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

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.

Welcome

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

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

“Critical (Caring) is Sharing”

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.

- The presenter's dogs have their own opinions particularly about FedEx, UPS and the USPS delivery personnel and may contribute to the content of today's webinar.

Objectives

1. How everything old is new (to CMS)
2. Learn about the new split-shared update to critical care (another modifier!)
3. Learn about CC in the global period following a procedure
4. How this may affect your tele-critical care services

What’s Old

In Critical Care Coding

CPT Definition: 99291

- Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
- Codify States:
  - Critical care services include the treatment of vital organ failure or prevention of further life–threatening conditions. Delivering medical care in a moment of crisis and in time of emergency is not the only requirement for providing CC services. Presence of a patient in an ICU or use of ventilation is not sufficient to bill a CC service. The following three criteria must be met for reporting CC service:
    - the severity of illness the intensity of services required to treat the illness, and the time spent in providing the care.
    - Proper documentation showing the medical necessity for providing CC services is an absolute requirement.
    - Usually, a critical care service is provided to a patient in a "critical care area" such as the coronary care unit (CCU), intensive care unit (ICU), respiratory care unit, or emergency room.

75 minutes and beyond

- 99292+: Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service)
- This code is used to report EACH additional 30 minute block of time beyond the first hour of critical care on any given calendar date. This code is used ONLY in conjunction with the 99291 code. EACH additional thirty minutes beyond the first hour of critical care is reported using this code. For example, if you spend 90 minutes on critical care in one calendar date, the encounter would be reported by using the 99291 for the first hour, plus one 99292 code used to report the additional 30 minutes.
- 99292 has a 15 minute threshold which must be crossed before each 30 minute increment can be billed.
  - If you provided 74 minutes of critical care on ONE calendar date, this encounter would be reported using ONLY the first hour 99291 code (because the 15 minute threshold for the additional 30 minute code was not crossed).
  - If you spent a total of 75 minutes during that ONE calendar date on critical care, you would report both the 99291 (for the first 60 minutes) and the 99292 for the additional 15 minutes. one second on critical care, this encounter would be reported by using both codes.

Critical Care in the ER

- For those payers who specify the use of modifier 25 with 99291/99292: If endotracheal intubation (31500) and cardiopulmonary resuscitation (CPR) (92950) are provided, separate payment may be made for critical care in addition to these services if the critical care was a significant, separately-identifiable service and was appended with modifier 25.

- https://www.aapc.com/blog/24587-ten-commandments-of-coding-critical-care-in-the-er/

What Qualifies as “Proper Documentation”

- Critical Care documentation should always include the following:
  - The organ system(s) at risk
  - Which diagnostic and/or therapeutic interventions were performed, including rationale
  - Critical findings of laboratory tests, imaging, ECG, etc., and their significance
  - Course of treatment (plan of care)
  - Likelihood of life-threatening deterioration without intervention

Critical Care Documentation Checklist

- ❑ Were you called to see the patient on an *emergency basis*?
- ❑ Does your note support *evidence of the threat of imminent deterioration* of patient's condition?
- ❑ Does your note demonstrate a need for *highly complex* medical decision making?
- ❑ Does your note support the critical illness or injury you are evaluating is *acutely impairing one or more organ systems?*
- ❑ Is your service required to *prevent further decline of a life-threatening condition*?
- ❑ Does the documentation indicate that an assessment of the patient and your service was provided to *support vital system function* and interventions were all listed?
- ❑ Does the documentation support that you were at bedside or immediately available on floor or unit?
- ❑ Does the documentation support any family discussions that were considered part of the critical care time due to patient being compromised?
  - ❑ Pt. is unable to participate in giving a relevant history
  - ❑ Discussions are required because family member must make medical decisions for the patient
  - ❑ A summary of content of discussion with reason (above) must be noted
- ❑ Does the documentation state: **"I spent a total of ____ minutes providing critical care services, excluding procedure time."**

Critical care services are defined as a physician's direct delivery of medical care for a critically ill or critically injured patient. **It involves decision making of high complexity to assess, manipulate, and support vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition.** Examples of vital organ system failure include but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure. CMS adds that in order to qualify as critical care for Medicare patients, "the failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant or life-threatening deterioration in the patient's condition".

Criteria

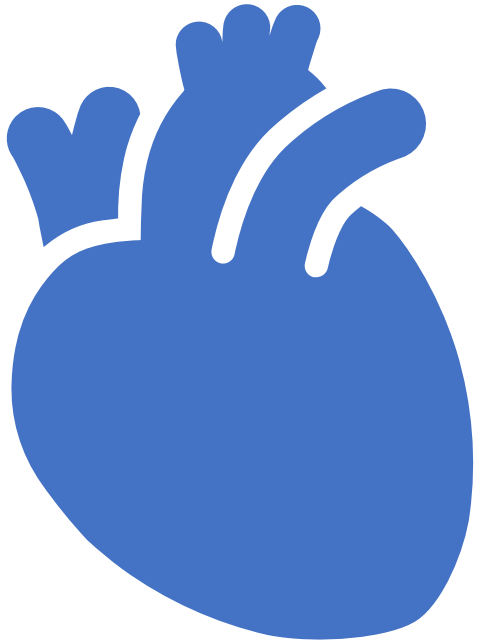
- Clinical Condition Criteria-high probability of sudden, clinically significant, or life threatening deterioration in the patient's condition which requires the highest level of physician preparedness to intervene urgently.
- Treatment Criteria-life and organ supporting interventions that require frequent, personal assessment and manipulation by the physician. Withdrawal of, or failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant or life threatening deterioration in the patient's condition;

Examples of CC Treatment

- Thrombolytics
- Anti-Arrhythmics
- Epinephrine, Atropine, Sodium Bicarbonate
- Cardioversion for Atrial Fibrillation or Atrial Flutter
- Defibrillation
- Fluid and of Blood administration for shock or impending shock
- Narcan
- NTG drip
- Mechanical ventilation – CPAP, BiPap, or ETT

Organ System Failure

- Examples of organ system failure include:
  - Central nervous system failure
  - Circulatory failure
  - Shock
  - Acute renal failure
  - Acute hepatic failure
  - Acute metabolic failure
  - Respiratory failure



What is bundled

Cardiac output measurements	Chest X-ray interpretation	Pulse oximetry	ABGs
EKG interpretation	Gastric intubation	Transcutaneous pacing	Ventilator management
	Peripheral venous access	Arterial puncture	

Time per 24 hr day, non-continuous

Includes

IN THE LOCATION WHERE THE CRITICAL CARE IS BEING PERFORMED

TIME FOR BUNDLED SERVICES

Doesn’t Include

- You may not count toward critical care the time spent performing other, separately reportable services (e.g., endotracheal intubation for airway support, 31500).

The CPT Codes

CPT[1]/ HCPCS	Description	Age	Time	Work RVUs[2]	Non-Facility PE RVUs[2]	Facility PE RVUs[2]	Mal-Practice RVUs[2]	Total Non-Facility RVUs[2]	Total Facility RVUs[2]
99291	Critical care first hour	above 5 yrs	30 or more	4.50	3.20	1.42	0.41	8.11	6.33
99292	Critical care addl 30 min			2.25	1.09	0.72	0.21	3.55	3.18
99466	Ped crit care transport	24 mos or younger	30-74 min	4.79	NA	1.71	0.31	NA	6.81
99467	Ped crit care transport addl		each addl 30–min incr	2.40	NA	0.86	0.15	NA	3.41
99468	Neonate crit care initial	28 days or younger	full day	18.46	NA	6.57	1.19	NA	26.22
99469	Neonate crit care subsq		full day	7.99	NA	2.84	0.51	NA	11.34
99471	Ped critical care initial	29 days thru 24 mos	full day	15.98	NA	5.69	1.03	NA	22.70
99472	Ped critical care subsq		full day	7.99	NA	3.04	0.53	NA	11.56
99475	Ped crit care age 2-5 init	2-5 yrs	full day	11.25	NA	4.34	0.82	NA	16.41
99476	Ped crit care age 2-5 subsq		full day	6.75	NA	2.62	0.48	NA	9.85
G0508	Crit care telehea consult 60		60 min	4.00	NA	1.70	0.33	NA	6.03
G0509	Crit care telehea consult 50		ea addl 50 min	3.86	NA	1.29	0.31	NA	5.46

Conversion Factor for 2022 and Sequestration (Reduction in Federal Pmt)

2022: $34.6062 per RVU

The suspension aligned with the current CARES Act legislation (H.R. 1868-117th Congress (2021-2022)) requiring all health plans to suspend the 2% sequestration reduction in payments from May 1, 2020 to March 31, 2022.

All claims that are based on Medicare payment (Medicare and Medicaid) with dates of service May 1, 2020 through March 31, 2022 will not apply the 2% reduction.

Effective April 1, 2022 through June 30, 2022, a 1% sequestration reduction will apply.

Effective July 1, 2022, the 2% reduction will automatically be applied and in line with the current CARES Act legislation

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Examples of Qualifying Conditions

- An 81-year-old male patient is admitted to the ICU following AAA resection. Two days after surgery he requires fluids and pressors to maintain adequate perfusion and arterial pressures. He remains ventilator dependent.
- A 67-year-old female patient is 3 days status post mitral valve repair. She develops petechiae, hypotension and hypoxia requiring respiratory and circulatory support.
- A 70-year-old admitted for right lower lobe pneumococcal pneumonia with a history of COPD becomes hypoxic and hypotensive 2 days after admission.

Examples of Non-Critical Care

- A dermatologist evaluates and treats a rash on an ICU patient who is maintained on a ventilator and nitro infusion that are being managed by an intensivist. The dermatologist should not report a service for critical care.
- Just because the patient is in the intensive care or other specialized care unit does not mean that critical care services have been performed or that the patient meets the definition of critically ill or injured.
- A surgery post-op patient is admitted to the ICU for monitoring. The patient is stable and does not require critical care treatment only monitoring and pain medication. This service is part of routine post-op care.

Telehealth CC consults

- Key word: consult
  - A request for opinion or advice, and a stated reason to substantiate the need for the service.
  - A report from the consulting provider back to the requesting provider. The consultant shall prepare a written report of his/her findings and recommendations, which shall be provided to the referring physician. The service is justified only if the consulting physician gives his opinion and/or advice to the requesting provider. Without a report back to the requesting provider, a consultation hasn't occurred.
- Additional Documentation
  - A statement that the service was provided using telemedicine;
  - The location of the patient;
  - The location of the provider; and
  - The names of all persons participating in the telemedicine service and their role in the encounter.
- https://providers.bluekc.com/Content/PDFs/paymentpolicies/Telehealth.pdf

What’s New

With Critical Care

Definition was removed May 9, 2021

- Formerly, policy for billing critical care services was reflected in several provisions in the Medicare Claims Processing Manual (sections 30.6.1(B), 30.6.12, and 30.6.13(H)) that were withdrawn effective May 9, 2021, in response to a petition under the Department's Good Guidance regulation at 45 CFR 1.5 See Transmittal 10742, https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Transmittals/r10742cp

- https://www.federalregister.gov/d/2021-23972/p-1347

Adoption of AMA's Prefatory Language – MPFS 2022

- Critical care services were defined in the withdrawn provisions of the Medicare Claims Processing Manual (IOM). The IOM definition tracked closely with the CPT Codebook prefatory language regarding critical care services.
- Adopted the CPT prefatory language as the definition of critical care visits. The CPT prefatory language states that critical care is the direct delivery by a physician(s) or other qualified healthcare professional (QHP) of medical care for a critically ill/injured patient in which there is acute impairment of one or more vital organ systems, such that there is a probability of imminent or life-threatening deterioration of the patient's condition.
- It involves high complexity decision-making to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition.
- Concurrent okay – different specialties:
  - critical care visits may be furnished as concurrent care (or concurrently) to the same patient on the same date by more than one practitioner in more than one specialty (for example, an internist and a surgeon, allergist and a cardiologist, neurosurgeon and NPP),
  - regardless of group affiliation, if the service meets the definition of critical care and is not duplicative of other services. Additionally, as for most Medicare-covered services, these critical care visits would need to be medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

MPFS (cont.)

- Similar to CMS' proposal for split (or shared) prolonged visits, the billing practitioner would first report CPT code 99291 and, if 75 or more cumulative total minutes were spent providing critical care, the billing practitioner could report one or more units of CPT code 99292.
- Time:
  - Joint time is counted once for purposes of reporting the split (or shared) critical care visit.
  - This is consistent with our proposed policy for all split (or shared) visits. It is also consistent with the CPT E/M Guidelines stating that, for split (or shared) visits, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted.
  - Critical care is a time-based service, document total time that critical care services were provided by each reporting practitioner (no start and stop times).
  - We stated that documentation would need to indicate that the services furnished to the patient, including any concurrent care by the practitioners, were medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

MPFS (cont.)

- Documentation:
  - To support coverage and payment determinations regarding concurrent care, we indicated that services would need to be sufficiently documented to allow a medical reviewer to determine
    - the role each practitioner played in the patient's care (that is, the condition or conditions for which the practitioner treated the patient).
    - to support coverage and payment determinations regarding split (or shared) critical care services, documentation requirements for all split (or shared) E/M visits would apply to critical care visits also (see section II.F.1. of this final rule).
- We also refer readers to the sections above on critical care billed the same day as other E/M visits, and critical care billed in conjunction with a global surgical procedure, for additional discussion of documentation requirements in support of services billed.

SPLIT-SHARED

- ~~A split/shared E&M service performed by a physician and a qualified NPP of the same group practice cannot be reported as a critical care service. (Each service must be reported separately with their own NPI number).~~

It is now Legit

Split Shared Rules

- Facility Only
  - NP or APP must be in same Medical Group
  - Must be in same Specialty
  - You cannot bill split-shared for facility-paid/employed NP/APP

Modifiers: FS

- FS (Split [or shared] evaluation and management visit).
  - Modifier FS will be used with claims for split (shared) visits performed in facility settings and split (or shared) critical care visits.
  - Practices (non-facilities) should not add the modifier to office or other outpatient visits (for instance, 99202-99215).
  - https://www.cms.gov/files/document/mm12543-internet-only-manual-updates-iom-critical-care-split-shared-evaluation-and-management-visits.pdf

Modifiers: FT
Critical care updates for a patient in a global surgical period

- FT (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]).
  - https://www.cms.gov/files/document/mm12550-internet-only-manual-updates-critical-care-evaluation-and-management-services.pdf

Wondering about POS 10?

- 02 - Place of Service for reporting Telehealth services rendered by a physician or practitioner from a Distant Site
- 10 - Place of Service for reporting Telehealth services provided in Patient's home
- Note: some payors are requiring providers to report if patient was at home or in another facility per the definitions
- (This code is effective January 1, 2022, and available to Medicare April 1, 2022.)
- Guidance has not yet been shared; keep with the PHE requirements about POS until further notice

Some Questions and Answers

- Question: does the shared/split extend to G0508 and G0509? Or just 99291-99292 during the PHE?
- Answer: The new Split/Shared guidelines are now permanent and are not driven by PHE. The codes applicable for the new Split/Shared visits are 99221-23, 99231-33, 99291-92. The Emergency Department codes 99281-99285 will continue to allow Split/Shared services as well, however, they must use the “substantive portion” rule as they are not permitted to bill these services on time.

Resources

- https://www.aliem.com/charting-coding-critical-care-time/
- https://acphospitalist.org/archives/2010/03/coding.htm
- https://www.icd10monitor.com/risks-associated-with-critical-care-coding
- https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2997CP.pdf
- https://www.healthicity.com/hubfs/healthicity/Resources/eGuides/Your%20EM%20Critical%20Care%20Questions,%20Answered/em%20questions%20answered-eguide.pdf?hsCtaTracking=fd93c51f-4e8a-418b-9dfa-d0e73c772e72%7C1c0084c5-b4fc-4c9a-9bee-3f535ea2439b
- https://med.noridianmedicare.com/web/jeb/article-detail/-/view/10525/nonphysician-practitioners-npps-evaluation-and-management-em-services

QUESTIONS

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