2300	HI01-02

Helpful Information

- What is the reference for the root of this issue in the IOMs?
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15 Section 30
- Can you tell us the denial message and remark code used for concurrent care?
  - D984 = Coverage/program guidelines were not met
  - N20 = Service not payable with other service rendered on the same date
- Where can one find the list of specialty codes?
  - NGS Website > Enrollment > Helpful Tips > Medicare Provider/Supplier Specialty Codes

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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