Improving Access to Quality Medical Care Webinar Series

Presented by

The Southwest Telehealth Resource Center, Arizona Telemedicine Program, and the Arizona Department of Health Services

Welcome

- SWTRC region - AZ, UT, CO, NM & NV
- Fellow HRSA Grantees
- All other participants

Land Acknowledgement

We respectfully acknowledge the University of Arizona is on the land and territories of Indigenous peoples. Today, Arizona is home to 22 federally recognized tribes, with Tucson being home to the O'odham and the Yaqui. Committed to diversity and inclusion, the University strives to build sustainable relationships with sovereign Native Nations and Indigenous communities through education offerings, partnerships, and community service.

The **Arizona Department of Health Services, the Arizona Telemedicine Program,** and **the Southwest Telehealth Resource Center** welcome you to this free webinar series.

The practice & deliver of healthcare is changing, with an emphasis on **improving quality, safety, efficiency, & access to care**.

Telemedicine can help you achieve these goals!

Webinar Tips & Notes

- When you joined the webinar your phone &/or computer microphone was muted
- Time is reserved at the end for Q&A, please use the **Chat function** to ask questions
- Please fill out the post-webinar survey
- Webinar is being recorded
- Recordings will be posted on the ATP website
    - http://telemedicine.arizona.edu/webinars/previous

Carol Yarbrough

"The Draft Medicare Physician Fee Schedule and Telehealth: with a Southwestern Kick!"

Disclaimer

- The opinions expressed in this presentation and on the following slides are solely those of the presenter and not necessarily those of the organizations sponsoring this webinar. The organizations do not guarantee the accuracy or reliability of the information provided herein.
- My two dogs have their own opinions particularly about FedEx, UPS and the USPS delivery personnel and may contribute to the content of today's webinar.

Agenda

- Learn Something New
  - Where are my resources?
- The Kick: The proposed Medicare Physician Fee Schedule
- Questions – Answers!

Learn Something New – Every Day!

SWTRC Regions

Arizona

Colorado

Nevada

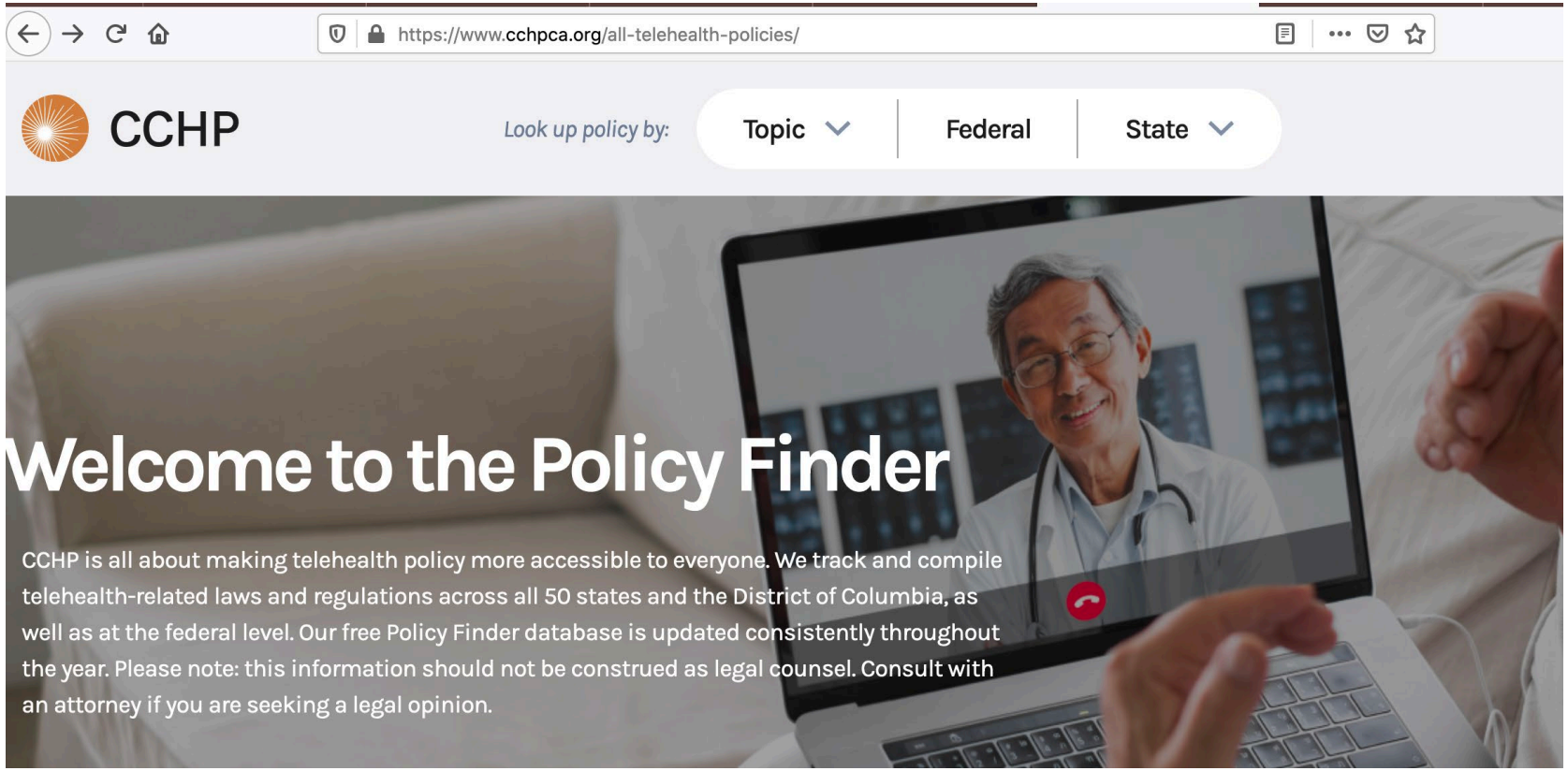
New Mexico

Utah

National Consortium of Telehealth Resource Centers (NCTRC) - Find your TRC

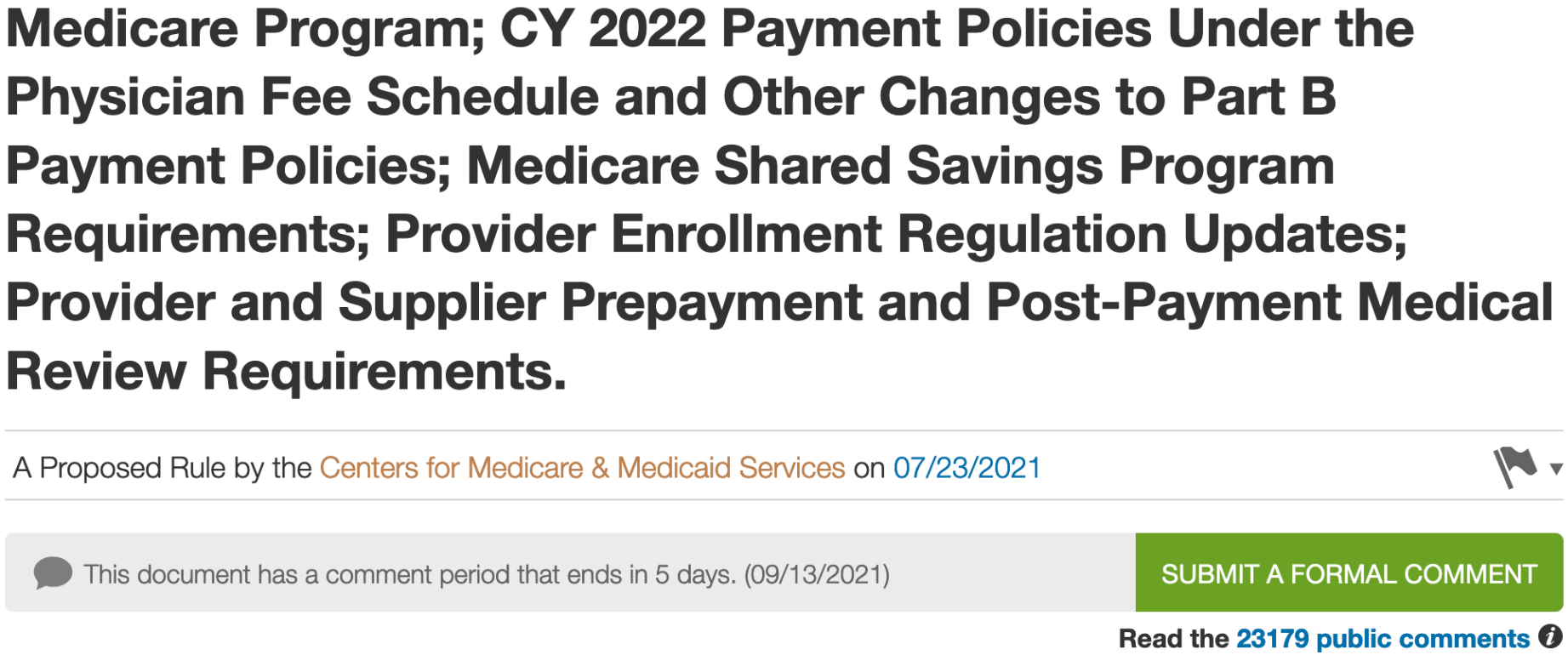
https://southwesttrc.org/region

CCHP – State Specific Resources



https://www.cchpca.org/all-telehealth-policies/

Where to find the draft MPFS details?



Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements.

A Proposed Rule by the Centers for Medicare & Medicaid Services on 07/23/2021

This document has a comment period that ends in 5 days. (09/13/2021)

SUBMIT A FORMAL COMMENT

Read the 23179 public comments

- https://www.federalregister.gov/documents/2021/07/23/2021-14973/medicare-program-cy-2022-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part

Main Points of What's Changing

- Conversion Factor Reduction (and resulting payment cuts)
- Expanded list of telehealth services
- New coverage for tele-behavioral health services
- Evaluation and Management Visits changes
- Payment for Physician Assistant services
- Continued implementation of appropriate use criteria
- Changes to Medicare Diabetes Prevention Program
- New coverage for remote therapeutic monitoring (RTM) services
- Increased reimbursement for care management services
- Launch of MIPS Value Pathways and other Quality Payment Updates

Conversion Factor aka Payment reduction

Budget neutrality adjustment to account for changes in RVUs (required by law)

Expiration of the 3.75 percent payment increase provided for CY 2021 by the Consolidated Appropriations Act, 2021 (CAA)

The proposed CY 2022 PFS conversion factor is $33.58, a decrease of $1.31 from the CY 2021 PFS conversion factor of $34.89.

The PFS conversion factor reflects the statutory update of 0.00 percent and the adjustment necessary to account for changes in relative value units and expenditures that would result from our proposed policies.

Expanded List of Telehealth services thru Dec 2023

- Post PHE, recall:
  - CMS beneficiary must be located in:
    - A county outside a Metropolitan Statistical Area (MSA) or
      - (the Census Bureau decides MSAs)
    - A Rural Health Professional Shortage Area (HPSA) in a rural census tract.
      - The Health Resources and Services Administration (HRSA) decides HPSAs
  - Telehealth Payment Eligibility Analyzer, https://data.hrsa.gov/tools/medicare/telehealth

Let's Look where those codes are

Code	Short Descriptor	Status	Can Audio-only Interaction Meet the Requirements?	Medicare Payment Limitations
99476	Ped crit care age 2-5 subsq	Available up Through the Year in Which the PHE Ends		
99477	Init day hosp neonate care	Temporary Addition for the PHE for the COVID-19 Pandemic		
99478	Ic lbw inf < 1500 gm subsq	Available up Through the Year in Which the PHE Ends		
99479	Ic lbw inf 1500-2500 g subsq	Available up Through the Year in Which the PHE Ends		
99480	Ic inf pbw 2501-5000 g subsq	Available up Through the Year in Which the PHE Ends		
96160	Pt-focused hlth risk assmt		Yes	
96161	Caregiver health risk assmt		Yes	
96164	Hlth bhv ivntj grp 1st 30		Yes	
96165	Hlth bhv ivntj grp ea addl		Yes	
96167	Hlth bhv ivntj fam 1st 30		Yes	
96168	Hlth bhv ivntj fam ea addl		Yes	

Review the codes on the list:
96161 – Permanent code on the list
99477 – Temporary during the PHE
99476, 99478, 99479 and 99480 – Category 3 codes

When PHE is over and the patient is in an HRSA-eligible geographic location at an eligible originating site, 99476 will be reimbursed through the end of CY2023. It will not be reimbursed the following calendar year, unless evidence collected confirms eligibility. At that time, then, it will be moved over to permanent status

Brief Communication Tech-Based CPT – now Permanent Addition

- Based on support from commenters, we are proposing to permanently adopt coding and payment for CY 2022, HCPCS code G2252 as described in the CY 2021 PFS final rule.
- Brief communication technology-based service, e.g. virtual check-in, 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

Extension of G2012 (5-10 minutes)

- Arizona

	National	Adjusted
Facility	$13.26	$12.97
Non Facility	$14.66	$14.30

- Colorado

	National	Adjusted
Facility	$13.26	$13.29
Non Facility	$14.66	$14.75

- Nevada

	National	Adjusted
Facility	$13.26	$13.55
Non Facility	$14.66	$14.94

- New Mexico

	National	Adjusted
Facility	$13.26	$12.98
Non Facility	$14.66	$14.23

- Utah

	National	Adjusted
Facility	$13.26	$12.81
Non Facility	$14.66	$14.09

Tele-Behavioral – can be audio only

- New Modifier!
  - TBD: to identify these mental health telehealth services furnished to a beneficiary in their home using audio-only communications technology.
  - The use of this modifier would also serve to certify that the audio-only telehealth service meets the requirements for the exception
    - The provider has the capacity to furnish the service using interactive two-way, real-time audio/video communication technology,
    - but instead used audio-only technology due to limitations or preferences.
- But – per the CAA, the beneficiary must have an in-person service from the from the mental health service provider furnishing a telehealth service within 6 months of the first mental health telehealth service. CMS suggests a similar requirement that an in-person item or service must be furnished within 6 months of a mental health telehealth service.

Good news for RHCs and FQHCs re: Telemental Health

- CMS wants to revise the current regulatory language for RHC or FQHC mental health visits to include visits furnished using interactive, real-time telecommunications technology.
- After the PHE, RHCs and FQHCs are not authorized to serve as distant site practitioners for Medicare telehealth services
- BUT - this proposed change would allow RHCs and FQHCs to report and receive payment for mental health visits furnished via real-time telecommunication technology in the same way they currently do when visits take place in-person, including audio-only visits when the beneficiary is not capable of, or does not consent to, the use of video technology.

E/M Clarification: Teaching Physician and PCE

- 2021 E/M Guidelines state the office/outpatient E/M visit level to bill is based either on
  - total time personally spent by the reporting practitioner or
  - medical decision making (MDM)
  - If a resident is involved, a teaching physician can bill for the service only if they are present for the key or critical portion of the service
  - But! Under the "primary care exception," teaching hospital primary care centers for certain services furnished by a resident without the physical presence of a teaching physician.
- CMS is proposing to clarify that the time when the teaching physician was present can be included when determining E/M visit level. Under the primary care exception specifically, only MDM would be used to select the visit level to guard against the possibility of inappropriate coding that reflects residents' inefficiencies rather than a measure of the time required to furnish the services.

Split Shared – Before and After

Issue	Prior Guidance	Proposed Rule
Who Can Bill?	Practitioner who performs a "substantive portion" of the E/M visit	Practitioner who performs more than half of the total (non-duplicated) time spent on the E/M visit
Setting of Care	Institutional setting other than a SNF	Any institutional setting, including SNF (other than visits required to be performed in their entirety by a physician)
Definition of "Same Group"	Not defined	Not defined (seeking comments)
Medical Record Documentation	Not defined	Must identify the practitioners who performed the visit and billing practitioner must sign and date the medical record
Claim Modifier	None	To be required (specific modifier not yet determined)
Critical Care	Split (or shared) billing not permitted	Split (or shared) billing permitted

Split Shared

Key takeaway – whomever spends the most time with the patient, is the person who signs the documentation and submits the billing

Paid at 85%

Critical Care – Cause for Concern

Use of AMA CPT prefatory language as the definition of critical care visits, including bundled services.

Allow critical care services to be furnished concurrently to the same patient on the same day by more than one practitioner representing more than one specialty, and that critical care services can be furnished as split (or shared) visits.

No other E/M visit can be billed for the same patient on the same date as a critical care service when the services are furnished by the same practitioner, or by practitioners in the same specialty and same group to account for overlapping resource costs.

These cannot be reported during the same time period as a procedure with a global surgical period.

Physician Assistant Reimbursement Change

- Effective 1/1/22: PAs to receive direct payment for professional services they furnish under Part B
- Before: Medicare currently can only make payment to the employer or independent contractor of a PA.
  - This means: PAs can't bill and be paid by the Medicare program directly for their professional services;
  - It also means: no option exists to reassign payment for their services or to incorporate with other PAs to bill the program for PA services.

Therapy – how to include PTAs and OTAs

- Any minutes that the PTA/OTA furnishes contribute to the time spent by a PT or OT for purposes of billing Medicare.
- Applies to
  - cases where one remaining unit of a multi-unit therapy service to be billed,
  - And a limited number of cases where more than one unit of therapy, with a total time of 24-28 minutes is being furnished.
  - CMS is proposing to allow one 15-minute unit to be billed with the CQ/CO assistant modifier and one 15-minute unit to be billed without the CQ/CO modifier in billing scenarios where there are two 15-minute units left to bill when the PT/OT and the PTA/OTA each provide between 9 and 14 minutes of the same service.

Medical Nutrition Therapy

CMS “propose[s] to revise § 410.130 (definitions) and § 410.132 (MNT) by: (1) Revising the chronic renal insufficiency definition; (2) striking the treating physician definition; and (3) revising conditions for coverage of MNT services, limitations on coverage of MNT services, and referrals.”

https://www.federalregister.gov/d/2021-14973/p-1318

Remote Therapeutic Monitoring

98975	Remote therapeutic monitoring (eg, respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment
98976	device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days
98977	device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days
98980	Remote therapeutic monitoring treatment management services, physician or other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes
98981	each additional 20 minutes (List separately in addition to code for primary procedure)

Prefatory Language

- Remote therapeutic monitoring services (e.g., musculoskeletal system status, respiratory system status, therapy adherence, therapy response) represent the review and monitoring of data related to signs, symptoms, and functions of a therapeutic response. These data may represent objective device-generated integrated data or subjective inputs reported by a patient. These data are reflective of therapeutic responses that provide a functionally integrative representation of patient status.
- Codes 98975, 98976, 98977 are used to report remote therapeutic monitoring services during a 30-day period. To report 98975, 98976, 98977, the service(s) must be ordered by a physician or other qualified health care professional.
- Code 98975 may be used to report the setup and patient education on the use of any device(s) utilized for therapeutic data collection. Codes 98976, 98977 may be used to report supply of the device for scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmissions. To report 98975, 98976, 98977, the device used must be a medical device as defined by the FDA.
- Codes 98975, 98976, 98977 are not reported if monitoring is less than 16 days. Do not report 98975, 98976, 98977 with other physiologic monitoring services (e.g., 95250 for continuous glucose monitoring requiring a minimum of 72 hours of monitoring or 99453, 99454 for remote monitoring of physiologic parameter[s]).
- Code 98975 is reported for each episode of care. For reporting remote therapeutic monitoring parameters, an episode of care is defined as beginning when the remote therapeutic monitoring service is initiated and ends with attainment of targeted treatment goals.

Differences between RPM and RTM

RPM	RTM as defined by the AMA	RTM as imagined by CMS
Monitored: Vitals' type data	Monitored: Non-Vitals' type data	Monitored: Non-Vitals' type data
Not limited to body system	Limited to respiratory or musculoskeletal	Limited to respiratory or musculoskeletal, expand past this
Time-specified for collection in order to bill (16 days)	Time-specified for collection in order to bill (16 days)	Time-specified for collection in order to bill (16 days)
Device: FDA defined	Device: FDA defined	Device: seeking comments
Data: auto-uploaded	Data: auto-uploaded or self-reported	Data: auto-uploaded or self-reported
Who can order: MDs, NPs (codes are in "E&M Section" of AMA CPT code book)	Who can order: MDs, NPs (codes are in the "Medicine Section" of AMA CPT book	Who can order: MDs, NPs (codes are in the "Medicine Section" of AMA CPT book
Who can perform and bill: combined minutes of MDs, NPs, clinical staff (fulfilling incident to)	Who can perform and bill: combined minutes of MDs, NPs, clinical staff (fulfilling incident to)	Who can perform and bill: clinical staff, therapists, and billing is done by anyone who can bill Medicare

Care Management Services

TABLE 12: CY 2022 CCM/CCCM/PCM Proposed Values

CPT Code	Short Descriptor	Current Work RVU	RUC-recommended Work RVU	CMS Proposed Work RVU
99490	CCM clinical staff first 20 min	0.61	1.00	1.00
99439	CCM clinical staff each add 20 min	0.54	0.70	0.70
99491	CCM physician or NPP work first 30 min	1.45	1.50	1.50
99X21	CCM physician or NPP work each add 30 min	new	1.00	1.00
99487	CCCM clinical staff first 60 min	1.00	1.81	1.81
99489	CCCM clinical staff each add 30 min	0.50	1.00	1.00
99X22 (currently G2064)	PCM physician or NPP work first 30 min	new	1.45	1.45
99X23	PCM physician or NPP work each add 30 min	new	1.00	1.00
99X24 (currently G2065)	PCM clinical staff first 30 min	new	1.00	1.00
99X25	PCM clinical staff each additional 30 min	new	0.71	0.71

https://www.federalregister.gov/d/2021-14973/p-601

What happened yesterday? 400 what?!

According to Becker's Review – there are five things to know:

1. The AMA made 405 changes in CPT, including 249 new codes, 63 deletions and 93 revisions. The changes will take effect Jan. 1.
2. 43 percent of editorial are tied to new technology services described in Category III CPT codes and the expansion of the proprietary laboratory analyses code set.
3. There is a series of 15 vaccine-specific codes to report and track immunizations and administrative services.
4. AMA created five CPT codes to report therapeutic remote monitoring. Those codes are: 98975, 98976, 98977, 98980 and 98981.
5. It also created codes for principal care management. The codes are: 99424, 99425, 99426 and 99427.

Principal Care Management

- A qualifying condition for Principal Care Management (PCM) services may be expected to last between three months to one year or until the death of the patient. The initiation of a PCM service will typically be triggered by an exacerbation of the patient's chronic condition or recent hospitalization. (30 min per month)
- CCM is expected to last at least 12 months. (20 min per month)

Resources

- CMS Proposes Cut to 'Conversion Factor' in Medicare Physician Fee Schedule, https://www.medpagetoday.com/practicemanagement/reimbursement/93577
- CMS Proposes New Regulation to Clarify Physician and NPP “Split (or Shared)” Billing Policy, https://www.jdsupra.com/legalnews/cms-proposes-new-regulation-to-clarify-3157466/
- Calendar Year (CY) 2022 Medicare Physician Fee Schedule Proposed Rule (Fact Sheet), https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2022-medicare-physician-fee-schedule-proposed-rule
- CMS Proposes Physician Payment Rule to Improve Health Equity, Patient Access: https://www.cms.gov/newsroom/press-releases/cms-proposes-physician-payment-rule-improve-health-equity-patient-access
- CMS Releases CY 2022 Proposed Rule for Physician Fee Schedule Payments, https://www.aha.org/special-bulletin/2021-07-14-cms-releases-cy-2022-proposed-rule-physician-fee-schedule-payments
- The Good and Bad of the Medicare Physician Fee Schedule Proposal, https://revcycleintelligence.com/news/the-good-and-bad-of-the-medicare-physician-fee-schedule-proposal
- Covid 19 FAQs, last updated July 2021

QUESTIONS

Improving Access to Quality Medical Care Webinar Series

Please check our websites for upcoming webinars and events

http://www.telemedicine.arizona

ARIZONA TELEMEDICINE PROGRAM

SOUTHWEST TELEHEALTH RESOURCE CENTER TRC

ARIZONA DEPARTMENT OF HEALTH SERVICES

Virtual Office Hours

Thursday, September 9th at 12:00pm PDT

HOT TOPIC

Telehealth in our Libraries

Please join us to learn best practices from other states, share resources and a review of what's happening here in AZ with the use of technology and bandwidth in our libraries for telehealth. Our conversation will focus on how AZ is investing Federal and local funding to create the ability for our libraries, chapter houses and schools to provide public spaces for private conversations about healthcare thru telehealth and community partnerships.

Janet Major, *Associate Director for Outreach and Education*
Arizona Telemedicine Program and the Southwest Telehealth Resource Center
&
Mala Muralidharan, *E-rate Administrator* for Public Libraries
Arizona State Library, Archives & Public Records

Register at www.Telemedicine.Arizona.edu
During the registration process you can submit questions for the panelist to answer during the Virtual Office Hours.

Hope you can join us!

ARIZONA TELEMEDICINE PROGRAM

ARIZONA DEPARTMENT OF HEALTH SERVICES

SOUTHWEST TELEHEALTH RESOURCE · CENTER TRC

Your opinion is valuable to us.
Please participate in this brief survey:

https://www.surveymonkey.com/r/SWTRCWebinar

This webinar series is made possible through funding provided by Health Resources and Services Administration, Office for the Advancement of Telehealth and the Arizona Department of Health Services