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BROAD RIVER REHAB

CY2022 Medicare Physician Fee Schedule Summary

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Overview

CY2022 Medicare Physician Fee Schedule Summary

On November 2, 2021, the Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2022 Medicare Physician Fee Schedule (MPFS) final rule. The MPFS applies to services rendered in physical therapy, occupational therapy and speech language pathology services provided in all Medicare B outpatient therapy settings except those provided in critical access hospitals.

Agenda

Agenda will cover:

- Calendar Year (CY) 2022 Conversion Factor
- KX and Medical Record Threshold for CY 2022
- Assistant Payment Reduction
- Telehealth Therapy Codes
- Supervision Requirements of an Assistants
- Remote Therapeutic Monitoring Codes

MPFS History and Background

- Since 1992, Medicare payment has been made under the PFS for the services of physicians and other billing professionals.
- Physicians' services paid under the PFS are furnished in a variety of settings, including physician offices, hospitals, ambulatory surgical centers (ASCs), skilled nursing facilities and other post-acute care settings, hospices, outpatient dialysis facilities, clinical laboratories, and beneficiaries' homes.
- Payment is also made to several types of suppliers for technical services, generally in settings for which no institutional payment is made.
- For many diagnostic tests and a limited number of other services under the PFS, separate payment may be made for the professional and technical components of services. The technical component is frequently billed by suppliers, like independent diagnostic testing facilities and radiation treatment centers, while the professional component is billed by the physician or practitioner.

MPFS History and Background

- The Medicare Physician Fee Schedule (MPFS) uses a resource-based relative value system (RBRVS) that assigns a relative value to current procedural terminology (CPT) codes that are developed and copyrighted by the American Medical Association (AMA) with input from representatives of health care professionals.
- Payments are based on the relative resources typically used to furnish the service. The relative weighting factor (relative value unit or RVU) is derived from a resource-based relative value scale.
- The components of the RBRVS for each procedure are:
  - (a) **professional component** (i.e., work as expressed in the amount of time, technical skill, physical effort, stress, and judgment for the procedure required of physicians and certain other practitioners);
  - (b) **technical component** (i.e., the practice expense expressed in overhead costs such as assistant's time, equipment, supplies); and
  - (c) **professional liability component.**
- These RVUs become payment rates through the application of a fixed-dollar conversion factor, i.e. the relative value unit (RVU) for each code determined by CMS, is multiplied by the annual conversion factor (a dollar amount) to yield the national average fee.
- Rates are adjusted according to geographic indices based on provider locality. Geographic adjustments (geographic practice cost index) are also applied to the total RVUs to account for variation in practice costs by geographic area.

MPFS History and Background

- Several factors need to be taken into account when calculating the final payment for Medicare Part B services.
  - Standard 20% Co-Pay
  - Non-Participating Status & Limiting Charge
  - Facility & Non-Facility Rates
  - Geographic Adjustments
  - Multiple Procedure Payment Reductions (MPPR)

Conversion Factor

- Payment rates are calculated to include an overall payment update specified by statute.
- The PFS conversion factor reflects the statutory update of zero percent and the adjustment necessary to account for changes in relative value units and expenditures that would result from CMS' finalized policies.
- With the budget neutrality adjustment to account for changes in RVUs (required by law), and expiration of the 3.75 percent temporary CY 2021 payment increase provided by the Consolidated Appropriations Act, 2021 (CAA), the CY 2022 PFS conversion factor is $33.59, a decrease of $1.30 from the CY 2021 PFS conversion factor of $34.89. This is a 3.71% reduction in payment compared to CY 2021.
- Keep in mind other payment reductions slated for CY 2022
  - 15 reduction to OTA and PTA services
  - Phase in of sequestration starting after March 2022 with a 1% cut through the end of June, after which the cuts would return to 2%.

Conversion Factor Example

	CPT	Description	Profrssional Component (Work RVU	Technical Component (PE RVU)	Professional Liability (MP RVU)	Conversion Factor
2021	97110	Therapeutic exercises	0.45	0.4	0.02	34.8931
		Component Price	15.701895	13.95724	0.697862	XXXXX
		Total Unadjusted PFS	$ 30.36			
		*.80	$ 24.29			
2022	97110	Therapeutic exercises	0.45	0.4	0.02	33.5983
		Component Price	15.119235	13.43932	0.671966	XXXXX
		Total Unadjusted PFS	$ 29.23			
		*.80	$ 23.38			
		2022 Adjustments				
		Conversion Factor	$ (0.90)			
		OTA (CQ) / PTA (CO)	$ (3.51)			
		MPPR	$ (6.72)			
		Sequestration (July 2022)	$ (0.45)			

Conversion Factor Example Update!

	CPT	Description	Profrssional Component (Work RVU	Technical Component (PE RVU)	Professional Liability (MP RVU)	Conversion Factor
2021	97110	Therapeutic exercises	0.45	0.4	0.02	34.8931
		Component Price	15.701895	13.95724	0.697862	XXXXX
		Total Unadjusted PFS	$ 30.36			
		*.80	$ 24.29			
2022	97110	Therapeutic exercises	0.45	0.4	0.02	34.6331
		Component Price	15.584895	13.85324	0.692662	XXXXX
		Total Unadjusted PFS	$ 30.13			
		*.80	$ 24.10			
		2022 Adjustments				
		Conversion Factor	$ (0.18)			
		OTA (CQ) / PTA (CO)	$ (3.62)			
		MPPR	$ (6.93)			
		Sequestration (July 2022)	$ (0.46)			

KX MODIFIER

- The BBA of 2018, preserves the therapy cap amounts as thresholds above which claims must include the KX modifier as a confirmation that services are medically necessary as justified by appropriate documentation in the medical record.
- Just as with the incurred expenses for the therapy cap amounts, there is one amount for PT and SLP services combined and a separate amount for OT services.
- This amount is indexed annually by the Medicare Economic Index (MEI). Claims for services over the KX modifier threshold amounts without the KX modifier are denied. For CY 2022 this KX modifier threshold amount is:
  - $2,150 for PT and SLP services combined, and
  - $2,150 for OT services.
- Along with this KX modifier threshold, the BBA of 2018 retains the targeted medical review (MR) process at a threshold amount of $3,000. For CY 2021 (and each calendar year until 2028 at which time it is indexed annually by the MEI), the MR threshold is $3,000 for PT and SLP services and $3,000 for OT services.

Assistant Payment Reduction- History

The Centers for Medicare & Medicaid Services states they are implementing the third and final part of the amendments made by section 53107 of the Bipartisan Budget Act (BBA of 2018) (Pub. L. 115-123, February 9, 2018).

The BBA of 2018 added a new section 1834(v) of the Act. Section 1834(v)(1) of the Act requires CMS to make a reduced payment for physical therapy and occupational therapy services furnished in whole or in part by physical therapist assistants (PTAs) and occupational therapy assistants (OTAs) at 85% of the otherwise applicable Part B payment for the service, effective January 1, 2022.

This reduction is applicable when more than 10% of the service for timed codes is provided by the physical therapy assistant or occupational therapy assistant. Furthermore, the reduction will be applied only to the 80% Medicare allowable portion and not applied to the 20% patient co-payment. Based on the reduction calculation (.20+(0.80*0.85), the reduction would equal 88% overall.

De Minimis Standard

They offered two different ways to compute this:

1. The simple method: Divide the total of the PTA/OTA + PT/OT minutes by 10, round to the nearest integer then add one minute to get the number of minutes needed to exceed the de minimis standard at and above which the CQ/CO modifier applies.
2. The percentage method: Divide the PTA/OTA minutes by the sum of the PTA/ OTA and therapist minutes and then multiply this number by 100 to calculate the percentage of the service that involves the PTA/OTA, if this number is greater than 10% the CQ/CO modifier applies.

De Minimis Standard: When it does & doesn't apply

- Portions of a service furnished by the PTA/OTA independent of the physical therapist/ occupational therapist, as applicable, that do not exceed 10% of the total service (or 15-minute unit of a service) are not considered to be furnished in whole or in part by a PTA/OTA, so are not subject to the payment reduction;

- Portions of a service that exceed 10% of the total service (or 15-minute unit of a service) when furnished by the PTA/OTA independent of the therapist must be reported with the CQ/CO modifier, alongside the corresponding GP/GO therapy modifier; are considered to be furnished in whole or in part by a PTA/OTA, and are subject to the payment reduction; and

- Portions of a service provided by the PTA/OTA together with the physical therapist/occupational therapist are considered for this purpose to be services provided by the therapist.

Case Study 1

Example #1 PTA – 23 minutes 97110 PT – 13 minutes 97110 PT – 30 minutes 97140 Total = 66 minutes – qualifies for billing four units (53 minutes through 67 minutes).

Billing Explanation:

- First Step: Assign units to services based on those that have at least 15 minutes or codes that were provided in multiples of 15 minutes. For 97110, assign one unit of 97110 with the CQ modifier because the PTA furnished at least 15 minutes of 97110 (therapeutic exercise). Then, assign two units of 97140 without the modifier, because the PT furnished the full 30 minutes of manual therapy.

- Second Step: Determine if the PTA furnished more than 10% of the remaining minutes of the 97110 service. To do this via the simple method: add the PTA's eight remaining minutes to the PT's 13 minutes for a total time of 21 minutes. Divide the total by 10 to get 2.1 minutes and round to the nearest integer, which is two minutes (the 10% time standard for this service). Add one minute to find the threshold number of minutes that would exceed the de minimis standard, which in this example is three minutes. Using the percentage method, divide the PTA's remaining eight minutes by the total 21 minutes of the service (8 PTA + 13 PT = 21 minutes) to get 0.38, then multiply the result X 100 = 38%.

- Final Step: Because eight minutes meets or exceeds the three-minute threshold, and 38% is greater than 10%, a second unit of 97110 is billed with the CQ modifier.

Case Study 2

Example #2 PTA – 19 minutes of 97110 PT – 10 minutes of 97110 Total = 29 minutes – two units of 97110 can be billed (23 minutes through 37 minutes).

Billing Explanation:

- First Step: Bill one unit of 97110 with the CQ modifier because a full 15 minutes was provided by the PTA, with four minutes remaining.

- Second Step: Determine if the PTA's four remaining minutes exceed the 10% de minimis standard. Simple method: Add together the PTA's four remaining minutes and the 10 PT minutes to get the total time of 14 minutes and divide by 10 to get 1.4 minutes and round to the nearest integer = one minute to get the 10% de minimis standard. Then add one minute to get a threshold minimum of two minutes for PTA time. If the PTA minutes are at or above the threshold, the CQ modifier applies. Percentage method: Divide the PTA's four remaining minutes by the total time of 14 to get 0.29 then multiply by 100 = 29%. If the resulting percentage is greater than 10%, the PTA modifier applies.

- Final Step: Bill another unit of 97110 with the CQ modifier since four minutes is greater than the two-minute threshold minimum and 29% is greater than 10%

Telehealth Allowances

The Public Health Emergency (PHE) has given therapy access to telehealth **temporarily**

- CMS is including additional therapy codes until the end of CY2023.
- CMS unfortunately did not add requested therapy codes for permanent use.
- CMS has encouraged stakeholders to provide more data as able.
- This is an area for continued advocacy!

Telehealth and CMS Updates

Regulatory Background

- In response to the spread of COVID-19, the Centers for Medicare & Medicaid Services (CMS) now allows audiologists and speech-language pathologists (SLPs) to provide telehealth services to Medicare Part B (outpatient) beneficiaries, retroactive to March 1, 2020, and for the duration of the public health emergency. CMS announced this expansion in an April 30, 2020, press release and its COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers [PDF].

CMS Clarifications May 25th 2020

Question: Can outpatient therapy services that are furnished via telehealth and separately paid under Part B be reported on an institutional claim (e.g., UB-04) during the COVID-19 PHE?

Answer: Yes, outpatient therapy services that are furnished via telehealth, and are separately paid and not included as part of a bundled institutional payment, can be reported on institutional claims with the “-95” modifier applied to the service line.

CMS Clarifications May 25th 2020

Question: Can therapy services furnished using telecommunications technology be paid separately in a Medicare Part A skilled nursing facility (SNF) stay?

Answer: Provision of therapy services using telecommunications technology (consistent with applicable state scope of practice laws) does not change rules regarding SNF consolidated billing or bundling. For example, Medicare payment for therapy services is bundled into the SNF Prospective Payment System (PPS) rate during a SNF covered Part A stay, regardless of whether or not they are furnished using telecommunications technology. Therapy services furnished to a SNF resident, whether in person or as telehealth services, during a non-covered SNF stay (Part A benefits exhausted, SNF level of care requirement not met, etc.) must be billed to Part B by the SNF itself using bill type 22X, regardless of whether or not they are furnished using telecommunications technology. New: 5/27/20

97110	Therapeutic exercises	Temporary Addition for the PHE for the COVID-19 Pandemic
97112	Neuromuscular reeducation	Temporary Addition for the PHE for the COVID-19 Pandemic
97116	Gait training therapy	Temporary Addition for the PHE for the COVID-19 Pandemic
97150	Group therapeutic procedures	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
97151	Bhv id assmt by phys/qhp	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
97152	Bhv id suprt assmt by 1 tech	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
97153	Adaptive behavior tx by tech	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
97154	Grp adapt bhv tx by tech	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
97155	Adapt behavior tx phys/qhp	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
97156	Fam adapt bhv tx gdn phy/qhp	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
97157	Mult fam adapt bhv tx gdn	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
97158	Grp adapt bhv tx by phy/qhp	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
97161	Pt eval low complex 20 min	Temporary Addition for the PHE for the COVID-19 Pandemic
97162	Pt eval mod complex 30 min	Temporary Addition for the PHE for the COVID-19 Pandemic
97163	Pt eval high complex 45 min	Temporary Addition for the PHE for the COVID-19 Pandemic
97164	Pt re-eval est plan care	Temporary Addition for the PHE for the COVID-19 Pandemic
97165	Ot eval low complex 30 min	Temporary Addition for the PHE for the COVID-19 Pandemic
97166	Ot eval mod complex 45 min	Temporary Addition for the PHE for the COVID-19 Pandemic
97167	Ot eval high complex 60 min	Temporary Addition for the PHE for the COVID-19 Pandemic
97168	Ot re-eval est plan care	Temporary Addition for the PHE for the COVID-19 Pandemic
97530	Therapeutic activities	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
97535	Self care mngment training	Temporary Addition for the PHE for the COVID-19 Pandemic
97542	Wheelchair mngment training	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
97750	Physical performance test	Temporary Addition for the PHE for the COVID-19 Pandemic
97755	Assistive technology assess	Temporary Addition for the PHE for the COVID-19 Pandemic
97760	Orthotic mgmt&traing 1st enc	Temporary Addition for the PHE for the COVID-19 Pandemic
97761	Prosthetic traing 1st enc	Temporary Addition for the PHE for the COVID-19 Pandemic

92507	Speech/hearing therapy	Temporary Addition for the PHE for the COVID-19 Pandemic
92508	Speech/hearing therapy	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
92521	Evaluation of speech fluency	Temporary Addition for the PHE for the COVID-19 Pandemic
92522	Evaluate speech production	Temporary Addition for the PHE for the COVID-19 Pandemic
92523	Speech sound lang comprehen	Temporary Addition for the PHE for the COVID-19 Pandemic
92524	Behavral qualit analys voice	Temporary Addition for the PHE for the COVID-19 Pandemic

What is Remote Therapeutic Monitoring RTM?

Remote Therapeutic Monitoring (RTM) is a family of five codes created by the CPT Editorial Panel in October 2020 and valued by the RUC at its January 2021 meeting — Remote Therapeutic Monitoring/Treatment Management CPT codes 98975, 98976, 98977, 98980 and 98981.

The RTM family includes three PE-only codes and two codes that include professional work — 98980 and 98981

History and Background

CMS notes that they questioned in the proposed rule whether the RTM codes as constructed could be used by therapists because the Medicare benefit does not include services provided incident to the services of a therapist.

Furthermore, they stated they viewed the clinical labor described in the RTM codes as being services incident to the billing practitioner's professional services. In the proposed rule they focused on therapists as providers of RTM services because we heard from stakeholders that the codes were developed in response to the needs of physical therapists.

They go on to note that speech-language pathologists, clinical social workers, registered dietitians, nutrition professionals and CRNAs also have Medicare benefits that do not include incident to services.

Therefore, they state, "*Despite our concerns about the construction of the codes, we believe the services described by the codes are important to beneficiaries*.

Thus, we are finalizing a policy that permits therapists and other qualified healthcare professionals to bill the RTM codes as described."

What are the CPT codes?

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

KEY Coding Rules

- Cumulative time spent for data review and patient/caregiver interaction is totaled for a calendar month (not each 30 days).
- The base code (98980) and add-on code (98981) are reported together on the claim based on total time following the end of the calendar month.
- We do not report these codes if activities total less than 20 minutes in a calendar month.
- Codes 98980, 98981 require at least **one interactive communication** with the patient or caregiver. The interactive communication contributes to the total time, but it does not need to represent the entire cumulative reported time of the treatment management service.
- Codes 98976 and 98977 represent the cost of supplies for specific types of monitoring systems.

Remote Therapeutic Monitoring (RTM)

98975, Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment. *(new code)*

98980, Remote therapeutic monitoring treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes. *(new code)*

98981, each additional 20 minutes (listed separately in addition to code for primary procedure). *(new code)*

Remote Therapeutic Monitoring (RTM)

Cumulative time spent for data review and patient/caregiver interaction is totaled for a **calendar month** (not each 30 days).

- The base code (**98980**) and add-on code (**98981**) are reported together on the claim based on total time following the end of the calendar month.
- Do not report these codes if activities total less than 20 minutes in a calendar month.
- Time related to any other services—such as a hearing evaluation or a speech-language session—must not be included in these codes

RTM versus RPM

- These codes have been created to be analogous to **remote physiologic monitoring codes** 99453, 99454, 99457, and 99458.
- Although, the main distinction between these code families is the data parameters that are being reviewed.
- The current remote physiologic codes are used to monitor physiologic parameters (eg, weight, blood pressure, pulse oximetry, respiratory flow rate, etc).
- The remote therapeutic monitoring codes (98975-98981) are used to monitor system status and response to prescribed home/self-management programs (eg, musculoskeletal system status, respiratory system status, therapy adherence, therapy response) representing the review and monitoring of data related to physical and functional performance, signs, symptoms, and functions of a therapeutic response.

Case Study

An asthmatic patient is prescribed a rescue inhaler equipped with an FDA-approved medical device that monitors when the patient uses the inhaler, how many times during the day the patient uses the inhaler, how many puffs/doses the patient uses each time, and the pollen count and environmental factors that exist in the patient's location at that time.

This is non-physiologic data. The data is then used by the treating practitioner to assess the patient's therapeutic response and adherence to the asthma treatment plan. This can enable the practitioner to better determine how well the patient is responding to the particular medication, what social or environmental factors affect the patient's respiratory system status, and what changes could be made to improve the patient's health.

Case Study

A 65-year-old male presents to the physician's or other QHP's office with exacerbation of a chronic condition. Following the visit, the physician initiates a remote therapeutic monitoring program to enable data collection and monitoring to support the therapeutic management of his condition.

Case Study

Clinical staff walks the patient through the set-up of the therapeutic monitoring technology. Educate the patient regarding how to use the technology and related daily tasks. For respiratory therapy monitoring, introduce the patient to the device and the mobile app. For musculoskeletal therapy monitoring, educate the patient on setting up the device, reviewing the 3D motion capture technology, and reviewing the specific exercises as prescribed by the physician or other QHP. Give the patient the opportunity to ask questions.

Case Study

A 66-year-old female, who has limited mobility caused by osteoarthritis of her knees, is enrolled in a remote therapeutic monitoring program to enable data collection and monitoring to support the therapeutic management of her musculoskeletal condition

CMS Final Thoughts

Our decision to finalize the proposed RTM codes and our proposed valuations for the services strikes a balance between supporting beneficiary access to care that these services describe and allowing for non-E/M billing practitioners to furnish and bill for these services."

Moreover, they allow opportunity for engagement and further conversation, noting, *"We acknowledge the major themes that emerged in the comments from stakeholders about broadening the base of practitioners that could furnish the RTM and RPM services, as well as maximizing the efficiency with which these services could be furnished."*

QUESTIONS?

Find Out More

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