2022 Medicare Physician Fee Schedule (MPFS) Final Rule Webinar

December 15, 2021
Webinar FAQ Document

1. **Question** – Are discharge services, such as those reported with Current Procedural Terminology (CPT®) codes 99238 or 99239, allowed to be reported as split/shared visits based on time?

   Answer – Yes, CPT® codes 99238 *Hospital discharge day management; 30 minutes or less* and 99239 *Hospital discharge day management; more than 30 minutes* would fall within the Evaluation and Management (E/M) Visit Code Family of Inpatient/Observation/Hospital/Nursing Facility, and the split/shared visit changes will apply.[1]

2. **Question** – Does the split services regulation apply to Provider Based Clinics, reporting with place of service 19/22, since these clinics fall under the facility fee schedule and guidelines for billing?

   Answer – The split/shared visit changes apply to the professional component. The update to split or shared visits refers to an E/M visit that is performed by both a physician and nonphysician practitioner (NPP) in the same group. The definition does not indicate that provider based clinics are exempt from the policy. The facility portion of the service would not be affected.[2]

3. **Question** – Do these changes to split/shared visits include drug store clinics staffed and billed by hospitals?

   Answer – The answer is dependent upon your provider enrollment with the Centers of Medicare & Medicaid Services (CMS). You will need to check with your Medicare Administrative Contractor (MAC).[3]

4. **Question** – When billing a split/shared visit and billing by the substantive component, do you combine the documentation to determine the level of service? I understand the billing provider must be the one to document the entire component.

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[1] Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule, "Table 26: Final Definition of Substantive Portion for E/M Visit Code Families", page 65153, available at: https://www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf (November 19, 2021)
[2] Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule, "F. Evaluation and Management (E/M) Visits", page 65150, available at: https://www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf (November 19, 2021)
[3] Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule, "F. Evaluation and Management (E/M) Visits", page 65150, available at: https://www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf (November 19, 2021)

Answer – Yes, you combine the documentation to determine the level of service. In the CPT® Manual Guidelines for E/M services, the instructions state that distinct time or documentation should be summed for determination of the code.[4]

5. **Question** – When would we use modifier 24 versus new modifier FT?

   Answer – Usage of modifier 24 *Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period* remains unchanged and would be reported when the service does not meet criteria for reporting modifier FT. Modifier 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* was created to identify when Critical Care Services are unrelated to the condition for which the patient's global surgical package applies.[5]

6. **Question** – Is the new FQ *The service was furnished using audio-only communication technology* modifier only allowed for Pro Fee billing?

   Answer – According to the MPFS Final Rule, the modifier should be reported by physicians or practitioners who have the capacity to furnish two-way, audio/video telehealth services but are providing the mental health services via audio-only communication technology in those instances where the use of audio-only technology is facilitating the access to care due to the patient's extenuating circumstances. There may be different instructions for after the public health emergency ends, so you may wish to contact your MAC to see how they would like the modifier used.[6]

7. **Question** – If the dietitians and nutrition professionals are working in the hospital outpatient department, would they have the option to bill directly and just use a site of service (SOS) for hospital outpatient department?

   Answer – As long as the dieticians and nutritional professionals are practicing within state regulations, facility bylaws, and they are credentialled appropriately with CMS, this would be allowable. The distinction is that the patient could not be an inpatient at the hospital or in a skilled nursing facility (SNF).[7]

8. **Question** – Is modifier FQ *The service was furnished using audio-only communication technology* effective 1/1/2022 or does the PHE affect this? Is the modifier applicable to all telehealth services that allow

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[4] CPT® 2022 Professional Edition, "Time," page 7

[5] Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule, "g. Critical Care Visits and Global Surgery", page 65164, available at: https://www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf (November 19, 2021)

[6] Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule, "d. Implementation of Provisions of the Consolidated Appropriations Act", page 65060, available at: https://www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf (November 19, 2021)

[7] Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule, "K. Payment for Medical Nutrition Therapy Services and Related Services", pages 65194-65198, available at: https://www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf (November 19, 2021)

audio (referring to PHE flexibilities), or would we only need to apply this modifier exclusively for mental health services?

Answer – While the modifier has an effective date, usage of the modifier may begin after the end of the PHE for COVID-19. You may wish to verify with your MAC when they expect the modifier's use to begin.[8]

9. **Question** – Our MAC has listed Place of Service (POS) 10 *Telehealth Provided in Patient's Home* with an implementation date of 4/1/2022. Does this POS apply to all telehealth services or is it specific to mental health telehealth, assuming the PHE will continue after 4/1/2022?

   Answer – CMS discusses POS 10 in Transmittal 11045, Change Request (CR) 12427, with an effective date of January 1, 2022 and an implementation date of April 4, 2022. The transmittal states that the POS was created for use by other payers and to facilitate claims processing and coordination of benefits for Medicare.

   Unfortunately, the transmittal does not state any specifics on how the modifier should be used, but MACs should process claims the same as they would if the claim contained POS 02 *Telehealth Provided Other than in Patient's Home*. Additional instructions are to be provided once the PHE for COVID-19 has ended.[9]

10. **Question** – For split/shared billing, it now applies to the ED setting. How do we bill services when 2 providers see the patient on the same day since ED is not a time-based code for 2022? This happens when the patient is in the ED during shift change and both providers see the patient during the same visit?

    Answer – For your scenario, the summation of History, Examination and Medical Decision Making (MDM) provided by each physician would be appropriate. Although CMS would allow for time to be a factor, time is not part of the CPT® code description, so this is a moot point.[10]

11. **Question** – Just to clarify, the Protecting Access to Medicare Act of 2014 (PAMA) lab reporting that was for 2019 dates of service (DOS) and was supposed to be submitted in Q1 2022 will now be delayed again?

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[8] Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule, "d. Implementation of Provisions of the Consolidated Appropriations Act", page 65055, available at: https://www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf (November 19, 2021)

[9] Transmittal 11045, Change Request 12427, "New/Modifications to the Place of Service (POS) Codes for Telehealth, " page 2, available at: https://www.cms.gov/files/document/r11045cp.pdf (October 13, 2021)

[10] Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule, "Table 26: Final Definition of Substantive Portion for E/M Visit Code Families", page 65153, available at: https://www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf (November 19, 2021)

Answer – Yes, the Protecting Medicare and American Farmers from Sequester Cuts Act was passed on December 10, 2021. This Act delays the data reporting period for a year and delays the application of the 15% phase-in reduction.[11]

12. **Question** – Can you please speak to the facility component of the billing for a telehealth service in a hospital outpatient department?

    Answer – You may wish to visit the VitalWare® COVID-19 Coding & Billing Resource Center, as there are previous webinars, FAQs and articles available that address the facility component of telehealth services. [12]

    An important point to remember is the pre-existing legislation regarding telehealth services, and that a patient's home is not designated as an originating site. Because of this, CMS has had to be creative with the flexibilities and waivers allowed. The patient's home may be designated as an outpatient department of the hospital, and the amount of paperwork required is dependent upon whether or not your facility will accept the lower reimbursement of a non-excepted provider-based department (PBD). If this is acceptable to you, then little paperwork is required. If you wish to receive the higher excepted PBD reimbursement, then specific information will need to be sent to your CMS Regional Office. [13]

    When the patient's home is designated as a PBD, then the services are not considered telehealth services. The services are reported as if the patient came into the facility. The claim should include condition code DR *Disaster Related* and modifier CR *Catastrophe/disaster related*. However, if the facility staff is merely supportive of the physician, then it is appropriate to report Healthcare Common Procedure Coding System (HCPCS) code Q3014 *Telehealth originating site facility fee*. [14]

[11] Congress.gov, S.610 Protecting Medicare and American Farmers from Sequester Cuts Act, "Sec. 4. Preserving Patient Access To Critical Clinical Lab Services,"
available at: https://www.congress.gov/bill/117th-congress/senate-bill/610/text (December 10, 2021)
[12] VitalWare® Resources Page "COVID-19 (Coronavirus) Coding & Billing Resource Center," available at: https://vitalware.com/resources/covid19
[13] COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing, "G. Hospital Outpatient – Locations off of Hospital Campus," pages 37-38, available at: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf (November 17, 2021)
[14] COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing, "LL. Hospital Billing for Remote Services," pages 165-168, available at: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf (November 17, 2021)