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Telehealth, Split or (Shared) Visit, Critical Care, and Teaching Physician Billing Proposals in the CY 2022 Medicare Physician Fee Schedule Proposed Rule

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On July 13, 2021, CMS released the Calendar Year (CY) 2022 Medicare Physician Fee Schedule (PFS) proposed rule, which includes several noteworthy proposals related to telehealth, billing for split (or shared) visits, critical care, and teaching physician services. The deadline for comments on the proposed rule is 5:00 p.m. on September 13, 2021.

CMS proposes to lengthen the period that an expanded list of Medicare covered telehealth services will be covered beyond the COVID-19 public health emergency (PHE); implement Consolidated Appropriations Act of 2021 (CAA) provisions that permanently remove geographic originating site restrictions on telehealth services used for purposes diagnosis, evaluation, or treatment of mental health disorders; and allow such services to be furnished to beneficiaries in their homes if certain prerequisites are satisfied. Additionally, CMS makes proposals to modify and clarify requirements related to billing for split (or shared) visits, critical care services, and teaching physician services taking into account recent updates to coding and payment of evaluation and management (E/M) visits that took effect January 1, 2021. Key proposals are summarized in more detail below.

Additions to the Medicare Telehealth Services List

Before the COVID-19 PHE, Medicare only covered certain services furnished via telehealth, including: (1) professional consultations, (2) office medical visits, (3) office psychiatry services, and (4) any additional service specified by the HHS Secretary when furnished via an interactive telecommunications system. These services are all included on a list that is amended and published annually in the PFS (the Medicare Telehealth List.) On an annual basis, CMS considers proposals to add services to the Medicare Telehealth List on a Category 1 basis. This means that these services are similar to the professional consultations, office visits, and office psychiatry services that are already covered on the list. Additionally, CMS may add services to the Medicare Telehealth List on a Category 2 basis if there is evidence of clinical benefit if provided through telehealth. Finally, in the CY 2021 PFS final rule, CMS established a new Category 3 to add services to the Medicare Telehealth list on a temporary basis following the end of the COVID-19 PHE. Category 3 services must have a likely clinical benefit when furnished via telehealth, but there is not yet sufficient evidence to consider these services for permanent addition on a Category 1 or Category 2 basis.

In response to the COVID-19 pandemic, CMS added 135 services to the Medicare telehealth list in CY 2020 on an interim basis through the March 31 COVID-19 interim final rule with comment period (IFC) and a sub-regulatory process established in the May 8 COVID-19 IFC . As part of the CY 2022 PFS Proposed Rule, CMS is proposing to retain all services added to the Medicare Telehealth List on a Category 3 basis until December 31, 2023, to ease the transition from the expanded list services added to the Medicare Telehealth List during the COVID-19 PHE. During this time period CMS will evaluate whether the services should be permanently added to the telehealth list after the COVID-19 Public Health Emergency has terminated. These Category 3 services include the following:

- Domiciliary, Rest Home, or Custodial Care Services, Established Patients (99336, 99337)

- Home Visits, Established Patient (99349, 99350)
- Emergency Department Visits, Levels 1-5 (99281-99385)
- Nursing Facilities Discharge Day Management (99315, 99316)
- Psychological and Neuropsychological Testing (96130-96133, 96136-96139)
- Psychological and Neuropsychological Testing (CPT codes 96130-96133; CPT codes 96136-96139)
- Therapy Services, Physical and Occupational Therapy, All levels (CPT codes 97161-97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507)
- Hospital Discharge Day Management (CPT codes 99238-99239)
- Inpatient Neonatal and Pediatric Critical Care, Subsequent (CPT codes 99469, 99472, 99476)
- Continuing Neonatal Intensive Care Services (CPT codes 99478-99480)
- Critical Care Services (CPT codes 99291-99292)
- End-Stage Renal Disease Monthly Capitation Payment codes (CPT codes 90952, 90953, 90956, 90959, 90962)
- Subsequent Observation and Observation Discharge Day Management (CPT codes 99217, 99224-99226)

Any services that were temporarily added to the Medicare Telehealth List on an interim basis to respond to the COVID-19 PHE, but were not extended on a temporary Category 3 basis in the CY 2021 PFS final rule, will be removed from the Medicare Telehealth List on the date that the COVID-19 PHE ends. These include certain Radiation Oncology; Ophthalmological; Speech, Language, and Audiology; Cariological; Ventilation Assistance Management; Neurological; Behavioral Health; Physical, Occupational, and Speech Therapy; Hospital Inpatient; Observation Care; Nursing Facility; Home; Office/Outpatient; Critical Care; and Cardiac and Pulmonary Rehabilitation Services. CMS is soliciting comment on whether any of these services should now be added to the Medicare Telehealth List on a Category 3 basis to allow a timeframe to collect more information so they can be considered for permanent addition in the future.

Expansion of Medicare Coverage for Telehealth Services for Diagnosis, Treatment and Evaluation of Mental Health Disorders

To implement provisions in the CAA, CMS is proposing that the geographic restrictions under the Medicare statute (section 1834(m)(4)(c)(i) of the Social Security Act) will not apply and the patient's home will be a permissible originating site for telehealth services furnished for the purpose of diagnosis, evaluation, or treatment of a mental health disorder. This expanded coverage will take effect for services furnished on or after the end of the PHE for COVID-19 provided that an in-person, non-telehealth service has been provided by the physician or practitioner furnishing mental health telehealth services within six months prior to the initial telehealth service and at least once every six months thereafter. These initial and periodic in-person visit requirements do not apply if the telehealth service would have been covered without the new CAA amendment.

CMS is seeking comments on an alternative proposal that would allow the prerequisite in-person non-telehealth service for certain mental health telehealth services to be furnished by a practitioner in the same specialty/subspecialty in the same group when the physician or practitioner who furnishes the telehealth service is unavailable or two professionals are practicing as a team. CMS notes that there are several circumstances under which, historically, CMS has treated the billing practitioner and other practitioners of the same specialty or subspecialty in the same group as if they were the same individual (e.g., for purposes of deciding whether a patient is a new or established patient, or whether to bill for an initial or subsequent visit). CMS is also interested in comments regarding the extent to which a patient routinely receiving mental health services from one practitioner in a group might have occasion to see a different practitioner in the same specialty in that group for the treatment of the same condition.

Additionally, CMS seeks comment on whether the proposed six-month interval for in-person visits between telehealth services for mental health services is appropriate, or whether a shorter or longer interval would be more appropriate. CMS notes that whatever time interval is established, the practitioner may schedule in-person visits more frequently if it is determined to be clinically appropriate or preferred by the patient.

CMS is also proposing to allow audio-only technology for these mental health telehealth services subject to beneficiary choice or technological limitations. The proposed expansion to allow audio-only telehealth services is limited to mental health telehealth services that meet the requirements of the new amendment (e.g., in-person service furnished within the past six months) and when the home is the originating site. Additionally, the practitioner still must have the capacity to furnish the service using interactive two-way, real-time audio/video communication technology. CMS is proposing to create a service-level modifier to identify these specific mental health telehealth services that could be furnished to a beneficiary using audio-only technology.

CMS also seeks comment on: (1) whether additional medical record documentation should be required to support the clinical appropriateness of audio-only telehealth; (2) whether or not to preclude audio-only telehealth for some high-level services, such as level 4 or 5 E/M visit codes or psychotherapy with crisis; and (3) any other guardrails that should be established to minimize program integrity and patient safety concerns that could arise with this proposed expansion of audio-only services.

Also consistent with the CAA, CMS proposes to revise 42 CFR § 410.78(b)(3) to add a rural emergency hospital as a permissible Medicare-eligible originating site for services furnished on or after January 1, 2023.

Direct Supervision through Real-Time Audio/Visual Technology

CMS seeks comment on whether to continue the flexibility to allow practitioners to meet the availability requirement for direct supervision through the use of real-time, audio/visual technology without limitation after the PHE for COVID-19. Alternatively, CMS seeks comment on whether it should continue the policy in place for a short period beyond the current end date (the later of the end of the year in which the PHE ends or December 31, 2021). CMS is also interested in feedback regarding whether the longer sunset of this policy should be allowed for only a subset of services, and whether a service level modifier should be required to identify when the requirements for direct supervision via two-way, audio/visual communications technology are satisfied.

Permanent Adoption of an Extended Virtual Check-in

CMS proposes to permanently adopt coding and payment for extended virtual check-ins (HCPCS code G2252). Originally adopted on an interim basis in the CY 2021 PFS final rule, HCPCS Code G2552 describes 11-20 minutes of medical discussion to determine the medical necessity of an in-person visit. This G-code is not an E/M code but instead is better described as a longer virtual check-in with a higher value. This code allows audio-only interactions to be used for a longer medical discussion to determine the necessity of an in-person visit. Additionally, this code is not a telehealth service that falls under the statutory payment restrictions of Section 1834(m) of the Social Security Act. Rather, this longer audio virtual check-in is a communication technology-based service subject to the same billing requirements as HCPCS code G2012 (e.g., if the service originates from a related E/M service or procedure within the next 24 hours or soonest available appointment, it will be bundled into that in-person service).

Remote Therapeutic Monitoring (RTM)

CMS proposes finalizing a family of five codes (CPT codes 989XI, 989X2, 989X3, 989X4, and 989X5) to describe Remote Therapeutic Monitoring (RTM) services. Similar to remote physiologic monitoring (RPM)

services, the RTM codes reflect staff and physician work, but the nature of the data collected and how it is collected differs from RPM services. Specifically, RTM services differ from RPM services because the requirements for RTM services allow: 1) non-physiologic data to be collected, and 2) allow data to be self-reported as well as digitally uploaded. According to the code descriptors, RTM codes are meant to monitor health conditions, including musculoskeletal status respiratory system status, therapy (medication) adherence, and therapy (medication) response. The devices used to collect RTM data must meet the FDA definition of a medical device described in section 201(h) of the Federal Food, Drug, and Cosmetic Act (FFDCA). CMS is seeking comment on the typical types of devices and the associated costs of devices that may be used to collect the various kinds of data included in the code descriptors for RTM services.

The proposed code structure for RTM services is similar to RPM services, with three direct practice expense-only (PE-only codes) (CPT codes 989X1, 989X2, and 989X3), and two professional work only codes (CPT 989X4 and 989X4). Yet, the RTM codes differ from RPM codes because they are general medicine codes rather than E/M codes, and therefore, cannot be designated as care management services. While the primary billers of RTM codes were projected to be nurses and physical therapists, as currently constructed, the RTM codes cannot be billed by physical therapists or any other practitioners that are not authorized to furnish and bill "incident to" services. CMS is seeking comment on how it may remedy the issues related to RTM code construction to permit practitioners who are not physicians or non-physician practitioners (NPP)s to bill the RTM codes.

Chronic Care Management (CCM) Services, including Complex Chronic Care Management (CCCM) and Principal Care Management (PCM)

For CY 2022, the RVS Update Committee (RUC) resurveyed the CCM code family and added five new CPT codes: 99X21, 99X22, 99X23, 99X24, and 99X25. As a result, the CCM/CCCM/PCM code family now includes five sets of codes, each with a base code and an add-on code. The sets vary by the degree of complexity of care, who furnishes that care (clinical staff or physician/NPP), and the time allocated for the services. CMS reviewed the RUC-recommended values for the 10 codes in the CCM family and is proposing to adopt the recommended work values for these codes, as well as, the RUC recommended PE inputs without refinements. CMS is seeking comment on whether keeping professional PCM and CCM at the same value creates an incentive to bill CCM instead of billing PCM when appropriate.

CMS has been receiving questions arising from COVID flexibilities allowing stakeholders to obtain beneficiary consent for certain services under general supervision. As a result, CMS is seeking comments on how different billing practitioners furnishing CCM at different sites (e.g., physician office settings, RHCs, FQHCs) have been obtaining beneficiary consent over the past year, and how different levels of supervision impact the consent process. CMS is specifically interested in the level of supervision necessary to obtain beneficiary consent when furnishing CCM services and this will be considered in future rulemaking.

Split (or Shared) Visits

To address a lack of clarity in current guidance, CMS proposes to define split (or shared) visits in a new section of the regulations at 42 CFR § 415.140. The rules around billing for split (or shared) visits have often been a source of confusion for practitioners. While "incident to" services are allowed in the non-facility setting provided that the visit meets the conditions of payment set forth in 42 CFR § 410.26(b)(1), "incident to" billing is not allowed in facility (e.g., hospital) settings. The only way that a physician and an NPP in a facility can "share" a visit and have their combined work taken into account when billing for services is when split (or shared) visit requirements are satisfied.

In the past, practitioners had to rely on manual guidance in the Medicare Claims Policy Manual (sections 30.6.1(B), 30.6.12, and 30.6.13(H)) to determine if services furnished by physicians and NPPs could be billed as a shared visit under the physician's billing number. This guidance was withdrawn effective May 9, 2021. Under the now-withdrawn manual guidance, CMS's longstanding policy was that the physician could bill for a split (or shared) E/M visit only if both the billing physician and an NPP in the same group each performed a substantive portion of the visit and furnished the visit in specified settings. If the applicable requirements were satisfied, shared/split billing allowed the service to be billed at the physician's higher rate of 80 percent of the lesser of the actual charge or the fee schedule amount for the service. Alternatively, if the physician did not perform a substantive portion of split (or shared) visit, and the NPP billed for the service, Medicare paid a lower rate of 80 percent of the lesser of the actual charge or 85 percent of the fee schedule rate.

Definition of Split (or Shared) Visits

For the first time, the new CPT guidelines for E/M services introduced a CPT definition of a split (or shared) visit, effective January 1, 2021. According to this definition:

A split or shared visit is defined as a visit in which a physician and other qualified health care professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physicians or other qualified health care professional(s) assessing and managing the patient on the day of the encounter is summed to define total time. Only distinct time should be summed for split or shared visits (that is, when two or more individuals jointly meet with or discuss the patient, only time of one individual should be counted).

When Split (or Shared) Visits Should Be Reported

While this definition provides some clarity, it fails to address which practitioner should report the visit when elements are performed by different practitioners, or whether the substantive portion of the visit must be performed by the billing practitioner. As a result, CMS addresses these topics in the CY 2022 PFS proposed rule, where CMS proposes to define split (or shared) visits in a new section of the regulations at 42 CFR § 415.140. The proposed regulations would define split (or shared) visits as those that:

- Are furnished in a facility setting by a physician and an NPP in the same group, where the facility setting is defined as an institutional setting in which payment for services and supplies furnished incident to a physician or practitioner's professional services is prohibited under the regulations on incident to billing (42 CFR § 410.26(b)(1)).

- Are furnished in accordance with applicable law and regulations, including conditions of coverage and payment, such that the E/M visit could be billed by either the physician or the NPP if it were furnished independently by only one of them in the facility setting (rather than as a split (or shared) visit).

How the "Substantive Portion" of the Split (or Shared) Visit Should Be Determined

CMS proposes that only the physician or NPP who performs the substantive portion of the split (or shared) visit would bill for the visit. "Substantive portion" is proposed to be defined as more than half of the total time spent by the physician and NPP performing the visit. The distinct time of service spent by each physician or NPP furnishing a split (or shared) visit would be summed to determine total time. For visits that are not critical care services, CMS is proposing that the same listing of activities that can count when time is used to select E/M visit level could count toward total time. Even though CMS proposes to define the "substantive portion" based on time, CMS clarifies that the practitioner providing the substantive portion of the visit could still select the

level for the split (or shared) visit based on medical decision making (MDM). CMS proposes that documentation in the medical record must identify the individual practitioners who performed the visit and that the individual who performed the substantive portion (and therefore bills the visit) would have to sign and date the medical record.

Other Important Proposed Changes to Split (or Shared) Visit Billing Guidance

Additionally, CMS proposes the following important changes to prior split (or shared) visit guidance. CMS proposes to:

- Allow split (or shared) visits to be billed for **new** patients for initial and subsequent split (or shared) visits.
- Allow split (or shared) visits for **critical care visits** when they are performed in any institutional setting. CMS made proposals specifically related to billing for critical care split (or shared) E/M Services, which are explained in further detail below.
- Allow split (or shared) visits for certain **Skilled Nursing Facility (SNF/NF)** E/M visits that are not required to be performed in their entirety by a physician.
- Allow practitioners to bill for **a prolonged E/M visit** as a split (or shared) visit if the time threshold for reporting prolonged services is met.

Same Group Requirement for Split (or Shared) Visits

One aspect of the proposed split (or shared) policy that remains consistent with longstanding CMS guidance, is that CMS is proposing that a physician and NPP must be in the same group in order for the physician and NPP to bill of a split (or shared) visit. If the physician and the NPP are in different groups, CMS expects that the physician and NPP would bill independently only for the services that they each specifically fully furnish. CMS is seeking comment on whether it should further define "group" for purposes of split (or shared) visit billing. While a specific definition was not proposed, CMS mentions that it has considered options such as requiring that the physician and NPP must be in the same clinical specialty, aligning the definition of "group" in this context with the definition of "physician organization" at 42 CFR § 411.351, or considering practitioners with the same billing tax identification number as being in the same group. With respect to the last option, CMS notes that this approach may be too broad because multi-specialty groups or health systems could include many practitioners who do not typically work together to furnish care to patients in the facility setting. Additionally, some of these approaches may not align with the definition of "group" for purposes of Medicare enrollment.

Finally, CMS is proposing to create a modifier for split (or shared) visits that would be required to be appended to claims for these visits irrespective of whether the physician or NPP bills for the visits. This would allow CMS to identify claims for split (or shared) visits more efficiently than to date where the only way to identify such visits has been through medical record review.

Critical Care Services

CMS's manual guidance applicable to billing for critical care services (Medicare Claims Processing Manual sections 30.6.1(B), 30.6.12, and 30.6.13(H)) was also withdrawn effective May 9, 2021. The CY 2022 PFS proposed rule also includes proposals to update critical care E/M visit policies taking into account recent revisions in E/M coding and payment.

Definition of Critical Care Services

CMS proposes to adopt the CPT prefatory language definition of critical care services, which means these services would be defined as "the direct delivery by a physician(s) or other qualified healthcare professional (QHP) of medical care for a critically ill/injured patient in which there is acute impairment of one or more vital organ systems, such that there is a probability of imminent or life-threatening deterioration of the patient's condition."

Definition of Qualified Health Profession (QHP)

Critical care services may be furnished by a physician or other QHP. In this context, CMS proposes to define QHP as "an individual who is qualified by education, training, licensure/regulation (when applicable) facility privileging (when applicable), and the applicable Medicare benefit category to perform a professional service within their scope of practice and independently report that service."

Critical Care Services Furnished by a Single Physician or NPP

For critical care services furnished by a single physician or NPP, CMS proposes to adopt the rule that CPT code 99291 should be used to report the first 30-74 minutes of critical on a given date (and that code should be used only once per date), and CPT code 99292 should be used for additional 30 minute time increments provided to the same patient. CMS is seeking comment on how practitioners should report CPT codes 9929 and 99292 when a service extends beyond midnight the following calendar day.

Critical Care Services Furnished as Concurrent Care

CMS proposes that "concurrent care," which occurs where more than one physician or qualified NPP furnishes services to the same patient on the same day, is covered when the services of each practitioner are medically necessary, and not duplicative. CMS proposes that critical care services may be furnished as concurrent care to the same patient on the same day by more than one practitioner in more than one specialty, regardless of group affiliation, if the service meets the definition of critical care and is not duplicative of other services.

When critical care is furnished concurrently by two or more practitioners in the same specialty and the same group to the same patient on the same day, the individual physician(s) or NPP(s) providing the follow-up or subsequent care would report their time using CPT code 99292 (the code for subsequent time intervals, and would not report CPT code 99291 (the primary service code). CPT code 99291 would not be reported more than once for the same patient on the same day by practitioners in the same specialty in the same group.

Where one practitioner begins furnishing the initial critical care service, but does not meet the time required to report CPT code 99291, and another practitioner in the same specialty and group continues to deliver critical care to the same patient on the same day, CMS proposes that the time spent by those practitioners could be aggregated to meet the time requirement to bill CPT code 99291. Once the time threshold necessary to report CPT code 99291 is met, CPT code 99292 would not be reported by the practitioner or another practitioner in the same specialty and group unless and until the additional 20 minutes of critical care services are furnished to the same patient on the same day.

Critical Care Services Furnished as Split (or Shared Services)

As referenced above, CMS proposes to allow critical care service to be reported when furnished as split (or shared) services. The aforementioned proposals related to split (or shared) services would apply with one exception, and time would be counted for CPT code 99292 in the same way as for prolonged E/M services. In short, CMS is proposing that the total critical care service time provided by a physician and NPP in the same group on the same day would be added up, and the practitioner who furnishes the substantive portion of the

total critical care time would report the critical care services. The only exception to the general split (or shared) visit rules that CMS proposes for critical care services is that the qualifying activities that would be counted toward the total cumulative time are the qualifying activities included in CPT codes 99291 and 99292 (rather than the qualifying activities for E/M code level selection). The billing practitioner would first report CPT 99291 and, if 75 or more cumulative total minutes were spent providing critical care, the billing practitioner would report one or more units of CPT code 99292, as applicable. For split (or shared) critical care services (unlike concurrent critical care services), when two or more practitioners spend time jointly meeting with or discussing the patient, the time may be counted only once.

Documentation Requirements for Critical Care Services

CMS proposes to require practitioners to document in the medical record the total time that critical care services were provided by each reporting practitioner (but does not necessarily require start and stop times). Services would need to be sufficiently documented to allow a medical reviewer to determine the role each practitioner played in the patient's care (i.e., the condition or conditions for which the practitioner treated the patient). The proposed documentation requirements for split (or shared) E/M visits would also apply to split (or shared) critical care visits.

Limitations on Critical Care Services

CMS proposes that no other E/M visit can be billed for the same patient on the same date as a critical care service when the services are furnished by the same practitioner, or by practitioners in the same specialty in the same group. CMS seeks comment on this proposal to better understand clinical practice for critical care and to determine if there are situations where CMS should pay for this that would not increase the potential for duplicative payment.

Based on the fact that critical care visits are included in some 10- and 90-day global surgical packages, CMS is proposing to bundle critical care visits with procedure codes that have a global surgical period.

Teaching Physician Billing

Under general teaching physician billing rules (outside the COVID-19 PHE), if a resident participates in a service furnished in a teaching setting, a teaching physician only can bill for the service if s/he is present for the key or critical portion of the service. For residency training sites that are located outside a metropolitan statistical area, PFS payment may also be made if a teaching physician is virtually present through audio/video real-time communications technology. In the case of E/M services, the teaching physician must be present during the portion of the service that determines the level of service billed.

CMS proposes that when total time (instead of MDM) is used to determine the office/outpatient E/M visit level, only the time that the teaching physician was present can be included. During the PHE, teaching physicians can count time that they are virtually present through real-time audio-video technology in the total time used for level selection. Outside the PHE, CMS proposes that this "virtual" presence only may be counted toward time used for level selection in residency training sites located outside of a metropolitan statistical area. CMS believes this is appropriate because CMS makes separate Medicare graduate medical education (GME) payments to account for Medicare's share of the costs of training the resident.

For services furnished under the primary care exception, CMS proposes that only MDM can be used to select the office/outpatient E/M visit level. CMS decided that because residents may be less efficient than teaching physicians, they may need more time to furnish care, and therefore, MDM would be a more accurate indicator of visit complexity than time. This also would guard against the possibility of residents furnishing visits that are

more complex than lower and mid-level complexity when this is no longer permitted under the primary care exception after the PHE ends. CMS seeks comment on whether time is an accurate indicator of the complexity of a visit in the context of services furnished under the primary care exception, and how teaching physicians could select office/outpatient E/M visits using time when directing the care of a patient through services furnished by a resident.

Take-Aways

The proposals in the CY 2021 PFS proposed rule reflect changes in care delivery arising from increased integration of clinically appropriate telehealth and virtual services, as well as an ongoing evolution toward more team-based care that includes the services of non-physician practitioners. Within the constraints of its statutory authority and where sufficiently supported by data of clinical benefit, CMS has extended coverage of certain telehealth services and has expanded coverage for telehealth services furnished for diagnosis and treatment of mental health disorders. CMS has clearly indicated that it is seeking comment on several key proposals related coverage of mental health and audio-only telehealth services, new shared (split) billing regulations, and billing for critical care and teaching physician billing services. This is an important time for stakeholders to weigh in on how these proposals will be operationalized as CMS is modifying and clarifying important payment policies.

For more information, please contact Allison Cohen or any member of Baker Donelson's Reimbursement team.