Coding&BillingQuarterly

ATS American Thoracic Society

Editor's Letter

Welcome to the January 2022 issue of the ATS Coding and Billing Quarterly. The CBQ has been providing updates to members and practices since 2007, and we look forward to continuing this tradition to educate you on coding, coverage, billing and regulatory matters going forward.

We have a packed newsletter with information we are excited to share with all of you. The majority is devoted to the Centers for Medicare and Medicaid Services (CMS) final rule for calendar year 2022, both Medicare Physician Fee Schedule (MPFS) and Hospital Outpatient Prospective Payment System (HOPPS) rules. In addition, there are updates on the new CPT Codes for Pulmonary Rehabilitation as well as several ICD-10 diagnosis code changes.

As is usual at this time of year, we have summarized the information from the CMS MPFS and HOPPS both of which go into effect Jan. 1, 2022. There are updates for a myriad of services including, critical care, split-shared visits, telehealth as well as updated teaching physician rules to name just a few. I urge you to read this section carefully and also refer to the CMS fact sheet or final rule for more details.

In addition to the articles, we have specifics on reimbursement by CPT code in the tables provided for both MPFS and HOPPS comparing 2022 to the existing 2021 payments. These may be helpful to share with your practice administrators. Of note, there is a slight decline in the 2022 Medicare conversion factor to $34.60 which will impact all professional reimbursement to a small degree.

Looking forward, we also have a webinar planned together with our CHEST colleagues in January when we will have a panel of discussants who will review the 2022 Final Rule in more detail. And, as always, we welcome your questions at codingquestions@thoracic.org.

Wishing all our members a safe and happy holiday season.

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CMS Issues Medicare Payment Rules for 2022 – Important Policies for ATS Members

In November, the CMS released the final payment rules for calendar year 2022, including the Medicare Physician Fee Schedule Rule and the Hospital Outpatient Prospective Payment rule. Both these rules contain important payment and policy information for ATS members. Below is a brief summary of some of the key policy changes that impact ATS members.

For information about the 2022 reimbursement rates for specific CPT services provided by pulmonary, critical care and sleep medicine physicians, please see the tables on page 7.

2022 Conversion Factor – Congress Intervenes to Avert Significant Cuts

The final Medicare conversion factor for 2022 is $34.60 – a decrease of $0.29 from the 2021 conversion factor. The original 2022 conversion factor was expected to be much lower, in the range of a $1.30 reduction from the 2021 level, but Congress intervened to reduce the level of overall cut. Congress enacted legislation to avert a 4 percent statutory cut from the PAYGO provisions, extended the moratorium on the 2 percent Medicare payment sequester, and reduced the scheduled 3.75 percent Medicare physician payment cut. One of the steps Congress took to avert larger payment cuts was to phase in payment reductions in the conversion factor over time in 2022. So, the $34.60 conversion factor will be reduced incrementally each quarter of 2022.

However, in early December, Congress passed and President Biden signed into law legislation averting much, but not all, of the 2022 cuts to the conversion factor. The law partially mitigates the scheduled 3.75% cut to the Medicare Physician Conversion Factor (CF) and both the Medicare Sequestration (2%) and PAYGO (4%) cuts. Specifically, the legislation would phase in cuts to the Medicare sequester at a rate of 0 percent for the first quarter of 2022, -1 percent for the second quarter of 2022 and return the cut to the full amount of -2 percent beginning in June of 2022 and continuing onward. The law also eliminates 3 percent of the CF cuts, resulting in a -.75 percent cut for the entirety of 2022. Finally, the law would subtract budget scorecard deficits for both the 5-year and 10-year windows from FY 2022 and add them to FY 2023, effectively pushing the implementation of a PAYGO sequester to 2023.

Join ATS/CHEST Webinar on 2022 Medicare Final Rules

The ATS, in collaboration with our colleagues at CHEST, will be holding a joint webinar on Jan. 20, at 4 pm ET to discuss key policy changes in 2022 that impact pulmonary, critical care and sleep medicine providers. The webinar is free to ATS and CHEST members. Please click here to register for the webinar.

New in 2022 HCPCS Level II Modifiers		
HCPCS Modifier	**Short Description**	**Long Description**
FT	Separate unrelated e/m	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]
FS	Split or shared e/m visit	Split [or shared] evaluation and management visit). - Append to claims for split/shared encounters in a *facility* setting.
FQ	Audio-only service	The service was furnished using audio-only communication technology
FR	Two-way a/v dir supervision	The supervising practitioner was present through two-way, audio/video communication technology

Due to the number of interacting policy changes enacted in this law, CMS is still recalculating the final conversion factor for 2022. A revised 2022 conversion factor is expected in the near future. Please note, the tables found on pages (insert pages) use the initial conversion factor published by CMS. These tables will be updated once the recalculated conversion factor is released.

Critical Care Services

- **Concurrent Critical Care** – CMS has changed its policy to note that, when medically necessary, critical care services can be furnished concurrently to the same patient on the same day by more than one practitioner representing more than one specialty, and critical care services can be furnished as split (or shared) visits.

- **Critical and E/M Visits** – CMS clarified that 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, if 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, the visit was medically necessary, and the services are separate and distinct, with no duplicative elements from the critical care service provided later in the day. Practitioners must report modifier -25 with the critical care code on the claim when reporting these critical care services.

Critical Care and Surgical Global Periods

CMS confirmed that critical care services may be paid separately in addition to a procedure with a global surgical period if the critical care is unrelated to the surgical procedure. Preoperative and/or postoperative critical care may be paid in addition to the procedure if the patient is critically ill (meets the definition of critical care) and requires the full attention of the physician, and the critical care is above and beyond and unrelated to the specific anatomic injury or general surgical procedure performed (e.g., trauma, burn cases). CMS created a new modifier FT for use on such claims to identify that the critical care is unrelated to the procedure. The FT should be reported with critical care visits performed during the global surgical period of another, unrelated procedure. However, the wording of the descriptor suggests they could also be reported with other unrelated services, such as an E/M visit, so stay tuned for more clarification from CMS on additional uses for this modifier. If care is fully transferred from the surgeon to an intensivist (and the critical care is unrelated), then modifier -55 must also be reported to indicate the transfer of care. Medical record documentation must support the claims.

Split (or shared) E/M visits

CMS refined policies for split (or shared) E/M visits to better reflect the current practice of medicine, the evolving role of non-physician practitioners (NPPs) as members of the medical team, and to clarify conditions of payment that must be met to bill Medicare for these services. In the CY 2022 PFS final rule, CMS established 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.

- By 2023, the substantive portion of the visit will be defined as more than half of the total time spent. For 2022, the substantive portion can be history, physical exam, medical decision-making, or more than half of the total time (except for critical care, which can only be more than half of the total time).

- Split (or shared) visits can be reported for new as well as established patients, and initial and subsequent visits, as well as prolonged services.

- A 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. The individual providing the substantive portion must sign and date the medical record.

- Codifying these revised policies in a new regulation at 42 CFR 415.140.

Teaching Physician Services

The AMA CPT office/outpatient E/M visit coding framework that CMS finalized for CY 2021 provides that practitioners can select the office/outpatient E/M visit level to bill based either on either total time personally spent by the reporting practitioner or medical decision making (MDM). Under existing regulations, if a resident participates in a service furnished in a teaching setting, a teaching physician can bill for the service only if they are present for the key or critical portion of the service. Under the so-called "primary care exception," in certain teaching hospital primary care centers,

the teaching physician can bill for certain services furnished independently by a resident without the physical presence of a teaching physician, but with the teaching physician's review.

- CMS finalized and clarified that when time, not MDM, is used to select the office/outpatient E/M visit level, only the time spent by the teaching physician in qualifying activities, including time that the teaching physician was present with the resident performing those activities, can be included for purposes of visit level selection. This does not apply when MDM is used. Under the primary care exception, time cannot be used to select visit level. Only MDM may be used to select the E/M visit level, to guard against the possibility of inappropriate coding that reflects residents' inefficiencies rather than a measure of the total medically- necessary time required to furnish the E/M services.

Telehealth Services under the PFS

As CMS continues to evaluate the inclusion of telehealth services that were temporarily added to the Medicare telehealth services list during the COVID-19 PHE, CMS finalized that certain services added to the Medicare telehealth services list will remain on the list through Dec. 31, 2023, allowing additional time for CMS to evaluate whether the services should be permanently added to the Medicare telehealth services list.

- CMS finalized that the agency will extend, through the end of CY 2023, the inclusion of certain services on the Medicare telehealth services list that would otherwise have been removed from the list as of Dec. 31, 2021, or the latter end of the COVID-19 PHE, whichever is later. CMS also extended inclusion of certain cardiac and intensive cardiac rehabilitation codes through the end of CY 2023. This will allow more time for stakeholders to gather data to submit to CMS in support of permanently adding services(s) to the Medicare telehealth services list. This will also reduce uncertainty regarding the timing of our processes with regard to the end of the PHE. Additionally, CMS is adopting coding and payment for a longer virtual check-in service on a permanent basis.

- CMS included the pulmonary rehabilitation HCPCS Level II code **G0424** in the file that lists all the services and codes covered for telehealth with timeframes. The ATS and CHEST have been in contact with CMS as the two new CPT codes that will replace the G code were not listed. We believe this is an oversight and have informed CMS to remove **G0424** effective Jan. 1, 2022, and replace with the two new CPT codes discussed later in this CBQ CPTs **94625** and **94626**.

- Section 123 of the Consolidated Appropriations Act of 2021 removed the geographic restrictions and added the home of the beneficiary as a permissible originating site for telehealth services furnished for the purposes of diagnosis, evaluation, or treatment of a mental health disorder. Section 123 requires that, for these services, there must be an in-person, non-telehealth service with the physician or practitioner within six months prior to the initial telehealth service and requires the Secretary to establish a frequency for subsequent in-person visits. CMS is implementing these statutory amendments, and finalizing that an in-person, non-telehealth visit must be furnished at least every 12 months, that exceptions to the in-person visit requirement may be made based on beneficiary circumstances (with the reason documented in the patient's medical record), and that more frequent visits are also allowed under the policy, as driven by clinical needs on a case-by-case basis.

- CMS is amending the current definition of interactive telecommunications system for telehealth services which is defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner to include audio-only communications technology when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients in their homes under certain circumstances.

- CMS is limiting the use of an audio-only interactive telecommunications system to 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, or does not consent to, the use of two-way, audio/video technology. CMS also finalized a requirement for the use of a new modifier FQ for services furnished using audio-only communications, which would serve to verify that the practitioner had the capability to provide two-way, audio/video technology, but instead, used audio-only technology due to beneficiary choice or limitations. CMS is also clarifying that mental health services can include services for treatment of substance use disorders (SUDs).

Modifier 93 – Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System:

CMS has created a new coding modifier to report telehealth services that use audio-only technology. The modifier—93—should be used to report real-time interaction between a physician or other qualified health care professional and a patient who is located away at a

distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of 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 when rendered via a face-to-face interaction.

Vaccine Administration Services

Administration of Preventive Vaccines

- Effective Jan. 1, 2022, CMS will pay $30 per dose for the administration of the influenza, pneumococcal and hepatitis B virus vaccines. In addition, CMS will maintain the current payment rate of $40 per dose for the administration of the COVID-19 vaccines through the end of the calendar year in which the ongoing PHE ends. Effective Jan. 1 of the year following the year in which the PHE ends, the payment rate for COVID-19 vaccine administration will be set at a rate to align with the payment rate for the administration of other Part B preventive vaccines.

In-Home Administration of COVID-19 Vaccines

- CMS will continue the additional payment of $35.50 for COVID-19 vaccine administration in the home under certain circumstances through the end of the calendar year in which the PHE ends.

COVID-19 Monoclonal Antibody Products

- CMS will continue to pay for COVID-19 monoclonal antibodies under the Medicare Part B vaccine benefit through the end of the calendar year in which the PHE ends. During this interim time, CMS will maintain the $450 payment rate for administering a COVID-19 monoclonal antibody in a health care setting, as well as the payment rate of $750 for administering a COVID-19 monoclonal antibody therapy in the home.

- Effective Jan. 1 of the year following the year in which the PHE ends, CMS will pay physicians and other suppliers for COVID-19 monoclonal antibody products as biological products paid under section 1847A of the Act; health care providers and practitioners will be paid under the applicable payment system, and using the appropriate coding and payment rates, for administering COVID-19 monoclonal antibodies similar to the way they are paid for administering other complex biological products.

Pulmonary Rehabilitation

Pulmonary Rehabilitation and Long COVID - CMS has expanded coverage of outpatient pulmonary rehabilitation services, paid under Medicare Part B, to beneficiaries who have had confirmed or suspected COVID-19 and experience persistent symptoms that include respiratory dysfunction for at least four weeks.

New CPT Codes for Pulmonary Rehab

CMS accepted for payment two new CPT codes to report pulmonary rehabilitation

- CPT **94625** - Physician or other qualified healthcare professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session))

- CPT **94626** - (Physician or other qualified healthcare professional services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session) (Do not report **94625**, **94626** in conjunction with **94760**, **94761**))

These new CPT codes replace the temporary G code – **G0424**, which will be retired on Dec. 31, 2021. Starting Jan. 1, 2022, physicians should start using the new CPT Codes **94625** and **94626** to report pulmonary rehabilitation services. While ATS is pleased CMS has adopted these new CPT codes, we are concerned and disappointed that CMS rejected work RVUs recommended by the AMA RUC Committee and instead adopted lower values. Despite the lower values adopted by CMS, these new CPT codes will raise the reimbursement rate above the current **G0424** payment rates.

Clinical Labor Pricing Update

For the first time in several years, CMS has updated the clinical labor wage prices used to determine Medicare reimbursements rates. The new clinical wage data is expected to increase reimbursement for specialties that use significant clinical labor inputs, including internal medicine. To avert large payment swings, CMS will phase in the new clinical wage rates over four years. Pulmonary providers are expected to see a 1 percent increase when the new clinical wage data is fully phased in.

ICD-10 Updates

The Center for Disease Control and Prevention updates ICD-10 diagnosis codes annually and these changes as we know take effect every Oct. 1. There are several changes and updates which are important for the ATS Membership to note.

Post COVID -19

There is a new code which has been highly anticipated related to COVID-19. The new code is ***U09.9*** *Post COVID-19 condition, unspecified*. This is used to document post-acute sequelae of COVID-19, or "long COVID" conditions, after the active illness has resolved. The condition(s) related to COVID-19 should be coded first, for example, pulmonary fibrosis (**J84.10**), chronic hypoxemic respiratory failure (**J96.11**), dyspnea, unspecified (**R06.0**) and others. **U09.9** should not be used with an active (current) COVID-19 infection.

Cough

Cough Diagnosis codes have also been expanded and include the following. It is important to remember to code the most specific diagnosis applicable.

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

Vaping-related disorders

ICD-10 codes for vaping-related disorders have also been updated and have been in effect since April 1, 2021. ***U07.0*** *Vaping-related disorder* should be coded as the primary diagnosis. Additional codes for pneumonitis (**J68.0**) or acute respiratory failure (**J96.0**-) or acute respiratory distress syndrome (**J80**) may also be used with this code. Associated respiratory signs and symptoms however (cough, shortness of breath) are not coded separately.

Question and Answers: How to Code for Time Spent with Patients on PAP Recall

Question: My patients with sleep apnea are calling for information about what to do with their PAP machine given the Phillips Respironics recall. How can I counsel them and be reimbursed for my time?

Answer: There is no one answer to this question. Counseling patients takes time and, in this instance, needs to be individualized to every patient asking for assistance. Many practices are including this discussion in an established E/M visit. Remember you may consider using time to select your level of service (**99212**-**99215**). If you are not able to see the patient in the office, you are still able to use the Telephone E/M service codes **99441**-**99443** which are also time-based codes with a minimum of five minutes. Currently, and for 2022, during the PHE, these continue to be reimbursed at a higher level and comparable to **99212**, **99213** and **99214**. As per the final MPFS ruling, they remain on the temporary telehealth services list through the end of the PHE only.

99441: Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian 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; 5-10 minutes of medical discussion. **99442:** 11-20 min. **99443:** 21-30 min.