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### Billing

## CMS designs drastic changes to its split/shared policy

Take careful notice of CMS' proposed split/shared visit policy if your practice's physicians and qualified health care professionals (QHP) regularly team up for hospital visits. CMS' plans for split/shared visits in 2022 bear little resemblance to the original policy.

In fact, the proposed plan is modeled on the split/shared policy for time-based office visits, with a few extra twists, according to a *Part B News* analysis of the proposed 2022 Medicare physician fee schedule released July 13 ([PBN 6/8/20](#)).

CMS recently withdrew its guidelines for split/shared visits from Internet-only Manual 100-04, Chapter 12, §30.6, and stated it would create a new policy through the rule-making process ([PBN 6/7/21](#)). Under CMS' proposed split/shared policy, two things would stay the same:

1. The visit must be performed by a physician and a QHP who are from the same group and who can bill Medicare directly for E/M services.
2. The service may be performed in the hospital setting — i.e., observation, inpatient, outpatient, emergency department.

But notable differences include CMS' plan to lift the restrictions on billing split/shared visits for nursing facility visits and critical care services.

Perhaps the most striking difference is that the visits could not be coded based on medical decision-making. Any non-critical care split/shared visit would be coded based on the CPT manual's guidelines for office E/M visits, using time

## Capture lucrative AWWs and IPPEs

Annual wellness visits (AWV) and initial preventive physical examinations (IPPE or "Welcome to Medicare" visits) are high-paying services available to every Medicare beneficiary, yet most don't elect to take advantage of them. Discover an easy-to-implement guide during the July 29 webinar **Annual Wellness and Welcome to Medicare Visits: How to Get Them Done and Get Them Paid**. Learn more: [www.codingbooks.com/YMPDA072921](http://www.codingbooks.com/YMPDA072921).

as the controlling factor. In that case, the physician and the QHP would add up the time they spent on any of the nine covered activities, such as preparing to see the patient, performing an appropriate exam or counseling the patient or family members, and select a code based on the total time. (See the chart, p. 3, for a comparison of the original and proposed policy.)

CMS plans to add its own touches to the E/M office visit guidelines by requiring practices to bill under the name and national provider identifier of the practitioner who performs more than 50% of the visit. Here's an example from the proposed rule:

“If the [QHP] first spent 10 minutes with the patient and the physician then spent another 15 minutes, their individual time spent would be summed to equal a total of 25 minutes. The physician would bill for this visit since they spent more than half of the total time (15 of 25 total minutes).” If the QHP performed the majority of the visit, it would have to be billed by the QHP.

CMS also indicates that a face-to-face visit would not be required to count time for a facility-based split/shared visit, and therefore bill the visit. For example, when outlining the activities that count toward a visit, CMS states that time should be calculated based on the performance of the specific activities “regardless of whether or not they involve direct patient contact.”

Does this mean one practitioner could spend time on services that don't require a patient visit, such as ordering tests, consulting with other practitioners and coordinating care, while the other practitioner performs the in-person portions, such as the physical exam? CMS doesn't say. Stay tuned to *Part B News*, which is submitting a comment requesting clarification.

CMS will maintain the requirement to combine overlapping time introduced by the new office E/M visits, but “overlapping time could only be counted once for purposes of establishing total time and who provided the substantive portion of the visit,” CMS states in the proposed rule.

For example, if the physician and QHP each spend 10 minutes with the patient and meet for another five minutes to discuss the plan of care, the five minutes could be counted toward the physician's visit to give her 15 minutes — and the full 25 minutes could be billed by the physician.

CMS did not specify that, for the purposes of selecting a code, practices should use the codes' typical times, or what to do if both providers perform the same amount of time. *Part B News* will submit a comment requesting clarity on this matter.

Other proposed revisions to the policy include:

- A new modifier: “There will be a modifier needed” to report split/shared facility visits, observes Melissa Billman, director of billing services, CE Medical Group, Murray, Utah. The modifier will allow Medicare to track these services.

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- New medical record requirements: “Medical records would have to list and note the two providers that treated the patient,” Billman says. Practices should note that the billing practitioner “should be the one signing the records,” Billman says.

CMS also seeks comment on a variety of related topics, including how it should define a group and whether emergency department services need special guidelines. “Additionally, we are seeking public comment on whether there should be a different listing of qualifying activities for purposes of determining the total time and substantive portion of split (or shared) emergency department visits, since those visits also have a unique construct,” the agency states.

### Early reaction hints at pushback

CMS will encounter resistance to its proposal if the early reaction of some industry experts is any guide.

“I don’t understand the need to do this,” says Maxine Lewis, CMM, CPC, CPC-I, CPMA, CCS-P, president, Medical Coding Reimbursement Management, Cincinnati. Lewis predicts the modifier requirement will cause confusion and frequently be forgotten.

“I can say it’s good that you can bill based on time, *but* — and you have to get through all the ‘buts,’” Lewis says.

The proposed plan “portrays a revisionist history of how shared visits were covered,” says David Glaser, shareholder, Fredrikson & Byron’s Health Law Group, Minneapolis. Glaser did not mince words in his critique of the proposal, which he described as “terrible” ([PBN blog 7/16/21](#)).

Compare and contrast: CMS’ original requirements for split/shared visits and its proposed update		
Requirement	Split/shared original	Split/shared proposed
Who performs the visit?	Physicians and QHPs from the same group who can bill Medicare for their services.	Physicians and QHPs from the same group who can bill Medicare for their services.
Where is the visit performed?	The hospital setting (inpatient, outpatient, observation, emergency department). (CMS 100-04, Chapter 12, §30.6.12(E)(2) – withdrawn)	Any institutional setting where incident-to billing is not allowed.
Can critical care services be billed?	No. (CMS 100-04, Chapter 12, §§30.12(E)(2) and 30.6.13(H) – withdrawn)	Yes.
Permitted for initial visits in the hospital setting?	Unclear.	Yes.
Permitted for new patient visits in settings such a nursing facility?	N/A – Split/shared was not permitted.	Yes.
How is the visit coded?	Based on combined medical decision-making unless counseling/coordination of care dominate the service.	Based on combined time spent on listed activities.
When can the practice bill the visit under the physician’s name and national provider identifier?	When the “physician provides any face-to-face portion of the E/M encounter with the patient.” (CMS IOM 100-04, Chapter 12, §30.6.1(B) – withdrawn)  AND  “... the physician and a qualified NPP each personally perform a substantive portion of an E/M visit face-to-face ... a substantive portion of an E/M visit involves all or some portion of the ... key components of an E/M service.” (CMS 100-04, Chapter 12, §30.6.13(H) – withdrawn)	The physician performs more than half the total time of the visit.
Can prolonged services be billed?	No.	Yes, under certain circumstances.
Must the billing practitioner must sign the chart for the visit?	No.	Yes.
Is a modifier required to bill the service?	No.	Yes.

Source: Part B News analysis of the proposed 2022 Medicare physician fee schedule and previous CMS billing policy

“Under the manual language defining shared visits, if the physician walked in and said, ‘How are you doing?’ to the patient, thereby obtaining history elements, it was appropriate to bill a shared visit. That is totally consistent with the way the incident to rules work; there is no ‘minimum threshold’ the supervising physician must meet to bill,” Glaser says.

“Time is a bad way to determine how important someone’s work is,” Glaser says. “The proposal sets up a situation where you might have a physician have a 20-minute conversation with a [nurse practitioner (NP)], but if the NP spends an additional one minute with the patient, the physician isn’t allowed to bill at all for the service the physician provided, and the total time of 41 minutes between the two professionals is compensated as 21 minutes of NP time. That is ill-conceived.”

Glaser also dismissed the signature requirement as a “purely bureaucratic” requirement. “A signature proves absolutely nothing,” Glaser says. The note simply needs to clearly indicate who performed the service. — *Julia Kyles, CPC* ([jkyles@decisionhealth.com](mailto:jkyles@decisionhealth.com)) ■

### Physician payments

## CMS proposes a 4% rate cut; opposition gets vocal

It didn’t take long for critics to lambast the proposed 3.75% reduction to the conversion factor after CMS announced its rate-setting plans July 13.

As proposed, the conversion factor would fall to \$33.58 in 2022, down from a rate of \$34.89 in 2021. A key component of Medicare physician fees, the conversion factor sets the unit value of each of a code’s relative value units; a cut to the conversion factor ratchets down physician fees across all specialties.

In the immediate aftermath of the rule’s release, industry groups that represent medical practices called on CMS to reverse course, saying that the cuts would produce significant harm.

“Due to budget neutrality requirements we were expecting this,” says Claire Ernst, associate director, government affairs with Medical Group Management Association (MGMA) in Washington, D.C. “Although [it’s] disappointing, we were not surprised by the proposed almost 4% drop in the conversion factor, since the \$3

billion congressional fix that mitigated this year’s [CY 2021] conversion factor cut was a one-time, year-long fix.”

Other groups voiced strong disappointment. The American College of Surgeons “strongly opposes cuts to surgical care” in the proposed rule, the group said in a July 14 statement.

“The decrease in the conversion factor ... could undermine the ability of health care providers to continue to deliver high-quality care to their patients, and Congress needs to intervene to prevent a decrease in Medicare payments,” AMGA cautioned in a statement released the day after the rule.

But some advocates doubt medical practices will again be able to lean on omnibus legislation, such as the Consolidated Appropriations Act (CAA) of 2021 that set up CY 2021 rates.

“The vibe I got from Congress was, ‘Don’t come to us with the exact same ask, try to get creative and find a different solution,’” Ernst relays. “That being said, MGMA will work with and look to Congress for a fix to mitigate the cuts.” — *Richard Scott, with additional reporting by Roy Edroso* ([rscott@decisionhealth.com](mailto:rscott@decisionhealth.com)) ■

### Telehealth

## Digital access: CMS will allow mental health patients to stay online, mulls extensions

CMS may keep at least some of the codes it allowed for telehealth during the public health emergency (PHE) through the end of 2023, and patients receiving mental health services via telehealth will be eligible for the digital services longer than that.

During the PHE, the agency has allowed hundreds of services to be performed via telehealth by providers not normally authorized to do so ([PBN 4/19/21](#)). In fact, many of the codes were not previously cleared for telehealth by any provider, and CMS added them on a “Category 3 basis” — that is, codes “for which there is likely to be clinical benefit when furnished via telehealth, but there is not yet sufficient evidence available to consider the services for permanent addition under the Category 1 or Category 2 criteria,” CMS explains in the proposed rule.

(continued on p. 6)

**Benchmark of the week**

## 2022 fee tally: Winners and losers under the proposed physician fee schedule

As providers brace for a nearly 4% cut to the 2022 conversion factor, the impact of relative value unit (RVU) changes on specialties fluctuates from a 10% gain for portable X-ray suppliers to a -9% drop for interventional radiology.

Most specialties would gain or lose no more than 2% in expected RVUs in 2022, according to a *Part B News* analysis of the proposed 2022 Medicare physician fee schedule, which CMS released July 13. These small increases may help offset the \$1.30 cut to the physician conversion factor that CMS also is proposing for next year. In the proposed rule, the agency announced a conversion factor of \$33.58, down from the 2021 rate of \$34.89

As the charts below reveal, a total of 20 specialties are on track for RVU gains, while 18 are projected to be in the red. Another 17 specialties, such as dermatology and emergency medicine, are projected to hold steady. – *Richard Scott* ([rscott@decisionhealth.com](mailto:rscott@decisionhealth.com))

### Top 20 specialty winners, estimated impact on total allowed charges, CY 2022

Specialty	Allowed charges (mil)	Impact of work RVU changes	Impact of PE RVU changes	Impact of MP RVU changes	Combined impact
Portable X-ray supplier	\$84	0%	10%	0%	10%
Endocrinology	\$506	0%	2%	0%	2%
Family practice	\$5,725	0%	2%	0%	2%
General practice	\$368	0%	1%	0%	2%
Geriatrics	\$175	0%	1%	0%	2%
Hand surgery	\$222	0%	2%	0%	2%
Anesthesiology	\$2,755	0%	1%	0%	1%
Internal medicine	\$9,906	0%	1%	0%	1%
Interventional pain management	\$900	0%	1%	0%	1%
Neurology	\$1,354	0%	0%	0%	1%
Nurse anesthesia / Anesthesia assistant	\$2,092	0%	1%	0%	1%
Nurse practitioner	\$5,288	0%	1%	0%	1%
Obstetrics/Gynecology	\$558	0%	1%	0%	1%
Optometry	\$1,108	0%	0%	0%	1%
Orthopedic surgery	\$3,273	0%	1%	0%	1%
Pediatrics	\$55	0%	1%	0%	1%
Physician assistant	\$2,810	0%	1%	0%	1%
Plastic surgery	\$319	0%	1%	0%	1%
Podiatry	\$1,847	0%	1%	0%	1%
Psychiatry	\$1,040	0%	1%	0%	1%

### Top 18 specialty losers, estimated impact on total allowed charges, CY 2022

Specialty	Allowed charges (mil)	Impact of work RVU changes	Impact of PE RVU changes	Impact of MP RVU changes	Combined impact
Interventional radiology	\$480	0%	-9%	0%	-9%
Vascular surgery	\$1,144	0%	-8%	0%	-8%
Radiation oncology and radiation therapy centers	\$1,660	0%	-5%	0%	-5%
Oral/Maxillofacial surgery	\$70	0%	-4%	0%	-4%
Allergy/Immunology	\$220	0%	-2%	0%	-2%
Cardiology	\$6,119	0%	-1%	0%	-2%
Hematology/Oncology	\$1,737	0%	-2%	0%	-2%
Independent laboratory	\$552	0%	-2%	0%	-2%
Nuclear medicine	\$50	0%	-2%	0%	-2%
Physical/Occupational therapy	\$3,976	-1%	-1%	0%	-2%
Radiology	\$4,397	0%	-2%	0%	-2%
Audiologist	\$58	0%	-1%	0%	-1%
Cardiac surgery	\$203	0%	-1%	0%	-1%
Infectious disease	\$639	0%	-1%	0%	-1%
Otolaryngology	\$1,037	0%	-1%	0%	-1%
Pathology	\$1,061	0%	-1%	0%	-1%
Rheumatology	\$541	0%	-1%	0%	-1%
Thoracic surgery	\$302	0%	-1%	0%	-1%

Source: Part B News analysis of Table 123 of the proposed 2022 Medicare physician fee schedule

(continued from p. 4)

But CMS adds that it may “revise the timeframe for inclusion of the [Category 3] services” while stakeholders “collect, analyze and submit data on those services to support their consideration for permanent addition to the list on a Category 1 or Category 2 basis.” This means they would be in effect through the end of 2023 at least.

CMS is proposing to make at least one telehealth code permanent in the final rule: **G2252** (Brief communication technology-based service, e.g., virtual check-in service).

No new telehealth codes were added in the rule. CMS says it “found that none of the requests we received by the February 10 submission deadline met our Category 1 or Category 2 criteria for permanent addition to the Medicare telehealth services list.”

### Mental health exception

Patients currently receiving mental health services are expected to get more telehealth coverage. CMS announced that it plans to grant greater leeway to mental health services provided via telehealth.

The agency “is proposing to implement recently enacted legislation that removes certain statutory restrictions to allow patients in any geographic location and in their homes access to telehealth services for diagnosis, evaluation and treatment of mental health disorders,” the proposed rule states.

The legislation CMS references is the Consolidated Appropriations Act (CAA), the omnibus spending bill that picked up a number of health-related provisions, such as the No Surprises Act, explains Claire Ernst, associate director, government affairs with the Medical Group Management Association (MGMA) in Washington, D.C.

The “Expanding Access to Mental Health Services Furnished Through Telehealth” part of the CAA specifies that such services should be made available by telehealth, provided that the patient is also seen in person within six months. The HHS Secretary has broad discretion over codes and billing.

CMS may also “amend the current regulatory requirement for interactive telecommunications systems” to allow greater use of audio-only telehealth, at least for mental health disorders furnished to established patients in their homes. “We believe that mental

health services are different from most other services on the Medicare telehealth services list,” CMS states, because “many of the services primarily involve verbal conversation where visualization between the patient and furnishing physician or practitioner may be less critical to provision of the service.”

MGMA has “insisted that CMS has the authority to modify the definition of ‘interactive telecommunications system’ to include the ability to deliver services via audio-only,” Ernst says. “In fact, CMS finalized a proposal last year in the 2021 rule that removed a sentence that previously said, ‘[t]elephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system.’ I saw that as paving the way for coverage of audio-only telehealth visits.”

It’s not *carte blanche* for mental health patients, however, and CMS solicits comments on whether it “should exclude certain higher-level services, such as level 4 or 5 E/M visit codes, when furnished alongside add-on codes for psychotherapy, or codes that describe psychotherapy with crisis.” Also, CMS will consider whether the definition of “direct supervision” it established for the PHE, with regard to services such as physical therapy provided by telehealth, should be extended after it’s over.

Several codes that had been proposed by stakeholders for urodynamics, biofeedback, neurological and psychological testing, therapy procedures and physical therapy evaluations, therapy test and measurement, therapy personal care, personal care and evaluation and therapy services were knocked out of contention.

Proposed for permanent addition to Category 3 but also knocked out because they’re “not separately billable under Medicare PFS” were several psychotherapy and education and training for patient self-management codes. Neurostimulators and neurostimulators analysis-programming codes were rejected for temporary Category 3 addition. — *Roy Edroso* ([redroso@decisionhealth.com](mailto:redroso@decisionhealth.com)) ■

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Quality Payment Program

## Big lift before MVP transition, with fewer quality measures, higher threshold

Your practice may be relieved that the debut of the new MIPS Value Pathways (MVP) model for the Quality Payment Program/Merit-Based Incentive Payment System (QPP/MIPS) has been pushed back again in the proposed 2022 Medicare physician fee schedule. But don't relax too much: A massive 15-point lift in the MIPS performance threshold will make the last year of the current MIPS structure challenging anyway.

First proposed in 2019, the MVP model is meant to both simplify MIPS with fewer performance measure and to make those measures "more relevant to a clinician's scope of practice" (*PBN 8/15/19*). In this rule CMS has laid out more of the measures and methods that it will use for the program when it begins its rollout in 2023.

### MIPS gets harder

No doubt there'll be some transition issues for those who choose to leap in for year one of MVP. But success under the MIPS model that remains in place for 2022 — with its long lists of measures and four MIPS performance categories — will also be significantly more difficult than in years past, because of a 10% jump in

the hard-to-control cost category and a 15-point rise in the performance threshold eligible clinicians must meet to avoid a penalty from 60 to 75 points.

"Meeting that minimum threshold was relatively easy before," says Dave Halpert, chief, client team at Roji Health Intelligence in Chicago. "In fact, 2021 is the first year that that the threshold is over 50 points. Before this, you could get what in school would be a failing grade and still avoid a penalty. In 2022, that is not going to be the case."

The effect of this lift may be felt more keenly because of the easy terms CMS gave during the pandemic, Halpert says.

"CMS offered an out for people through the extreme and uncontrollable circumstances process," Halpert says. "It's unlikely that they will extend this any longer, meaning 2022 is going to finally be the year that they've been promising, where there'll be a significant separation between those who perform well and those who do not — and that will mean larger penalties and more meaningful incentives."

Data completeness — that is, the percentage of one's patients who qualify for a measure that must be reported on for that measure to be scored — remains at 70%. The exceptional performance score rises to 89%, but as exceptional performance bonuses in MIPS have been scant, this probably doesn't make much difference to most participants (*PBN 11/9/20*).

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PAS 2021

## A higher 'cost'

Adding to the difficulty, the category weights for quality performance and cost performance — that is, how efficiently participants provide care — have changed. Currently, the part of a MIPS score based on quality, a category for which participants can choose from among dozens of measures, is worth 40% of total score; cost, which is based only on administrative claims and offers participants no element of choice, is worth 20%.

In 2022, the quality category loses 10%, while the cost category gains 10%, putting them both at 30%. The improvement activities category remains at 15%, and the promoting interoperability category remains at 25%, according to the proposals.

“Nobody knows what they’re getting into with the cost measures right now,” Halpert says. “CMS did not score providers on cost last year and says they are not going to be releasing any information about costs because there wasn’t enough data to provide meaningful and reliable feedback; results on cost from 2020 will not come out until August. The upshot is that, for the majority of the year, no one will know where how they’ve performed previously and what they’ll need to do to improve.”

Cost category is currently based on two measures: the total per capita cost (TPCC) and Medicare spending per beneficiary clinician (MSPB clinician).

Starting in 2022, CMS will also calculate cost scores for five “episode-based cost measures” for providers for whom these are relevant: Two procedural measures (melanoma resection, colon and rectal resection); one acute inpatient measure (sepsis); and two chronic condition measures (diabetes, asthma/chronic obstructive pulmonary disease). Case minimums that make providers eligible for these measures range from 10 to 20 relevant episodes.

This may lead to some surprises when 2022 cost scores are revealed. “MIPS participants can identify trends within their organization but they don’t have access to the global view of the patient,” Halpert says. That can put MIPS participants at risk. “If there is significant leakage and patients are admitted to other hospitals or seen in other emergency departments, the first time MIPS participants will hear about it is when they receive their scores,” Halpert adds.

## Quality no snap

CMS proposes only six new quality measures as well as a vaccine-related measure (SARS-CoV-2 Vaccination by Clinicians) and removal of 19 measures — but your options are more scaled back than that suggests.

“They are making what they call ‘substantive’ changes to 84 of the existing quality measures,” Halpert says. “But what that means is, those measures will lose their benchmarks. Since they’ve also proposed that a measure without a benchmark is worth zero points, there is suddenly a larger disparity between what can earn points this year and what could earn points next year. So it looks like they’ve taken away only 19 measures, but really in terms of being able to earn points for measures, it’s going to be a lot harder for people to choose measures that are going to earn that good quality score.”

CMS also proposes measures for each of its MVPs for 2023 — for example, the Rheumatology MVP gets nine quality measures, such as “gout serum urate target,” and 11 improvement activities.

## The MVP transition

The new episode-based measures for the cost category are a harbinger of the MVP framework now set to debut in 2023, which promises a growing role for comparative performance scoring for this category in the future. MIPS will be “transitioning” to MVP, and “any proposal to sunset traditional MIPS would be made in future rulemaking,” CMS says. The current goal is to make MVP mandatory in 2028.

CMS listed seven MVP “clinical area” categories to be introduced in 2023: rheumatology; stroke care and prevention; heart disease; chronic disease management; lower extremity joint repair (e.g., knee replacement); emergency medicine; and anesthesia. CMS also says it’s working on “voluntary subgroup reporting to help provide patients and clinicians[with] information that is clinically meaningful at a more granular level.”

All MVP participants would submit a limited number of measures in the four current MIPS categories, as well as a “foundational layer” category. This includes the participant’s choice of one of two population health measures — Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System Program

(MIPS) Eligible Clinician Groups, or Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions — and Promoting Interoperability measures from the MIPS menu.

Also, CMS will require “QCDRs, qualified registries, health IT vendors, and CMS-approved survey vendors” to align with MVP starting in 2023.

### Other QPP/MIPS features

Certified nurse-midwives and clinical social workers (CSW) are added to the provider types that can qualify as eligible clinicians. Because of the nature of their practices, CSWs are exempted from the Promoting Interoperability performance category. CMS also says they “anticipate the cost category would be reweighted for the majority of [both] these clinician types.”

Small practices still get a three-point bonus in 2022.

Participants in the advanced alternative payment model (APM) part of QPP will continue to use the APM Performance Pathway (APP) reporting option established in 2021.

Qualifying APM participants (QPs) will continue to receive a lump sum incentive payment of 5% of earnings. CMS is also moving forward with a plan to make bonus payments to qualified participants (QP) via their TINs in special cases, such as when the QP has separated from the APM with which they qualified for their bonus. — *Roy Edroso* ([redroso@decisionhealth.com](mailto:redroso@decisionhealth.com)) ■

### Billing

## Limits proposed for teaching physician billing

You will find a couple of key revisions to the billing rules for teaching physicians should certain pieces of the proposed 2022 Medicare physician fee schedule take hold as planned.

For one, CMS is seeking to tighten the billing rules for residents and teaching physicians when reporting E/M office/outpatient services (**99202-99215**), which were significantly revised in 2021.

“We are proposing that 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,” the agency states in the proposed rule.

As CMS notes, it makes separate payment for a resident’s time spent providing care alongside a teaching physician under Medicare Part A. Therefore, by CMS’ reasoning, paying for a resident’s time during E/M office/outpatient visits constitutes an overpayment.

The time-based proposals for E/M office/outpatient codes align with policies already contained in the Medicare Claims Processing Manual, notes Betsy Nicoletti, CPC, president of Medical Practice Consulting in North Andover, Mass.

Nicoletti points to section 100.1.4 of Chapter 12 of the manual, which stipulates that the teaching physician must be present for codes reportable by time, such as critical care services (*see resource, below*).

“I think it is helpful whenever CMS clarifies their policies, particularly in regards to E/M code selection,” Nicoletti says. “It helps medical practices accurately and compliantly select the codes, which is good for us all.”

### The ‘primary care exception’

CMS also is taking aim at the levels of E/M services that a resident can bill under the “primary care exception,” which allows residents to bill for “certain services of lower and mid-level complexity furnished by a resident without the physical presence of a teaching physician,” the proposed rule states.

The agency proposes that residents can only use medical decision-making — not time — to select the appropriate E/M office/outpatient level.

“The intent of the primary care exception ... is that E/M visits of lower and mid-level complexity furnished by residents are simple enough to permit a teaching physician to be able to direct and manage the care of up to four residents at any given time and direct the care from such proximity as to constitute immediate availability,” CMS states.

Because residents are in training, they may require more time than normal to furnish the service, and that could skew the accuracy of the code level selection. CMS calls MDM “a more accurate indicator of the complexity of the visit.”

Also, note: At the expiration of the COVID-19 public health emergency (PHE), E/M office/outpatient levels 4 and 5 (i.e., 99204-99205, 99214-99215) will no longer be included in the primary care exception. — *Richard Scott* ([rscott@decisionhealth.com](mailto:rscott@decisionhealth.com)) ■

**RESOURCE**

- Chapter 12, Medicare Claims Processing Manual: [www.cms.gov/files/document/medicare-claims-processing-manual-chapter-12](https://www.cms.gov/files/document/medicare-claims-processing-manual-chapter-12)

**Billing**

## Physician assistants would be paid directly under Part B

CMS proposes to begin direct payment to physician assistants (PA) for professional services they provide. Right now, Medicare can only make payment to the PA's employer or provider for whom the PA is a contractor. Under the proposal, mandated by the Consolidated Appropriations Act of 2021 that passed in December 2020, PAs would also be able to accept or reassign payment for their services.

The update “creates a level playing field” for PAs with other non-physician practitioners, such as nurse practitioners or advanced practice RNs, explains Michael Powe, vice president for reimbursement and professional advocacy for the American Academy of PAs (AAPA), based in Alexandria, Va. The AAPA has been lobbying Congress for direct billing capabilities since 2017.

The change will allow PAs to directly bill for services performed in all settings, in both rural and non-rural areas. However, as non-physician practitioners (NPP), PAs will continue to be paid at 85% of the physician allowable amount. They also will continue to be required to work under physician supervision.

“This isn't changing the scope of practice or rate of payment for PAs, just making sure all health care providers are treated the same” for Part B reimbursement, Powe says.

“For the real-life practice implications, say a surgical PA wants to work on a contractual basis with” multiple surgical practices, Powe says. Unlike other NPPs, the PA would have to be paid for services through each practice instead of billing Medicare directly, making the reimbursement process more convoluted and time-consuming, he explains.

In a more costly scenario, PA-owned rural health clinics (RHC) until now have been unable to bill for services that Medicare requires but “carves out” of the RHC payment bundle. Where other providers are able to simply bill separately for such services, which

include COVID-19 or pregnancy testing, PAs have not had a way to do that until now. — *Laura Evans, CPC* ([levans@decisionhealth.com](mailto:levans@decisionhealth.com)) ■

**Value-based care**

## Shared Savings ACOs get a year off from electronic clinical quality measures

After their first year of using the Alternative Payment Model (APM) Performance Pathway (APP) reporting method, participants in the Shared Savings program are spared further challenges as CMS delays the full transition to electronic clinical quality measures (eCQM) and MIPS clinical quality measures (MIPS CQM) and scales back some program requirements.

Last year, participants in the largest CMS accountable care organization (ACO) program were told to report quality for both QPP and Shared Savings purposes via APP ([PBN 12/14/20](#)). This required that they swap out their CAHPS for ACOs reporting with CAHPS for MIPS, and the 2021 proposed rule required as well that they abandon the Web Interface reporting method and report instead eCQM and MIPS CQM via APP, which would require all-payer reporting, not just Medicare reporting. But in the final rule for 2021, CMS bowed to stakeholder pressure and pushed that requirement back a year.

This year, stakeholders objected again, complaining that, among other things, “the increased cost of modifying existing electronic health record (EHR) technology, obtaining new EHR interfaces and aggregation tools, and updating performance dashboards” made this transition burdensome. Commenters also expressed concern about the readiness of vendors such as registries.

CMS cites a survey from the National Association of ACOs (NAACOS) that found noted 77% of respondents “indicated they do not have the infrastructure in place to aggregate data on behalf of their ACO participant TINs on quality performance across all payers starting in 2022.”

This year, CMS has postponed the eCQM/MIPS CQM requirement again and says it will do so in 2023 as well.

“The vast majority of Shared Savings ACOs will continue to use the Web Interface option of reporting this year — they are comfortable with this method and it is still available as part of the APP in 2021. As such, it’s no change for 2021,” says Lauren Patrick, president and CEO of Healthmonix in Malvern, Pa.

“However, many proactive Shared Savings ACOs are beginning the transition to the needed data collection, aggregation and analysis in order to achieve success once the Web Interface sunsets,” Patrick adds. “While CMS has proposed extending the runway for movement to all-payer reporting, they have also offered a few incentives, such as scoring on one eCQM/CQM in the initial year(s).”

In 2022, forward-looking Shared Saving participants can, if they wish, report three eCQM/MIPS CQM measures and administer a CAHPS for MIPS survey, and CMS will calculate the two claims-based measures included under the APP. Whichever method they choose, they must achieve a score equivalent to or higher than the 30th percentile of the performance benchmark on at least one measure in the APP measure set to meet their program requirements. CMS originally proposed to move this to the 40th percentile in 2023, but will do so in 2024 instead.

That’s good news for now, but when it happens the eCQM/MIPS CQM transition will remain tough until other parts of the process, particularly tech vendors, get it together, says Dave Halpert, chief, client team at Roji Health Intelligence in Chicago.

“Even if they have certified EHR, there are still some granular issues,” Halpert says. “For example, ACOs with multiple EHRs — each with its own data output — don’t have the ability to report some measures the way they’re supposed to be measured.” For instance, Halpert says, “if you’re looking at the hemoglobin A1c measure for patients with diabetes, you’re supposed to be looking for the most recent hemoglobin A1c level,” but many systems “look at each encounter, rather than looking at the unique patient.”

“We have been focused over the last year on convincing CMS to give ACOs more time before dramatically overhauling the way quality is measured within MSSP,” a spokesman for NAACOS tells Part B News. “With an extra three years before moving to eCQMs, we need CMS to work closely with ACOs and EHR vendors to find a solution that accurately

measures quality performance, is manageable for ACO providers, executable for EHR vendors and improves the quality of care Medicare beneficiaries receive.”

In this rule CMS is also proposing to allow new Shared Savings participants who are in the early, one-sided, reward-no-risk BASIC track to stay an extra year in that status before accepting two-sided risk.

“All ACOs have been challenged by the COVID-19 pandemic and public health emergency (PHE),” Patrick explains. “Utilization has been difficult to predict and managing expenditures and revenue have been difficult. Participation in the Shared Savings program is optional for health care providers, and CMS wants ACOs to be successful. Allowing this flexibility for those in the BASIC track provides the ability to better ensure foundational footing before moving into additional risk.”

Another break for Shared Saving ACOs: CMS will allow primary care services supplied by telehealth during the PHE to be included among the primary care services used in the Shared Savings Program’s beneficiary assignment methodology, provided the ACO sees the patient in person every six months.

“It appears that allowing the inclusion of telehealth serves to further cement the relationship and should be counted in the beneficiary assignment,” Patrick says. “There is a trend to a larger percentage of care occurring through telehealth; if we do not include telehealth, then attribution could be skewed inappropriately for those patients that are receiving more of their care through these platforms.”

CMS also proposes to add the primary care codes used for attribution, pending finalization, the proposed chronic care management (CCM) code **99X21**, principal care management (PCM) codes **99X22**, **99X23**, **99X24** and **99X25**, as well as prolonged office or other outpatient E/M service code **G2212** and communication technology-based service (CTBS) code **G2252** if payment for that code is made permanent in the final. — Roy Edroso ([redroso@decisionhealth.com](mailto:redroso@decisionhealth.com)) ■

*Physician payments*

## Fee schedule round-up: Payment and policy updates

Don't miss out on other important updates contained in the proposed 2022 Medicare physician fee schedule.

**Therapy assistants to be paid at 85% for certain services starting Jan. 1.** The statutorily required pay reduction for physical therapy assistants (PTA) and occupational therapy assistants (OTA) is set to begin next year. However, the good news is that CMS appears to be reducing the number of cases when it will require use of modifiers CQ (Outpatient physical therapy services furnished in whole or in part by a physical therapy assistant), and CO (Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant) to trigger that reduction, according to the proposed physician fee schedule.

By law, Medicare must reduce payment for therapy services provided “in whole or in part” by a PTA or OTA. The debate has been over exactly how CMS will define “in part.” For next year, the agency is proposing to revise its so-called “de minimus” standard to allow a timed therapy service to be billed without the CQ/CO modifiers for cases when a PTA/OTA participates in providing care to a patient with a physical therapist or occupational therapist (PT/OT), but the PT/OT meets the Medicare billing requirements for the timed service even without the minutes done by the PTA/OTA by providing more than the 15-minute midpoint (the eight-minute rule).

Overall, however, the modifiers and pay reduction would apply in the following cases, according to CMS:

- When the PTA/OTA independently provides a service, or a 15-minute unit of a service “in whole” without any involvement by the PT/OT.
- For PTA/OTA involvement in services that are not defined in 15-minute increments, including supervised modalities, evaluations/reevaluations and group therapy.
- When the PTA/OTA provides eight minutes or more of the final unit of a case in which the PT/OT does less than eight minutes of the same unit of service.
- When both the PTA/OTA and the PT/OT each furnish fewer than eight minutes of a final 15-minute unit of service during a patient encounter.

**Two outdated NCDs tagged for deletion.** As it did in the 2021 rule, CMS proposes to remove some old national coverage determinations (NCD) next year, in some cases because their technology has become obsolete or because the policy has been superseded by another Medicare policy. Medicare administrative contractors (MAC) will still be able set local coverage determinations for treatments described by deleted NCDs. Next year, the two NCDs proposed for retirement include (with NCD number):

- NCD 180.2 Enteral and Parenteral Nutritional Therapy (effective 7/11/84). The policy is outdated, according to some stakeholders and it adds to patient and provider burdens by requiring repeated review of medical necessity for patients with chronic diseases who need enteral or parenteral nutrition services, CMS states. “Local contractors have proposed LCDs that, if finalized, would provide parenteral and enteral nutrition coverage for certain Medicare beneficiaries,” the agency says, so coverage would continue without the NCD.
- NCD 220.6 Positron Emission Tomography (PET) Scans (effective 9/3/13). This one is also potentially outdated, according to stakeholders. Back in 2000, CMS set a policy of “broad national non-coverage for non-oncologic indications of PET” that required a new NCD to be issued every time someone wanted to add a new non-oncological indication. This was broadened somewhat in 2013, but the restrictive language remained in a subsection of the NCD. CMS is proposing to strip it out, though NCD sections 220.6.1 through 220.6.20 would be left intact.

CMS requests comment on deletion of these NCDs and nominations for any other NCDs that may have outlived their usefulness.

**Potentially misvalued codes.** CMS says it received five public nominations for misvalued codes this year, including cervical spinal fusion code (**22551**) a digestive tract surgical procedure (**49436**), ultrasound treatment of prostate cancer (**55880**), insertion of a cervical dilator (**59200**) and intraocular lens procedures to treat cataracts (**66982-66986**). However, in each case, the nominator did not submit detailed data to support that the service was misvalued, so CMS says it is not planning to pursue their revaluation but is soliciting comments on the issue. — *DecisionHealth staff* ([pbnfeedback@decisionhealth.com](mailto:pbnfeedback@decisionhealth.com)) ■

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