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

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Professor of Medicine
Pulmonary and Critical Care
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Chief, Pulmonary & Critical Care
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Omar Hussain, DO
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Amy M. Ahasic, MD, MPH
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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
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
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
“…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

<table>
<thead>
<tr>
<th></th>
<th>CPT Code</th>
<th>2021 (minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>99202</td>
<td>15-29</td>
</tr>
<tr>
<td></td>
<td>99203</td>
<td>30-44</td>
</tr>
<tr>
<td></td>
<td>99204</td>
<td>45-59</td>
</tr>
<tr>
<td></td>
<td>99205</td>
<td>60-74</td>
</tr>
<tr>
<td><strong>Established</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>99211</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>99212</td>
<td>10-19</td>
</tr>
<tr>
<td></td>
<td>99213</td>
<td>20-29</td>
</tr>
<tr>
<td></td>
<td>99214</td>
<td>30-39</td>
</tr>
<tr>
<td></td>
<td>99215</td>
<td>40-54</td>
</tr>
</tbody>
</table>

- 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
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!

*You didn’t bill
High Complexity MDM: 2 of 3
99205/99215

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

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Short Descriptor</th>
<th>Status</th>
<th>Audio Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>94002-94004</td>
<td>Vent mgmt inpat subq day</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20</td>
<td></td>
</tr>
<tr>
<td>94664</td>
<td>Evaluate pt use of inhaler</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20</td>
<td></td>
</tr>
<tr>
<td>99202-99205</td>
<td>Office/outpatient visit new</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20</td>
<td></td>
</tr>
<tr>
<td>99212-99215</td>
<td>Office/outpatient visit est</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20</td>
<td></td>
</tr>
<tr>
<td>99221-99223</td>
<td>Initial hospital care</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20</td>
<td></td>
</tr>
<tr>
<td>99231-99233</td>
<td>Subsequent hospital care</td>
<td>Available up Through December 31, 2023</td>
<td></td>
</tr>
<tr>
<td>99238-99239</td>
<td>Hospital discharge day</td>
<td>Available up Through December 31, 2023</td>
<td></td>
</tr>
<tr>
<td>99291-99392</td>
<td>Critical care, 1st hr and subq 1/2</td>
<td>Available up Through December 31, 2023</td>
<td></td>
</tr>
<tr>
<td>994141</td>
<td>Phone e/m phys/chp 5-10 min</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20</td>
<td>Yes</td>
</tr>
<tr>
<td>99442</td>
<td>Phone e/m phys/chp 11-20 min</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20</td>
<td>Yes</td>
</tr>
<tr>
<td>99443</td>
<td>Phone e/m phys/chp 21-30 min</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20</td>
<td>Yes</td>
</tr>
<tr>
<td>99468-99469</td>
<td>Neonate crit care initial and subq</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20</td>
<td></td>
</tr>
<tr>
<td>99471-99472</td>
<td>Ped critical care initial and subq</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20</td>
<td></td>
</tr>
<tr>
<td>99475-99476</td>
<td>Ped crit care age 2-5 init and subq</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20</td>
<td></td>
</tr>
<tr>
<td>99495-99496</td>
<td>Trans care mgmt 14 or 7 day</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20</td>
<td></td>
</tr>
<tr>
<td>99497-99498</td>
<td>Advncd care plan 30 min</td>
<td>Available up Through December 31, 2023</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Full list available at: [https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html](https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html)
### Other Payers: Parity or Pandemonium?
March 2020

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

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Time (min)</th>
<th>RVU</th>
<th>2022 Medicare $</th>
</tr>
</thead>
<tbody>
<tr>
<td>99441</td>
<td>5-10</td>
<td>0.70</td>
<td>57</td>
</tr>
<tr>
<td>99442</td>
<td>11-20</td>
<td>1.30</td>
<td>92</td>
</tr>
<tr>
<td>99443</td>
<td>&gt;20</td>
<td>1.92</td>
<td>130</td>
</tr>
</tbody>
</table>
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
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
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
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

• Split (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
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
New Modifiers

<table>
<thead>
<tr>
<th>HCPCS Modifier</th>
<th>Short Description</th>
<th>Long Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>FT</td>
<td>Separate unrelated e/m</td>
<td>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]</td>
</tr>
<tr>
<td>FS</td>
<td>Split or shared e/m visit</td>
<td>Split [or shared] evaluation and management visit). - Append to claims for split/shared encounters in a facility setting.</td>
</tr>
<tr>
<td>FQ</td>
<td>Audio-only service</td>
<td>The service was furnished using audio-only communication technology</td>
</tr>
<tr>
<td>FR</td>
<td>Two-way a/v dir supervision</td>
<td>The supervising practitioner was present through two-way, audio/video communication technology</td>
</tr>
</tbody>
</table>
ICD-10 Updates

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