Health Law Hacks

CRACKING THE CODE OF HEALTHCARE COMPLIANCE

Medicare Physician Fee Schedule Final Rule for 2023

Critical Changes to E/M Coding and Payment

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Richelle Marting is an attorney, registered health information administrator, and certified coder who focuses on healthcare coding, billing, and reimbursement issues. She has served as an outpatient multi-specialty surgery coder, hospital-based outpatient coder, compliance coordinator for a large multi-specialty medical group, interim system privacy officer, and interim director of managed care. As an attorney she advises clients proactively on complex reimbursement questions and has guided multiple clients through extensive Medicare, OIG and private payor audits and investigations. She has also served as an expert in litigation in matters involving health information management, reimbursement, and privacy.

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Anne Kindling devotes her legal practice to health and hospital law, administrative and regulatory defense, and civil litigation. Anne counsels organizational and individual health care providers on physician contracts, medical staff relations, peer review and risk management, practice compliance issues such as HIPAA and EMTALA, professional licensure, and defense of medical malpractice claims throughout Kansas. Her nearly 30 years of experience as an attorney includes over 10 years managing claims and risk management for a 500-bed hospital and multi-specialty clinic, pairing her sound legal knowledge with field experience that affords her clients practical solutions to complex questions.

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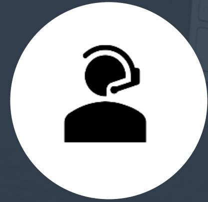
Overview

Evaluation and Management

Remote Monitoring

Telehealth Policy



RHCs/FQHCs

Evaluation and Management Services

American Medical Association changed the E/M section substantially, including general guidelines, elimination of all observation codes, revaluing hospital codes, deleting level 1 consult codes, and merging nursing facility/nursing home codes.

CPT makes some of the most significant changes to the E/M codes in decades

Level of Service Reporting

Extending 2021 changes to office visit codes to all E/M categories

No more history, exam levels

No more 1995, 1997 exam level disputes

HISTORY		Brief	Brief	Extended	Extended
HPI ☐ Location ☐ Severity ☐ Timing ☐ Mod. Factors ☐ *Chronic Condition 1 ☐ Quality ☐ Duration ☐ Context ☐ Assoc. S/S ☐ *Chronic Condition 2 *1997 Only After 4/19/12 Cmts: ☐ *Chronic Condition 3		1 element ☐	2 – 3 elements ☐	> 4 elements or status of ≥ 3 chronic or inactive conditions	> 4 elements or status of ≥ 3 chronic or inactive conditions ☐
ROS ☐ Constitutional ☐ ENMT ☐ GI ☐ Integumentary ☐ Endo ☐ Eyes ☐ Card/Vas ☐ GU ☐ Hem/Lymph ☐ All/Immun ☐ Resp ☐ Musculo ☐ Neuro ☐ Psych ☐ All Others Neg.		None ☐	Pertinent 1 system ☐	Extended 2 – 9 Systems ☐	Complete ≥ 10 systems or some systems with statement "All others negative" ☐
PFSH ☐ Past Medical ☐ Past Family ☐ Past Social (Not required for 99231 – 99233, 99261 – 99263, 99311 – 99333	Established/ ER	None	None ☐	1 ☐	2 -3 ☐
	New/ Consult/ Admit	None	None ☐	1 – 2 ☐	3 ☐
Mark the entry farthest to the right for each history area. To determine the history level, draw a line down the column with the circle farthest to the left.		**PF** ☐	**EPF** ☐	**Detailed** ☐	**Comprehensive** ☐

EXAM				
Organ Systems No distinct exam documentation; carried fwd from prev. ☐ Constitutional ☐ ENMT ☐ GI ☐ Integumentary ☐ Eyes ☐ Card/Vas ☐ GU ☐ Hem/Lymph/Immun ☐ Resp ☐ Musculo ☐ Neuro ☐ Psych	Area or System Related to Problem ☐	2 – 4 Systems/ Body Areas ☐	5 – 7 Systems/ Body Areas ☐	8 or more Systems ☐
Body Areas ☐ RUE ☐ LUE ☐ RLE ☐ LLE ☐ Head ☐ Neck ☐ Chest ☐ Abdomen ☐ Genitalia/Groin/Buttock ☐ Back	**PF** ☐	**EPF** ☐	**Detailed** ☐	**Comprehensive** ☐

E/M Guidelines

CPT

- Exact Same Subspecialty
- On call providers' specialties are imputed based on specialty of provider being covered
- NPPs and physicians considered same subspecialty as the docs they work with

CMS

- Doesn't recognize subspecialties
- Does not address on-call guideline
- NPPs "are always classified in a different specialty than the physician"

E/M Guidelines: Initial Visits

CPT

- Current: Attending only.
  - Others use consult or subsequent care codes
- New: Once per specialty/subspecialty/same group practice per admission
- Allows consulting providers to report initial codes
  - Patient admitted from another site of service the same day, report both with -25

CMS

- Current: Multiple providers; attending uses –AI
- Remember NPPs/physicians are different specialties
- No subspecialty recognition
- **Deviation from CPT:** Patient admitted from another site of service, report only 1 code
- **"Retain current billing policy" that provider must see patient in ED, admit** clarified in final rule to match current IOM language

E/M Guidelines: Prolonged Services

Primary E/M Service	Prolonged Code*	Time Threshold to Report Prolonged	Count physician/NPP time spent within this time period (surveyed timeframe)
Initial IP/Obs. Visit (99223)	G0316	105 minutes	Date of visit
Subsequent IP/Obs. Visit (99233)	G0316	80 minutes	Date of visit
IP/Obs. Same-Day Admission/Discharge (99236)	G0316	125 minutes	Date of visit to 3 days after
IP/Obs. Discharge Day Management (99238-9)	n/a	n/a	n/a
Emergency Department Visits	n/a	n/a	n/a
Initial NF Visit (99306)	G0317	95 minutes	1 day before visit + date of visit +3 days after
Subsequent NF Visit (99310)	G0317	85 minutes	1 day before visit + date of visit +3 days after
NF Discharge Day Management	n/a	n/a	n/a
Home/Residence Visit New Pt (99345)	G0318	140 minutes	3 days before visit + date of visit + 7 days after
Home/Residence Visit Estab. Pt (99350)	G0318	110 minutes	3 days before visit + date of visit + 7 days after
Cognitive Assessment and Care Planning (99483)	G2212	100 minutes	3 days before visit + date of visit + 7 days after
Consults	n/a	n/a	n/a

E/M Guidelines: Split/Shared

CPT

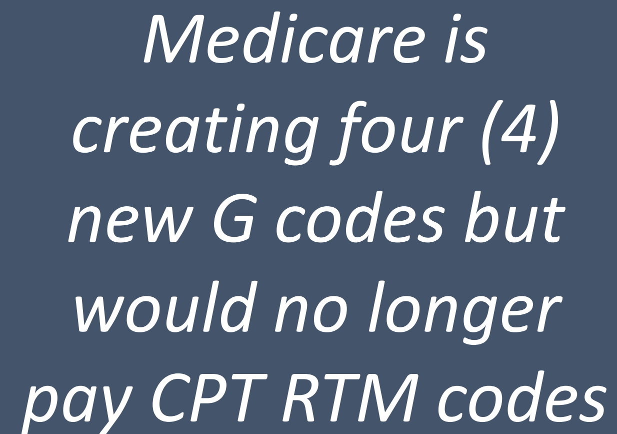
- Not limited to facility setting
- Does not define who reports

CMS

- Limited to facility setting
- Professional rendering substantive portion reports
- "More than half"
- Delaying definition of substantive until 1/1/2024

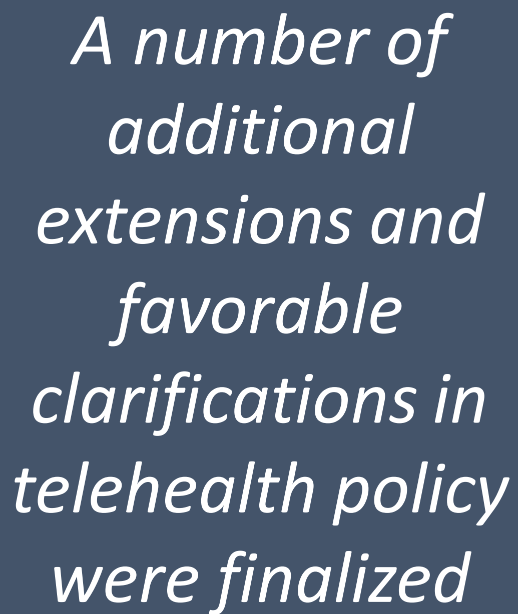
Observation Codes Eliminated

- Today's "Inpatient" codes become more generally "hospital" codes
- Observation consults: Office/other outpatient category
- Values for hospital category changing (today, inpatient/observation valued the same)
- Observation discharge 99217 didn't require time
- All hospital discharges should now document time



Reporting Monitoring

Medicare ***did not finalize*** its proposal



Telehealth Policy

"We found that none of the requests we received by the February 10th submission deadline met our Category 1 or Category 2 criteria for permanent addition to the Medicare Telehealth Services List"

Temporary v. Category 3

Temporary

- End when the PHE ends

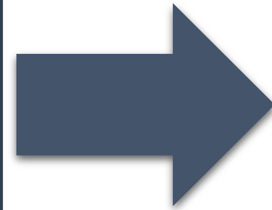
Category 3

- In effect until 12/31/23
- No extension to 12/31/23 date
- Watch federal legislation & potential extension through 12/31/24

The Future of Temporary, Category 3 Telehealth After the PHE

Temporary

- Continue 151 days after the PHE ends, rather than expiring the day the PHE ends



Category 3

- Currently removing from eligible telehealth services list 12/31/2023
- If the PHE extends well into 2023, “we may consider revising this policy” to cover category 3 telehealth through the end of 2024
- Watch pending legislation

Caution

- Current policy would remove *therapy codes* from the list of eligible telehealth services 12/31/2023
- Federal statute allows PT/ST/OT to bill as eligible distant site providers 151 days after the PHE ends
- As of today:
    - PHE could end **April 11, 2023**
    - 151 days after is September 9, 2023
    - End dates for therapy codes and end dates for therapists as eligible distant site providers **do not align**

Temporary ≠ Category 3

Temporary

- Audio-only codes

Category 3

- Audio-only is permanently allowed for certain mental/behavioral telehealth services to patients at home
- Watch for legislation

Medicare Telehealth After the PHE

Temporary codes will be available **151 days after PHE ends** (not removed the day the PHE expires)

Removal

HCPCS	Short Descriptor
77427	Radiation tx management x5
92002	Eye exam new patient
92004	Eye exam new patient
92550	Tympanometry & reflex thresh
92552	Pure tone audiometry air
92553	Audiometry air & bone
92555	Speech threshold audiometry
92556	Speech audiometry complete
92557	Comprehensive hearing test
92563	Tone decay hearing test
92565	Stenger test pure tone
92567	Tympanometry
92568	Acoustic refl threshold tst
92570	Acoustic immitance testing
92587	Evoked auditory test limited
92588	Evoked auditory tst complete
92601	Cochlear implt f/up exam <7
92625	Tinnitus assessment
92626	Eval aud funcj 1st hour
92627	Eval aud funcj ea addl 15
93750	Interrogation vad in person
94002	Vent mgmt inpat init day
94003	Vent mgmt inpat subq day
94004	Vent mgmt nf per day
96125	Cognitive test by hc pro
99218	Initial observation care
99219	Initial observation care
99220	Initial observation care
99221	Initial hospital care
99222	Initial hospital care
99223	Initial hospital care
99234	Observ/hosp same date
99235	Observ/hosp same date
99236	Observ/hosp same date
99304	Nursing facility care init
99305	Nursing facility care init
99306	Nursing facility care init
99324	Domicil/r-home visit new pat
99325	Domicil/r-home visit new pat
99326	Domicil/r-home visit new pat
99327	Domicil/r-home visit new pat
99328	Domicil/r-home visit new pat
99341	Home visit new patient
99342	Home visit new patient
99343	Home visit new patient
99344	Home visit new patient
99345	Home visit new patient
99441	Phone e/m phys/qhp 5-10 min
99442	Phone e/m phys/qhp 11-20 min
99443	Phone e/m phys/qhp 21-30 min
99468	Neonate crit care initial
99471	Ped critical care initial
99475	Ped crit care age 2-5 init
99477	Init day hosp neonate care

Extensions for 151-days after PHE ends

- Originating site: Anywhere in the U.S. where the patient is located. **Expands PHE flexibility**
- RHCs, FQHCs as distant site providers and current payment methodology.
- **CAHs' distant site provider eligibility ends the day the PHE ends**
- Delay 6-month in-person visit requirement for certain
- **Major clarification:** "we clarify that we do not believe this requirement applies to beneficiaries who began receiving mental health telehealth services in their homes during the PHE"
  - 12-month in-person visit requirements apply, but there are notable exceptions

Place of Service, Modifier Reporting

- Location where telehealth service was rendered
  - Through PHE, 151-days after with modifier -95
  - Use POS code that would have been reported had the service been furnished in-person for 151-days after PHE ends
  - Using POS 02 causes payment at facility rate
- **Day 152+, use POS 02 or 10**
- **POS 02 and 10 will be paid at facility rate**
- **POS 10 will only be paid for services eligible to patients at home**
- Modifier -93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System
  - RHCs, FQHCs currently using –FQ will change to -93
- Supervising practitioners continue to be required to append the “FR” modifier on any applicable telehealth claim when required to be present through an interactive real-time, audio and video telecommunications link, as reflected in each service’s requirement

Place of Service, Modifier Reporting

- Location where telehealth service was rendered
  - Through PHE, 151-days after with modifier -95
  - Use POS code that would have been reported had the service been furnished in-person for 151-days after PHE ends
  - Using POS 02 causes payment at facility rate
- **Medicare will continue to allow for payment at the POS where the service would have ordinarily been rendered if in-person through 12/31/2023 (versus 151-days after PHE ends). Report with -95.**
- **152-days after PHE, facility originating sites *can* use POS 02**
- Eff. 1/1/2023: Modifier -93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System
  - RHCs, FQHCs currently using –FQ will change to -93
- Supervising practitioners continue to be required to append the “FR” modifier on any applicable telehealth claim when required to be present through an interactive real-time, audio and video telecommunications link, as reflected in each service’s requirement

Supervision of Telehealth

- After December 31 of year when PHE ends, pre-PHE rules for direct supervision return
  - Immediate availability, virtual presence goes away
- No final decision on the future of virtual presence and supervision. Stay tuned for 2024 proposed rule in July and submit comments!

Supervision of Telehealth

After December 31 of the year in which the PHE ends, the **pre-PHE rules for direct supervision at § 410.32(b)(3)(ii) would apply**. As noted in the CY 2022 PFS final rule (86 FR 65062), this means the temporary exception to allow immediate availability for direct supervision through virtual presence, which facilitates the provision of telehealth services by clinical staff of physicians and other practitioners incident to their professional services, will no longer apply. As such, after the end of the calendar year in which the PHE ends, Medicare telehealth services can no longer be performed by clinical staff incident to the professional services of the billing physician or practitioner who directly supervises the service **through their virtual presence.**

Provider Impact

- These changes impact providers in several ways
  - Provider productivity valuation/compensation
  - Location of care
  - Direct vs. indirect supervision/immediate availability
  - Documentation

Telehealth and Provider Licensing

- Licensing requirements were relaxed in many states as a result of the PHE to maximize access to healthcare nationwide safely
- There is no federal license scheme that authorizes physicians to practice anywhere within the US (and its territories) with one single license
- The individual states have the police power to regulate the practice within their respective state borders
- This results in a patchwork of licensing requirements and laws across the 50 states and US territories

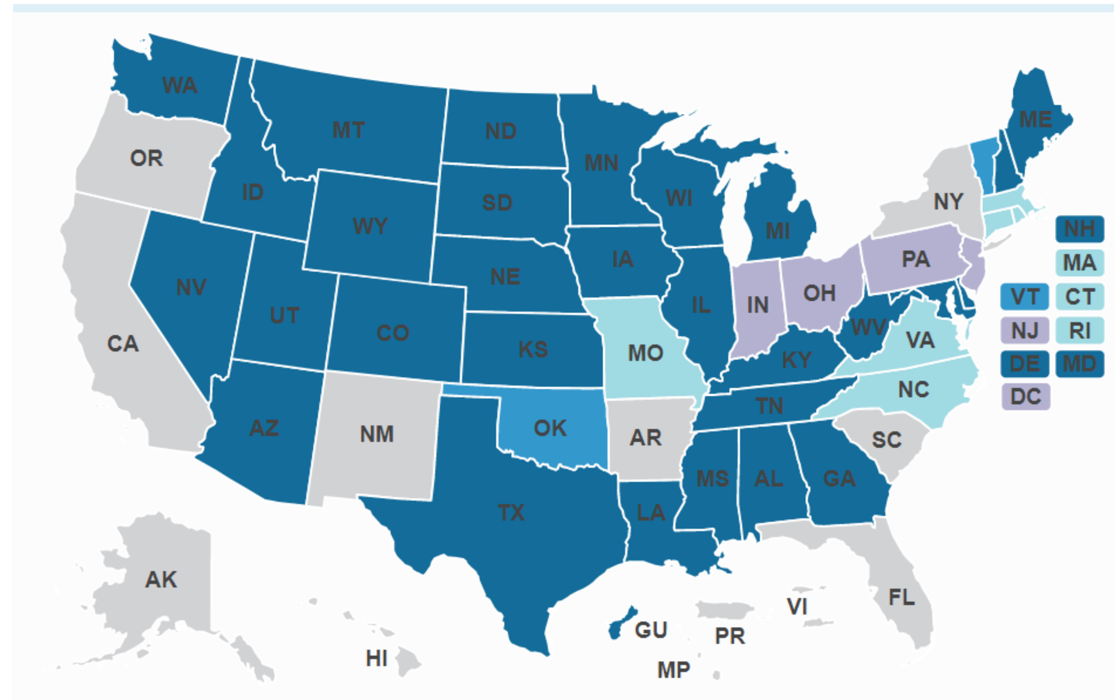
Telehealth and Provider Licensing

- Currently 10 states have a waiver process for out-of-state physicians to provide telemedicine within their state borders
- Federation of State Medical Boards created the Interstate Medical Licensure Compact (IMLC) – operational since 2017

Interstate Medical Licensing Compact

- IMLC Eligibility
  - Graduated from an accredited medical school or one listed in the International Medical Education Directory
  - Completed ACGME or AOA accredited postgraduate training
  - Passed each component of the USMLE, COMLEX or equivalent in no more than three attempts for each component
  - Hold an unrestricted medical license in a Compact member-state
  - State of Principal License is the physician's primary residence (and declared state of residence for federal income tax purposes)
  - Physician must practice at least 25% in state for Principal License
  - Physician is employed in the state of Principal License
  - No history of disciplinary actions
  - No criminal convictions (or deferred adjudications)
  - Not under investigation

Interstate Medical Licensing Compact



= Compact Legislation Introduced

= IMLC Member State serving as State of Principal License (SPL) processing applications and issuing licenses*

= IMLC Member State non-SPL issuing licenses*

= IMLC Passed; Implementation In Process or Delayed*

* Questions regarding the current status and extent of these states' and boards' participation in the IMLC should be directed to the respective state boards.

Nurse Licensure Compact

- Pending NLC legislation
- Currently No Action
- NLC State
- NLC enacted: Awaiting implementation.
- Partial Implementation

Psypact

U.S

Map Key

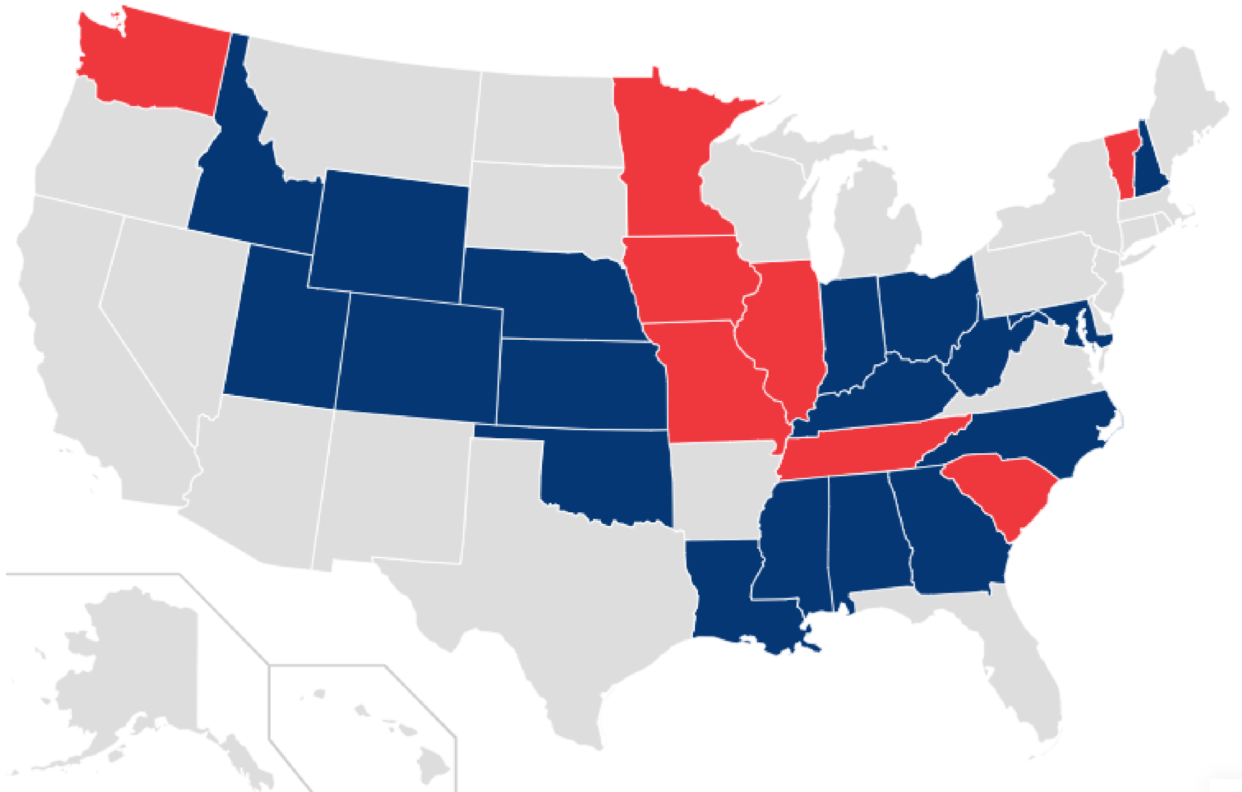
- PSYPACT Participating State
- Enacted PSYPACT Legislation -practice under PSYPACT not permitted
- PSYPACT Legislation introduced

Physical Therapy Licensure Compact

Washington, D.C.

- Member State – Actively Issuing and Accepting Compact Privileges
- Enacted Legislation – Not Yet Issuing or Accepting Compact Privileges
- PT Compact Legislation Introduced
- Non-Member States Without Legislation Introduced

Speech Therapy Licensure Compact



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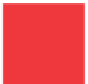

Legislation Pending

RHCs, FQHCs

Increased coverage and separate payment for pain management services is on the way.

New codes added to separately pay for specified set of pain management and treatment services

Questions?

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