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Hot Topics in Therapy Documentation and Billing

Speakers:

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- **Melissa Lally, BSN RN-BC, Lincoln Reimbursement Solutions**
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Moderator:

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Housekeeping Reminders

- All attendees are on mute
- Handouts were provided in the reminder email for this webinar sent 1 hour ago
- **Questions for Speakers:** submit them using the Q&A button on the attendee control panel
- **Technical Questions:** submit them using the Chat button on the attendee control panel
- **Recording:** will be emailed to all registered attendees 48 hours after concluded; posted for NARA Members on the Portal within 24 hours

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Disclaimer

The information shared in today's presentation is shared in good faith and for general information purposes only. It is accurate as of the date and time of this presentation. Providers should seek further guidance and assistance from CMS and their Medicare Administrative Contractor (MAC), and state and national associations, and continue to watch for new developments and information regarding the topics discussed today.

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Agenda

- Impact of CY 2022 Regulations
  - Therapist Assistant Modifiers
  - Telehealth
  - Remote Therapeutic Monitoring
- Top Billing Red Flags in 2021 and How to Avoid Them in 2022
  - ICD-10-CM Coding
  - NCCI Edits
  - Unattended Estim

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THERAPIST ASSISTANT MODIFIERS

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Therapist Assistant Modifiers: Background

- Bipartisan Budget Act of 2018 (BBA):
  - Creation of assistant modifiers by 1/1/2019
  - Payment for services provided by PTA/OTA at 85% of the fee schedule beginning 1/1/2022
- CY 2019 Medicare Physician Fee Schedule (MPFS) Final Rule:
  - Established the CQ and CO modifiers, required beginning 1/1/2020
  - Determined the ***de minimis* standard**: A service is considered furnished in whole or in part by a PTA/OTA when *more than 10% of the service* is furnished by the assistant

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Therapist Assistant Modifiers: Background

- CY 2020 MPFS Final Rule:
  - Revised definition of "service" to mean the *de minimis* standard will be applied to untimed CPT/HCPCS codes and to each 15-min unit of codes timed in 15-min increments.
  - Time the PT/OT and PTA/OTA spend furnishing services to the same patient at the same time will not count for purposes of applying the *de minimis* standard.
  - CMS also revised their policy to allow separate reporting, on 2 different claim lines, of the number of 15-min units of a code to which the modifiers do not apply and the number of 15-min units of a code to which the modifiers do apply.
    - For example, PTA provides 15 min 97110GPCQ; PT provides 15 min 97110GP

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CY 2022 MPFS Clarifications and Updates

- Beginning with dates of service on and after 1/1/2022, services provided by a PTA or OTA (i.e., services with the CQ/CO modifiers appended to the CPT code(s) on the claim) will be paid at 85% of the Medicare Physician Fee Schedule.
- The 15% reduction applies to the allowed charge after the beneficiary copayment (i.e., to the 80% of the fee schedule rate).

NOTE: This is for Medicare Part B only in all settings (e.g., private practice, SNF, hospital OP, rehab agency) *except* critical access hospitals.

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CY 2022 MPFS Clarifications and Updates

- CMS finalized a modification of the *de minimis* standard which applies when one unit of a timed therapy service remains to be billed and to specific "two remaining unit" cases.
  - CQ/CO modifiers do not apply when the PT/OT provides 8 min or more of the last unit of a timed service on their own, regardless of any time provided by the PTA/OTA.
  - When there are 2 remaining units to be billed and the PT/OT and PTA/OTA each provide between 9 and 14 min of the same service for which the total time is at least 23 min and no more than 28 min, one unit is billed with the CQ/CO modifier, and one unit is billed without the modifier.

https://www.cms.gov/medicare/therapy-services/billing-examples-using-cqco-modifiers-services-furnished-whole-or-part-ptas-and-otas

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CY 2022 MPFS Clarifications and Updates

- The CQ and CO modifiers apply when:
  - The PTA/OTA furnishes all minutes of a service independent of the PT/OT
  - The PTA/OTA furnishes a portion of the service (or unit of service) separately from the portion furnished by the PT/OT, such that the minutes for that portion furnished by the PTA/OTA exceed 10% of the total minutes for that service (or unit of service)
    - For example, PT performs 10 min 97110; PTA performs 5 min 97110 – bill one unit 97110 with the CQ modifier (5 min = 66% of 15 min)

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Assistant Modifier Example

PT/OT provides 30 min of 97110; the PTA/OTA provides 5 min of 97110

- Total time = 35 min; 2 units can be billed
- Since the PT/OT provided a full 30 min of 97110, 2 units 97110 would be billed without the CQ/CO modifier
- Record/document the 5 min provided by the PTA/OTA with the total time for the treatment session

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Assistant Modifier Example

PTA/OTA provides 22 min 97110; PT/OT provides 23 min 97110

- Total time = 45 min; 3 units can be billed
- Bill 1 unit 97110 with the CQ/CO modifier because the PTA/OTA provided 15 min with 7 min remaining
- Bill 1 unit 97110 without the CQ/CO modifier because the PT/OT provided 15 min with 8 min remaining
- Apply the 8 min rule to the final unit of 97110 and bill <u>without</u> the CQ/CO modifier because the therapist provided enough minutes (8 or more) to bill the final unit without the assistant's minutes

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Assistant Modifier Example

PT/OT provides 12 min 97110; PTA/OTA provides 14 min 97110; PT/OT provides 20 min 97140

- Total time = 46 min; 3 units can be billed
- Bill 1 unit 97140 without the CQ/CO modifier because the PT/OT provided the full 15 min unit (with 5 min remaining)
- 2 units 97110 remain to be billed. The PT/OT and PTA/OTA each provided between 9 and 14 min independent of one another, with a total time between 23 and 28 min. In this "two remaining units" scenario, 1 unit is billed with the CQ/CO modifier and the other is billed without the modifier.

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CQ/CO Modifier Documentation Requirements

- No specific documentation to support CQ/CO is required, however, CMS has stated that documentation should clearly reflect who provided the service and should contain "sufficient detail" to determine if the *de minimis* standard was exceeded.

- Documentation must reflect all minutes/services rendered to the patient, regardless if the minutes are billable.

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Other Payers and the CQ/CO Modifiers

- Humana
  - CO/CQ effective 1/1/2020
  - OTA/PTA service paid at 85% of the contracted rate or base maximum amount payable under the member's plan effective 1/1/2022
- Tricare
  - CO/CQ effective 4/16/2020
  - OTA/PTA services shall be reimbursed at the non-physician class CMAC effective 1/1/2022
- UHC
  - CO/CQ effective 1/1/2020
  - Reimbursement?

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Claim Processing with Payment Reduction

1. Application of the beneficiary's deductible
2. Application of the MPPR
3. Application of the beneficiary's 20% coinsurance
4. Application of the 15% reduction for PTA/OTA services
5. *Application of 2% sequestration* (2% effective July 1, 2022)*
6. Coinsurance / secondary insurance

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Example of Claim Processing

- 3 units of 97110
  - One unit of 97110 allowed amount = $28.12
  - MPPR applies to next two units for allowed amount = $46.77
  - Total allowed = $74.89
  - 20% coinsurance = $14.98
  - $74.89-$14.98 = $59.91
  - 15% reduction for assistant modifier = $50.92
  - If sequestration applies = $49.90

Medicare pays $49.90 and patient or secondary pays $14.98 for a total payment of $64.88

Note Impact: Three units of 97110 delivered by an assistant in 2021 is $8.99 higher

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Conversion Factor Impact

- Dec 10, 2021: Biden Signed the ***Protecting Medicare & American Farmers from Sequester Cuts Act*** into law
  - CMS will receive a 3% increase to partially offset the planned 3.75% cut
    - Current conversion factor will be a -0.75% impact across all codes
  - Temporary moratorium on the 2% sequestration
    - April 1, 2022 – 1% sequestration will be in effect
    - July 1, 2022 – 2% sequestration will return

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Example of Conversion Factor on Specific Codes

- On average, 97530 decreased by ~6%

REND PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC	AMT	PROV PD
1235618786	1109 110921	11	1	97530	GP	49.00	37.92 $35.64	0.00	7.58	CO-45	11.08	30.34
	1109 110921	11	1	97112	GP	45.00	26.09	0.00	5.22	CO-45	10.88	20.87
										CO-59	8.03	
	1109 110921	11	1	97110	GP	42.00	22.87	0.00	4.57	CO-45	12.57	18.30
										CO-59	6.56	
	1109 110921	11	1	97140	GP	45.00	21.36	0.00	4.27	CO-45	17.91	17.09
										CO-59	5.73	
PT RESP	21.64	CLM STATUS	19	CLAIM TOTALS		181.00	108.24	0.00	21.64		72.76	86.60
BILL TYPE 111	DRG CD		ADJ TO TOTALS:		INTEREST	0.00		LATE FILING CHARGE	0.00		NET	86.60

- Unattended Estim decreased on average by ~8%

	1028 102821		1	G0283	GPCQ	18.22	9.69 $8.91	0.00	1.94	CO-59	8.53	7.75
	1026 102621		1	97110	GP	68.29	22.84	0.00	4.57	CO-59	45.45	18.27
	1028 102821		2	97110	GPCQ	136.58	45.68	0.00	9.14	CO-59	90.90	36.54
	1028 102821		1	97112	GPCQ	71.23	33.82	0.00	6.76	CO-45	37.41	27.06
	1026 102621		1	97162	GP	161.03	98.01	0.00	19.60	CO-45	63.02	78.41
PT RESP	42.01	CLM STATUS	1	CLAIM TOTALS		455.35	210.04	0.00	42.01		245.31	168.03
BILL TYPE 742	DRG CD		ADJ TO TOTALS:		INTEREST	0.00		LATE FILING CHARGE	0.00		NET	168.03

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TELEHEALTH

First, check state practice act.

Then, check payer policy.

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Terminology (CMS)

- **Telehealth:** Services provided by real-time, two-way audio/video technology that are described by HCPCS/CPT codes and *paid under the Physician Fee Schedule*. Telehealth visits replace in-person visits.
  - CMS does not use the term telehealth to describe services provided remotely using real-time, two-way audio/video technology to patients under Medicare Part A. Rather, CMS uses terms like "services provided remotely using technology" or "using telecommunications technology to furnish a service".
- **Communication Technology-Based Services (CTBS):** Assessment and management services provided using various forms of technology (e.g., online patient portal, telephone, synchronous two-way audio/video) that do not take the place of a in-person visit but are intended to address a patient-identified need that has arisen since the last "interaction" with the provider and requires immediate attention.

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Telehealth and Therapy Services: Medicare Part B

- PTs, OTs, and SLPs (and PTAs and OTAs) are eligible providers of telehealth services under Medicare Part B for the duration of the COVID-19 PHE, as long as allowed by state law.
- Telehealth services should be reported with modifier 95 on both professional (CMS 1500) and institutional (UB-04) claims.
  - On professional claims, the POS code should be the same as what it would have been had the service been provided in person (e.g., POS 11).
- In the CY 2022 Medicare Physician Fee Schedule Final Rule, CMS finalized the addition of the several PT/OT/SLP codes to the Medicare telehealth list on a "Category 3" basis through 12/31/2023.
  - **CMS did not (cannot) add PTs, OTs, and SLPs as eligible providers of telehealth outside of the PHE.** Once the COVID-19 PHE ends, therapists will be unable to provide and bill for telehealth services (unless they provide the service incident-to a physician/NPP).

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Remote Visits and Therapy Services: Medicare Part A – Skilled Nursing Facility

- CMS states in the COVID-19 FAQ document (6/19/2020) that therapy services may be furnished remotely to a Part A SNF patient during the COVID-19 PHE (consistent with state scope of practice laws), and that such services would remain subject to consolidated billing.
- During the COVID-19 Office Hours call on 6/2/2020, CMS clarified that minutes provided remotely to a patient in a Part A SNF stay may be counted on the MDS.
- CMS clarified in the COVID-19 FAQ document (4/9/2020), and again in the CY 2021 Medicare Physician Fee Schedule final rule, that if the patient and practitioner are "in the same institutional setting" and are using telecommunications technology to furnish a service, the practitioner should bill as if the service was furnished in person, and the service would not be subject to any of the telehealth requirements (such as the application of modifier 95).

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Remote Visits and Therapy Services: Medicare Part A – Home Health

- In the first Interim Final Rule released 3/30/2020, CMS stated that during the COVID-19 PHE, providers could use "various types of telecommunications systems (that is, technology)" in addition to remote patient monitoring, in conjunction with in-person visits.
- Use of technology must be included on the HH plan of care.
- Visits provided remotely cannot replace an in-person visit, and therefore, are not counted toward the LUPA threshold or reported on the claim.
- In the CY 2021 HH PPS final rule, CMS made these current flexibilities with the use of technology permanent after the end of the PHE.

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Telehealth: Medicare Part B

- Approved therapy HCPCS/CPT code list for telehealth during the COVID-19 PHE:

97161-97163	*97129*
97164	*97130*
97165-97167	97750
97168	97755
97110	97760
97112	97761
97116	92521-92524*
97150	92507*
97530	*92508**
97535*	*92610*
97542	*92526*
96125	*96105*

*May be delivered audio-only during the PHE

- Codes in *blue* have been added to the telehealth list as "Category 3" codes through 12/2023.
- Codes in *red* are available through the end of the PHE only.

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Medicare Billing For Telehealth Services

- When billing Part B claims for telehealth services provided on or after 3/2/2020, and for the duration of the PHE, bill with:
  - Place of Service (POS) code equal to what it would have been had you furnished the service in person;
  - Modifier 95, indicating that you did indeed perform the service via telehealth; and
  - The GP, GO, GN modifier.
- After PHE expires, some codes will no longer be billable with modifier 95.
- E-Visit and virtual check-in codes are permanent additions to the therapy code list as of 1/1/2021.
  - CY 2021 rulemaking made these codes permanent, meaning they are no longer restricted by the timeline of the COVID-19 PHE.

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Telehealth: Specific Payer Requirements

	HUMANA	UHC	AETNA	CIGNA
Allowed Services	92507, 92508, 92521-92524, 92526, 92610, 96105, 97161-97168, 97110, 97112, 97116, 97129, 97130, 97150, 97530, 97535, 97542, 97550, 97755, 97760, 97761, 98966-98968, 98970-98972, G2250, G2251	92507, 92521-92524, 92526, 96105, 97129 (SLP only), 97130 (SLP only), 97161-97168, 97110, 97112, 97116, 97530, 97535, 97750, 97755, 97760, 97761	92507, 92508, 92521-92524, 92526 (commercial plans), 97161-97168, 97110, 97112, 97116, 97150, 97530, 97535, 97542, 97750, 97755, 97760, 97761*	92507, 92508, 92521-92524, 97110, 97112, 97161-97168, 97530, 97755, 97760, 97761
Modifiers	Modifier 95	Modifier 95	Modifier 95 or GT	Modifier 95 or GT
Professional or Institutional Claim	Professional claim w/ POS that would have been reported face-to-face (e.g., POS 11). Also allowed on institutional claims.	Beginning 1/1/2021, professional claim w/ POS 02 indicating telehealth. Institutional claims for duration of PHE only.	For commercial plans, professional claim billed w/ POS 02. For Medicare, POS 02 or POS that would have been reported face-to-face. Also allowed on institutional claims.	Professional claim w/ POS that would have been reported face-to-face (e.g., POS 11). Institutional claims for duration of PHE only.
Timeframe	DOS 3/6/20 through duration of PHE only	Effective 1/1/2021	Effective 1/1/2021	Effective 1/1/2021

*Applicable CPT codes for Aetna are accessible via the provider Availity portal. This list may not be comprehensive/current.

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Documentation Requirements for Telehealth

- The standard of care for practicing telehealth is the same as that of in-person services.
- Documentation requirements (medical necessity, skill, goals, etc.) are the same as well.
- In addition:
  - Informed consent (check practice act, state law, payer policy)
  - Telehealth platform/technology used
  - Presence of a "presenter" or other caregiver/family member
  - Location of therapist and patient

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Medicare Reimbursement For CTBS

(2022 Fee Schedule – Region in TX)

Telephone Assessments: (Available through PHE only)

- 98966 = $12.91
- 98967 = $21.69
- 98968 = $31.34

Communication Technology-Based Services: (Available permanently as of 1/1/2021)

- G2250 = $9.13
- G2251 = $12.41
- 98970 = $11.53
- 98971 = $19.97
- 98972 = $31.00

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Telehealth News Worth Mentioning

- Oct 2021, Medicare released new place of service (POS) codes effective 1/1/2022:
  - 02: Telehealth provided other than patient's home
    - Descriptor: The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.
  - 10: Telehealth provided in patient's home
    - Descriptor: The location where health services and health related services are provided or received through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.
  - United Healthcare will also recognize these codes
  - Permanent changes
- Other payers vary state to state/region to region

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REMOTE THERAPEUTIC MONITORING

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Remote Therapeutic Monitoring (RTM)

- Allow for monitoring of health conditions, including musculoskeletal system status, respiratory system status, therapy (medication) adherence, and therapy (medication) response, and allow for non-physiologic data to be collected.
  - Data can be self-reported as well as digitally uploaded
  - Use of an FDA-approved device (e.g., ARIA digital care management platform) is required for data collection and reporting
- No details specific to documentation of the services to support medical necessity are given or addressed by CMS in the final rule.

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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
  - Untimed code, subject to *de minimis* standard
- 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
- 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
  - Device codes, not subject to *de minimis* standard
  - Codes not reported if monitoring is less than 16 days

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Remote Therapeutic Monitoring (RTM)

- 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
- 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 20 minutes (list separately in addition to code for primary procedure)
  - Both codes are subject to *de minimis* standard

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2022 Fee Schedule For RTM Codes

	P.	Par	Non-Par	Limit.C	E
	98975	$19.58	$18.60	$21.39	01/01/2022
	98976	$57.11	$54.25	$62.39	01/01/2022
	98977	$57.11	$54.25	$62.39	01/01/2022
	98980	$49.66	$47.18	$54.26	01/01/2022
#	98980	$30.45	$28.93	$33.27	01/01/2022
	98981	$39.90	$37.91	$43.60	01/01/2022
#	98981	$30.30	$28.79	$33.11	01/01/2022

* Click on a row to view additional information about the Procedure Code

- These amounts apply when services is performed in a facility setting.

C - The payment for the technical component is capped at the OPPS amount.

Limiting charge applies to unassigned claims by non-participating providers.

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Remote Therapeutic Monitoring (RTM)

- Must be provided under a therapy POC when furnished by a therapist or assistant – GP/GO/GN modifiers are required.
- Classified as “sometimes therapy” services – count toward the annual therapy threshold, but MPPR does not apply.

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RTM and CQ/CO Modifiers

PT provided the first 20 min of RTM services during the calendar month; PTA provided another 17 min and PT another 10 min during the calendar month.

- Total time = 47 minutes; two 20-min units can be billed
- Bill one unit 98980 without the CQ modifier because the first 20 min of RTM services were performed by the PT.
- Bill one unit 98981 with the CQ modifier because the PTA's minutes exceed the *de minimis* standard (i.e., >10 % of the remaining 20 min unit)

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Top Billing Red Flags in 2021 and How to Avoid Them in 2022

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ICD-10-CM CODING

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Most Prevalent ICD-10 Change

As of 10/1/2021, CMS eliminated ICD-10-CM code M54.5 (low back pain) due to lack of specificity.

Additional Code Choices:

1. S39.012: Low back strain
2. M51.2-: Lumbago due to interverterbral disc displacement
3. M54.4-: Lumbago with sciatica
4. M54.50: Low back pain, unspecified
5. M54.51: Vertebrogenic low back pain
6. M54.59: Other low back pain

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ICD-10 Common Denial Reasons

ICD-10 was first introduced in ***2015***

- Most payers placed a temporary moratorium on ICD-10 edits
- As of June 2021, this moratorium has been lifted
  - Seeing more ICD-10 denials / non-payments
  - **Excludes1** rejections / denials
    - Two diagnosis codes should not be coded together
    - Prohibits us from using additional codes that could potentially confuse or distract from the primary diagnosis
  - **Z code** denials – Orthopedic aftercare

TIPS:

- Code to the most specific code possible
  - Use L, R, and/or bilateral when possible
  - Do not include additional codes for signs and symptoms that are already associated with the primary diagnosis

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Documentation to Support ICD-10-CM Coding

- **Medical diagnosis** – Identified and documented by the physician or non-physician practitioner
  - Order/referral
  - H&P, operative report, admission orders

- **Therapy treatment diagnosis** – Identified or determined by the evaluating therapist

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Documenting to Support ICD-10-CM Coding

- Diagnosis code selection may trigger medical review
  - Consider coding patterns or "habits"
  - Know payer policy/MAC Local Coverage Article
- Understand the importance of accurate coding when "painting the picture" of your patient
  - Do you paint the ***same picture*** for every patient?

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Unspecified vs. Other Specified: PT Example

Category R26: Abnormalities of gait and mobility

- R26.0 Ataxic gait (staggering gait)
- R26.1 Paralytic gait (spastic gait)
- R26.2 Difficulty in walking, NEC
- R26.8 - Other abnormalities of gait & mobility
  - R26.81 Unsteadiness on feet
  - R26.89 Other abnormalities of gait & mobility
    - » For example: Trendelenburg gait, festinating gait, etc.
- R26.9 Unspecified abnormalities of gait & mobility
  - » Use if *nothing* is documented re: gait deviation, deficits, device, etc.

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ICD-10-CM Coding Example: OT

- 73 yo male referred to OT s/p L TSA secondary to severe OA. c/o L shoulder pain 8/10 w/ all active movement. Demonstrates ↓ shoulder A/PROM in all planes affecting (I) with ADL/IADL. Barthel Index: 65.

Medical diagnoses:

- **Z47.1**, Aftercare following total joint replacement
- **Z96.612**, Presence of L TSA

Treatment diagnoses:

- **M25.512**, L shoulder pain
- **M25.612**, L shoulder stiffness
- **Z74.1**, Need for assist w/ personal care

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ICD-10-CM Coding Example: PT

- 67 yo female referred to PT with a diagnosis of Parkinson's disease. Pt reports she has fallen 3 times in the past 6 months. MMT BUEs and LEs grossly WFL. Pt demonstrates festinating gait w/ difficulty initiating movement. Amb 200' on levels w/ SBA and no device. TUG = 17 sec.

Medical diagnosis:

- **G20**, Parkinson's Disease

Treatment diagnoses:

- **R26.89**, Other abnormalities of gait and mobility
- **Z91.81**, History of falling

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ICD-10-CM Coding Example: ST

- 58 yo female referred to ST s/p nontraumatic subarachnoid hemorrhage. Pt presents with expressive aphasia and attention and concentration deficits.

Medical AND Treatment diagnoses:

- **I69.020**, Aphasia following nontraumatic SAH
- **I69.010**, Attention and concentration deficits following nontraumatic SAH

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NCCI EDITS

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NCCI Procedure to Procedure (PTP) Edits

- Promote correct coding and prevent improper payments by "bundling" component codes into the most inclusive code.
- 2020 and 2021 edits were changed several times and payers were are following separate rules.
- Often, when two codes are billed together or two procedures are billed together, the insurance company will only pay for one of those codes and indicate on our remittance that the payment for the other code is "bundled" into the payment of another.

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NCCI Edit Changes

- **CMS** made decision to retain the edits that were in effect prior to 1/1/2020 and delete the 1/1/2020 PTP edits. These changes were made retroactive to 1/1/2020.
- **Cigna** followed CMS' decision and made their policy effective 1/1/2020.
- **Aetna** followed CMS' decision and made the edit deletions retroactively effective to 1/1/2020. Aetna's policy is consistent with the CMS changes. Aetna is completing an audit of claims back to 1/1/2020 and asks that providers do not resubmit these claims, but that they will reprocess them.
- **Humana** followed CMS on the edits and will retroactively reprocess claims to 1/1/2020, but providers must resubmit their claims.
- **United Health Care** recently reinstated the use of modifier 59 for codes that other payers do not.

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Blue Plan

SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED
		CLAIM CONTINUED FROM PREVIOUS PAGE				
0415 041521		2	97530	59GP	119.90	88.14
0415 041521		2	97140	GP	127.88	61.62
0415 041521		1	97110	GP	68.29	33.93
36.74 CLM STATUS 1			CLAIM TOTALS		316.07	183.69

Aetna

0922 092221	1	1	97530	GP	49.00	13.00
0922 092221	2	1	97112	GP	45.00	16.75
0922 092221	3	1	97110	GP	42.00	8.38
0922 092221	4	1	97140	GP	45.00	21.03

CMS

1021 102121	11	1	97530	GP	49.00	37.92
1021 102121	11	1	97112	GP	45.00	26.09
1021 102121	11	1	97110	GP	42.00	22.87

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Example of Blue Plan Non-Payment

0913 091321		1	97530	GP	-49.00		0.00	0.00 CO-231
0913 091321		1	97110	GP	-42.00	30.17	0.00	0.00
0913 091321		1	97140	GP	-45.00	28.55	0.00	0.00
-30.00 CLM STATUS 22			CLAIM TOTALS		-136.00	58.72	0.00	0.00
0913 091321		1	97530	GP59	49.00	32.26	0.00	0.00
0913 091321		1	97110	GP	42.00	30.17	0.00	0.00
0913 091321		1	97140	GP	45.00	22.87	0.00	0.00
30.00 CLM STATUS 1			CLAIM TOTALS		136.00	85.30	0.00	0.00

231 Mutually exclusive procedures cannot be done in the same day/setting

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Example of Aetna Non-Payment

REND PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC	AMT	PROV PD
	1123	112321	1	97535	GO	94.04		0.00	0.00	PI-234	94.04	0.00
REM: M15												
	1123	112321	1	97530	GO	59.95	36.25	0.00	7.25	CO-45	23.70	29.00
REM: N6												
	1130	113021	1	97535	GO	47.02		0.00	0.00	PI-234	47.02	0.00
REM: M15												
	1130	113021	1	97530	GO	59.95	36.25	0.00	7.25	CO-45	23.70	29.00

234 This procedure is not paid separately

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Documentation to Support Separate and Distinct Services

Treat the patient → Document skilled service → Select CPT code → Bill CPT code – w/ units, modifiers

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Documentation to Support Separate and Distinct Services

- Billing record:
  - 1 unit 97150, group
  - 1 unit 97110-59, ther ex
- Documentation to support modifier -59:
  - 97110: Progressed pt from sub-maximal isometric R shoulder ex to max isometric and eccentric shoulder flex/abd as per protocol. Exercises performed in front of mirror for visual feedback; pt instructed to add new ex to HEP.
  - 97150: Pt completed AROM and PRE of R elbow/wrist/hand as per flow sheet **in supervised format with one other patient**. Required cues to complete full ROM and maintain neutral shoulder rotation.

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UNATTENDED ESTIM

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Unattended Estim Non-Payment

97014 vs. G0283

Medicare requires G0283

Example of response on a claim where incorrect code is billed:

REND PROV	SERV DATE	POS	NOS	PROC	MODS	BILLED	ALLOWED	DEDUCT	COINS	GRP/RC	AMT	PROV PD
1105	110519		1	97012	GP	22.30	12.02	0.00	0.00	CO-59	12.67	4.62
										CO-253	0.09	
										OA-23	4.92	
1105	110519			97014	GP	21.59		0.00	0.00	CO-96	21.59	0.00
REM: N174												
1105	110519		2	97530	GP	119.90	66.37	0.00	0.00	CO-59	68.14	24.78
										CO-253	0.51	
										OA-23	26.47	
PT RESP		CLM STATUS 20		CLAIM TOTALS		163.79	78.39	0.00	0.00		134.39	29.40
BILL TYPE 743	DRG CD	ADJ TO TOTALS:		INTEREST		0.00	LATE FILING CHARGE		0.00	NET	29.40	

96 Non-covered charge(s)

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Appeals and Reprocessing Process

- Process varies payer to payer
- Reconsideration with documentation to prove that services were provided separately and distinctly
- Ensure the modifier is appended to the claim

- Do not settle – payment for these services should be paid separately if that is the intent!

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Access To This Recording & Handouts

- NARA Members
  - Recording & slide handout will be available under Webinars tab on the Member Portal by end of day December 16th
  - Link to Member Portal: https://nara.myhubintranet.com/
- Non-Members
  - Recording & slide handout will be emailed by end of day December 17th
- NARA Membership is for the entire organization and includes access to past webinars, alerts to key legislative and regulatory changes or happenings impacting the industry, participation in town hall and special interest group calls, access to a multidisciplinary network of rehab providers, discounts on conferences, etc: https://www.naranet.org/membership/trial-membership

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Questions?

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Thank You!

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Resources

- Aetna. COVID-19: Telemedicine FAQs: https://www.aetna.com/health-care-professionals/covid-faq/telemedicine.html
- Center for Connected Health Policy. State Summary Chart (Fall 2021): https://www.cchpca.org/2021/10/Fall2021_StateSummaryChart_FINAL.pdf
- Center for Connected Health Policy. State Telehealth Laws and Reimbursement Policies: https://www.cchpca.org/resources/state-telehealth-laws-and-reimbursement-policies-report-fall-2021/
- Cigna. Virtual Care: https://static.cigna.com/assets/chcp/resourceLibrary/medicalResourcesList/medicalDoingBusinessWithCigna/medicalDbwCVirtualCare.html
- CMS. Annual Therapy Update Code List and Dispositions: https://www.cms.gov/Medicare/Billing/TherapyServices/AnnualTherapyUpdate
- CMS. Billing Examples Using CQ/CO Modifiers: https://www.cms.gov/medicare/therapy-services/billing-examples-using-cqco-modifiers-services-furnished-whole-or-part-ptas-and-otas
- CMS. Coronavirus COVID-19 Stakeholder Calls: https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts
- CMS. COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers: https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf

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- CMS. COVID-19 FAQs on Medicare FFS Billing: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf
- CMS. List of Telehealth Services for CY 2022: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
- CMS. Medicare Telemedicine Health Care Provider Fact Sheet: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
- CMS. MM12126. 2021 Annual Update to the Therapy Code List: https://www.cms.gov/files/document/mm12126.pdf
- CMS. MM12446. 2022 Annual Update to the Therapy Code List: https://www.cms.gov/files/document/mm12446-2022-annual-update-therapy-code-list.pdf
- CMS. MM12397. Reduced Payment for Physical Therapy and Occupational Therapy Services Furnished in Whole or In Part by a Physical Therapist Assistant or an Occupational Therapy Assistant: https://www.cms.gov/files/document/mm12397-reduced-payment-physical-therapy-and-occupational-therapy-services-furnished-whole-or-part.pdf
- CMS. National Correct Coding Initiative Edits: https://www.cms.gov/Medicare/Coding/NCCI-Coding-Edits
- CMS. Transmittal R11045. New/Modifications to the POS Codes for Telehealth: https://www.cms.gov/files/document/r11045cp.pdf

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Resources

- CY 2022 Medicare Physician Fee Schedule Final Rule: https://public-inspection.federalregister.gov/2021-23972.pdf
- Humana Claims Payment Policy, Modifiers CO and CQ: https://www.humana.com/provider/medical-resources/claims-payments/claims-payment-policies
- Humana Policy Guidance for Telehealth. https://www.humana.com/provider/coronavirus/telemedicine
- ICD-10-CM Official Guidelines for Coding and Reporting FY 2022: https://www.cms.gov/files/document/fy-2022-icd-10-cm-coding-guidelines.pdf
- OCR. FAQs on Telehealth and HIPAA during the COVID-19 PHE: https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf
- Palmetto GBA. Medicare Physician Fee Schedule Part B: https://www.palmettogba.com/palmetto/fees_front.nsf/fee_main?OpenForm
- TRICARE Policy Manual, Chapter 11: Physical Therapist Assistants and Occupational Therapy Assistants
- UHC Commercial Reimbursement Policy, Modifiers CO and CQ: https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-reimbursement/COMM-Physical-Med-Rehab-PT-OT-and-Evaluation-Mgmt-Policy.pdf
- UHC Telehealth Policy for PT/OT/ST: https://www.uhcprovider.com/en/resource-library/news/Novel-Coronavirus-COVID-19/covid19-telehealth-services/covid19-telehealth-pt-ot-st.html

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