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CMS Proposed Physician Fee Schedule Rule CY2022 & the Potential Impact on Your Business


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Housekeeping Reminders

- All attendees are on mute
- A copy of these slides will be provided at the end of the webinar
- Format: Presentation followed by Question & Answer
- **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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Objectives

We will review the Proposed Rule related to the following issues:

- Payment
 - Conversion Factor
 - E/M Codes and Impact
- MIPS
- Telehealth/Remote Patient Monitoring
- Assistant Supervision in Private Practice
- Assistant Payment Reduction
 - Updates and examples
- Health Equity Feedback Request
- Advocacy



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Payment


Conversion Factor PROPOSED at \$33.58 for CY2022, down from \$34.89 for CY2021

Year	Conversion Factor
2017	\$35.89
2018	\$36.00
2019	\$36.04
2020	\$36.09
2021	\$34.89
2022 (PROPOSED)	\$33.58

$\text{Payment} = [(\text{RVU work} \times \text{GPCI work}) + (\text{RVU PE} \times \text{GPCI PE}) + (\text{RVU MP} \times \text{GPCI MP})] \times \text{CF}$

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Payment

- MACRA essentially froze PFS increases through 2024
- Expiration of the 3.75% increase resulting in \$3 Billion dollar infusion into the PFS from Consolidated Appropriations Act 2021
- Budget neutrality adjustments related to RVU changes for practice expense resulting from the wage data update, whenever there are increases...there must be decreases!
- **Overall estimated impact for therapy approximately -4% for CY2022**

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Payment

Physicians were set to get some significant increases in the E/M codes last year (2021)...with a projected impact on therapy of **-9%**
CAA reduced that by approximately 3%
Moratorium on G2211 reduced that by approximately 3%

In this proposed rule, limited discussion about the Evaluation and Management, a few refinements but nothing significant

Future impact? Moratorium on the E/M add on code G2211 through 2023, then what?

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MIPS

- MACRA 2015 lead to Quality Payment Program (QPP)
- Transitional implementation over 5 years (2017-2021)...step up of performance threshold
- 2022 Mature MIPS...50/50 split bonus to penalty
- Institutional providers still excluded due to requirement to bill on institutional forms (UB04)



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MIPS 2022 Proposal

Performance Threshold	Exceptional Performance Bonus	Bonus Points Removed	Bonus Points Renewed
<ul style="list-style-type: none"> • Increased to 75 points 	<ul style="list-style-type: none"> • Extended for another year • 89 points • Estimated potential of 14% bonus, exceeding goal of 10% 	<ul style="list-style-type: none"> • High priority measures (6 points) • End to End (6 points) • Data completeness (18 points) • -30 total point impact 	<ul style="list-style-type: none"> • Complex patient (10 points) • Small Practice (6 points) • Quality improvement (10 points) • +26 total point impact


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Telehealth and RPM

- PHE has given therapy access to telehealth temporarily
- Codes
 - CMS is proposing including additional therapy codes to category 3 list (created temporarily) until the end of 2023.
 - CMS did not propose to add therapy codes to the Category 1 and 2 lists of approved telehealth codes.
 - CMS is seeking additional information on these codes.



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Telehealth and RPM

- Clinicians
 - Even though we might have codes available to bill, PTs, OTs, and SLPs have not been added to the list of eligible practitioners for telehealth services, so therapists will no longer be able to use telehealth after the year end of the expiration of the PHE.
 - We should be advocating that therapists be added as eligible practitioners.

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Remote Therapeutic Monitoring (RTM)

- RTM codes were created (989X1-5) for practitioners who are not eligible to bill Remote Physiologic Monitoring (RPM) but are services of similar nature.
- Essentially, RTM codes are E/M codes for therapists who cannot bill E/M codes.

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Remote Therapeutic Monitoring (RTM)

- RTM codes are used to monitor health conditions using FDA approved medical devices.
- CMS discovered that RTM codes are “incident to” codes which makes them unavailable to therapists.
- CMS is seeking additional input on how to resolve this issue.

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Assistant Supervision in Private Practice

- PHE allowed for direct supervision to be provided via audio-visual technology through the end of the calendar year of the expiration of the PHE.
- Proposed rule discusses making this policy permanent.
- CMS is seeking comment if this flexibility should be permanent.

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Assistant Supervision in Private Practice

- Pros/Cons
 - Makes supervision in Private Practice “easier”.
 - May impact Private Practice vs Rehab Agency decisions on behalf of providers.
- State Practice Acts may have overarching requirements on supervision.




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Assistant Payment Reduction

- Section 53107 of Bipartisan Budget Act of 2018
- 15% Reduction
 - Applies to the 80% that Medicare covers, impact 12%
 - CO/CQ Modifiers
 - De minimis standard
 - Remaining units



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Assistant Payment Reduction

- De minimis standard – the services are considered to have been furnished in whole or in part when more than 10% of the services is furnished by the assistant.
 - Applies to each 15-minute unit.
 - Services provided by assistant in conjunction with the therapist are considered to be provided by the therapist and the CO/CQ does not apply.

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Assistant Payment Reduction

- Steps for determining when the CO/CQ modifier applies:
 - First, determine total number of timed units to be billed

Step 1. Identify the timed codes furnished for 15 minutes or more. When any timed services were provided by the PTA/OTA, that is in full 15-minute increments, the CO/CQ modifier applies.


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Assistant Payment Reduction

- Steps for determining when the CO/CQ modifier applies:
 - Step 2.** Identify services in which the therapist and assistant provided minutes of the same code. This includes “remaining minutes” in Step 1 above a 15-minute unit. Determine if the de minimis standard has been exceeded. If so, apply the CO/CQ modifier.
 - *Some exceptions apply


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Assistant Payment Reduction

- Steps for determining when the CO/CQ modifier applies:
 - Step 3.** Identify services in which the therapist and assistant provided minutes of differing codes. After applying Step 1 for each service, compare the “remaining minutes” furnished by PT/OT for one service with the “remaining minutes” furnished by PTA/OTA for a different service. Apply CO/CQ if the assistant minutes are greater than the therapist minutes. Do not apply CO/CQ if therapist minutes are greater than assistant minutes. *Some exceptions apply


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Assistant Payment Reduction

- Steps for determining when the CO/CQ modifier applies:
 - Step 4.** Identify the different services in which the therapist and assistant each independently provided the same number of minutes. Once Step 1 is completed for each service, and remaining minutes of differing services provided by therapist and assistant are the same, choose which service to bill (not both) and apply the CO/CQ if the assistant services were billed.


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Assistant Payment Reduction

- For the remaining minutes unit, in general, if the assistant provided 8 mins or more and the therapists provided less than 8 minutes, or when both assistant and therapists both provided less than 8 minutes of the same service, the modifier applies (see Table 19 of the rule).

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Assistant Payment Reduction

TABLE 19: Billing Scenario Examples Where CQ/CO Modifier Applies

	Billing Scenario	Stakeholders' Rules
Scenario 1	PT/OT (6 minutes) + PTA/OTA (8 minutes) - for a total of 14 minutes.	The PTA/OTA provided 8 minutes or more and the PT/OT provided less than 8 minutes; therefore, the <i>de minimis</i> standard is exceeded. Bill with the CQ/CO modifier.
Scenario 2	PT (5 minutes) + PTA/OTA (5 minutes) - for a total of 10 minutes.	Both the PT/OT and the PTA/OTA provided less than 8 minutes; so the <i>de minimis</i> standard is exceeded. Bill with the CQ/CO modifier


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Assistant Payment Reduction

- Conversely, the modifier would not apply when the therapist provides 8 or more minutes and the assistant provides less than 8 of a timed code.
- Medicare agrees that if the therapists supply enough mins to bill on their own for the service provided, then the modifier should not apply (See Table 20 from the rule).

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Assistant Payment Reduction

TABLE 20: Billing Scenario Examples Where the “Midpoint Rule” Applies

	Billing Scenario	Therapy Stakeholder Midpoint Rule
Scenario 1	PT (8 minutes) + PTA/OTA (7 minutes) – for a total of 15 minutes.	The PT/OT bills without the CQ/CO modifier because they provided enough minutes on their own (8 minutes or more) without the PTA’s/OTA’s time to bill the one unit. Disregard PTA/OTA minutes.
Scenario 2	PT (11 minutes) + PTA/OTA (11 minutes) - for a total of 22 minutes.	The PT/OT bills without the CQ/CO modifier because they provided enough minutes on their own (8 minutes or more) without the PTA’s/OTA’s time to bill the one unit. Disregard PTA/OTA minutes.


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Assistant Payment Reduction Examples

- Example A (start on page 286 of Proposed Rule)
 - PTA, 10 mins of 97110; PT, 5 mins of 97110. Total – 15 mins (1 units)
 - Analysis – bill 1 unit with CQ modifier because the PTA provided 8 mins or more and the PT provided less than 8 mins.



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Assistant Payment Reduction Examples

- Example B
 - PTA, 5 mins of 97110; PT, 6 mins of 97110. Total – 11 mins (1 units)
 - Analysis – bill 1 unit with CQ modifier because the PTA and PT provided less than 8 mins. Because neither of them achieved 8 mins on their own, the de minimis standard applies.


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Assistant Payment Reduction Examples

- Example C
 - PTA, 22 mins of 97110; PT, 23 mins of 97110. Total – 45 mins (3 units)
 - Step 1 – 97110 – PTA 15 mins gets CQ; with 7 mins remaining. Also apply Step 1 to PT’s 23 minutes which results in 15 mins of 97110 and 8 mins remaining.
 - Compare the remaining minutes and apply CQ modifier according to tables above – PT- 8 mins, PTA 7 mins, no CQ modifier.


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Assistant Payment Reduction Examples

- Example D
 - PTA, 14 mins of 97110; PT, 12 mins of 97110; PT – 20 mins 97140; Total – 46 mins (3 units)
 - Step 1 – Bill 1 unit of 97140, no CQ with 5 mins remaining.
 - 2 units remain to be billed and 97110 gets billed 1 unit with the CQ and one unit without. The remaining 5 mins of 97140 does not get billed.


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Assistant Payment Reduction Examples

- Example E
 - OTA, 11 mins of 97535; OT, 11 mins of 97530; Total – 22 mins (1 unit)
 - The “tie-breaker” scenario applies – Ch 5 of the MCPM Section 20.2.C.
 - Bill 1 unit of either service applying the CO modifier only if you bill the OTA service.


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Assistant Payment Reduction Examples

- Example F – Untimed Codes
 - OTA, 20 mins of 97150; OT, 20 mins of 97150; Total – 40 mins of Group Therapy (1 unit)
 - The “tie-breaker” scenario does not apply because it is not 2 different timed codes – Ch 5 of the MCPM Section 20.2.C.
 - De minimis standard applies and bill the 97150 with the CO modifier. *Reason: both OTA and OT delivered 20 minutes of group.*

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Assistant Payment Reduction

- Concerns:
 - Fairly straight forward when full units are provided.
 - Extremely tedious when parts of units are provided.
 - Can software vendors code this in time?
 - Can the MAC software accept two lines with the same CPT code on the same day, one with a modifier and one without?

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Health Equity

- COVID-19 Public Health Emergency highlighted widening gap in health equity
- CMS requesting stakeholder feedback that will be used to create a comprehensive RFI focused on closing this gap in CMS programs and policies
- The ASK? Include in your comments what data/reports would be helpful?

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Why advocacy?

Year	Policy	Net Reduction
2011-2030	Sequestration	-2%
2013	MPPR	-50% Practice Expense (PE) for second and subsequent codes
2020-2024	MACRA in 2015	0% increase PFS
2015	MIPS	0% for institutional providers indefinitely due to CMS billing requirements
2021	PAYGO	-4%
2022	BBA 2018 Assistant Reduction	-15% of 80% of Medicare Allowable
2022	PFS budget neutrality	Up to -4%
2024	PFS budget neutrality expiration of the moratorium of G2211	Up to -6%

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Advocacy Wins

- PT Compact
- Therapy caps
- Tricare and OTA/PTA care delivery
- E/M impact on therapy codes
- Application of the de minimis policy by unit
- PDPM parity adjustment



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Advocacy Opportunities



- Adding PT, OT and SLP as eligible clinicians for telehealth
- Use of therapy codes and telehealth
- Therapy assistant payment reduction
- RTM codes and therapy use
- Inability for institutional providers to participate in MIPS
- Including rehab therapists in HIT and information exchange

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