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Summary of Policies in the Calendar Year (CY) 2022 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List

Note: We revised this Article due to a revised CR 12519. In the Article, we added language to show that the originating site facility fee doesn't apply to Medicare telehealth services when the originating site is the patient's home. For mental telehealth services, we show there must be a non-telehealth service every 12 months (instead of 6 months) after initiating telehealth. These changes are in dark red font on page 2. We also changed the CR release date, transmittal number, and the web address of the CR. All other information is the same.

MLN Matters Number: MM12519 Revised
Related Change Request (CR) Number: 12519
Related CR Release Date: December 2, 2021
Effective Date: January 1, 2022
Related CR Transmittal Number: R11146CP
Implementation Date: January 3, 2022

Provider Types Affected

This MLN Matters Article is for physicians, providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services they provide to Medicare patients.

Provider Action Needed

In MLN Matters Article MM12519, you'll learn about:

- Updates to payment policies and Medicare payment rates for services physicians and Non Physician Practitioners (NPPs) provide that Medicare pays for with the MPFS in CY 2022
- Updates to Medicare Telehealth Services and Telehealth origination site facility fee payment amounts
- Billing for Physician Assistant (PA) Services and other policy changes related to Medicare Part B

Make sure your billing staff knows about these changes.

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Background

This Article gives a summary of the policies in the CY 2022 Medicare Physician Fee Schedule (MPFS). Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary to establish by regulation a fee schedule of payment amounts for physicians' services for the subsequent year. CMS issued a final rule (CMS-1751-F) that updates payment policies and Medicare payment rates for physicians and NPP services that we pay for using the MPFS.

These changes apply to services you provide in CY 2022.

Medicare Telehealth Services

For CY 2022, we aren't adding any new Category 1 HCPCS codes to the list of Medicare telehealth services. We're also not adding any new Category 2 HCPCS codes to the list of telehealth services. Codes that we added to the telehealth services list on a Category 3 temporary basis, for the Public Health Emergency (PHE), will remain on the Medicare telehealth through the end CY 2023. This allows time to get more evidence and comments on the Category 3 codes to support possible permanent addition to the list, or possible removal from the list.

HCPCS codes G0422 and G0423, and CPT codes 93797 and 93798, are changing status on the Medicare telehealth services list to Category 3, "Available up Through the Year in Which the PHE Ends or December 31, 2023, whichever is later".

Also, from the provisions of the Consolidated Appropriations Act, 2021 (CAA), concerning services for the purpose of diagnosis, evaluation, or treatment of mental health disorders, effective immediately on and after the official end of the PHE for COVID-19, you may be able to continue to offer these services as telehealth services. The previous telehealth restrictions limiting mental health services to be only available to patients residing in rural areas will no longer apply. The patient's "originating sites" of a physician's office, a hospital, or other medical care settings, will also expand to include the patient's home. We clarified that patient's home includes temporary lodging. This could be hotels, homeless shelters, or nursing homes, that are a short distance from the patient's actual home and the "originating site facility fee" doesn't apply.

Medicare telehealth services require that you do the services over real-time audio and visual interactive telecommunications. For purposes of diagnosis, evaluation, or treatment of mental health disorders, if the patient doesn't have the technical capacity or the availability of real-time audio and visual interactive telecommunications, or they don't consent to the use of real-time video technology, we allow audio-only communication for telehealth mental health services to established patients located in their homes. The CAA of 2021 requires that an in-person, face to face, non-telehealth service takes place within 6 months of the first mental health telehealth services. There's a requirement for an in-person service within 6 months prior to starting telehealth. For CY 2022, there must be a non-telehealth service every 12 months thereafter, but with exceptions documented in the medical record. When a subsequent in-person, face to face,

non-telehealth service for mental health service does occur, and original telehealth practitioner is unavailable, we allow the clinician's colleague in the same subspecialty and in the same group practice, to provide the in-person, face to face, non-telehealth service to patient.

See the list of telehealth services codes.

Telehealth Origination Site Facility Fee Payment Amount Update

Section 1834(m)(2)(B) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services you provide from October 1, 2001, through December 31, 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, we increase the telehealth originating site facility fee by the percentage increase in the Medicare Economic Index (MEI) as defined in Section 1842(i)(3) of the Act. The MEI increase for 2022 is 2.1%. Therefore, for CY 2022, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80% of the lesser of the actual charge, or $27.59 (The patient is responsible for any unmet deductible amount and Medicare coinsurance).

Billing for Physician Assistant (PA) Services

For CY 2022, we're implementing policy to make direct payment to PAs for their provider services instead of requiring that only a PA's employer or independent contractor must bill for PA services. Effective January 1, 2022, program payment for PA services is 85% of what we pay a physician under the MPFS. We can make payment directly to a PA who bills the program for their services. This change under the PA statutory benefit category now provides PAs with the option to:

- Reassign payment for their services
- Incorporate with other PAs and bill the program for PA services

Teaching Physician Services

For CY 2022, we're clarifying that when teaching physicians select total time as their evaluation and management (E/M) visit level to bill for office/outpatient E/M visits that involve the care of residents, we can make payment to teaching physicians. However, this payment to teaching physicians under the MPFS includes only the total time that the physician is present during the visit, not the resident's time.

For the primary care exception, we finalized the proposed policy that allows selection of medical decision making (MDM) as the sole E/M visit level indicator for office/outpatient E/M visits and not total time.

Split (Or Shared) Evaluation and Management (E/M) Visits

For CY 2022, we're refining our longstanding policies for split (or shared) E/M visits:

- Definition of split (or shared) E/M visits as E/M visits you provide in the facility setting by a physician and an NPP in the same group
- By 2023, the practitioner who provides the substantive portion of the visit (more than half of the total time spent) will bill for the visit. For 2022, the substantive portion can be history, physical exam, MDM, or more than half of the total time (except for critical care, which must be more than half of the total time)
- You can report split (or shared) visits for new as well as established patients, and initial and subsequent visits, as well as prolonged services
- Requiring reporting of a new modifier on the claim to identify these services, to inform policy and help make sure program integrity
- Documentation in the medical record must identify the two individuals who performed the visit. The individual providing the large portion must sign and date the medical record.
- Codifying these revised policies in new regulations at 42 CFR 415.140.

Critical Care Services

For CY 2022, we're refining and clarifying our longstanding policies:

- Critical care services are defined in the CPT Codebook prefatory language for the code set
- The CPT listing of bundled services aren't separately payable
- When medically necessary, you can provide critical care services at the same time to the same patient on the same day by more than 1 practitioner with more than 1 specialty, and you can provide critical care services as split (or shared) visits
- We can pay critical care on the same day as other E/M visits by the same practitioner or another practitioner in the same group of the same specialty, if the practitioner documents that:
  - The E/M visit was provided prior to the critical care service at a time when the patient didn't require critical care
  - The visit was medically necessary
  - The services are separate and distinct with no duplicative elements from the critical care service provided later in the day

Practitioners must report modifier -25 on the claim when reporting these critical care services.

- We can separately pay for critical care services paid in addition to a procedure with a global surgical period if the critical care is unrelated to the surgical procedure. Preoperative and, or postoperative critical care may be paid in addition to the procedure if the patient is critically ill (meets the definition of critical care) and requires the full attention of the physician, and the critical care is unrelated to the specific anatomic injury or general surgical procedure performed (for example, trauma, burn cases). We're creating a new modifier that will require on such claims to identify that the critical care is unrelated to the procedure. If care is fully transferred from the surgeon to an intensivist (and the critical care is unrelated), you must report the appropriate modifiers to show the transfer of care. Medical record documentation must support the claims.

Changes to Patient Coinsurance for Additional Procedures You Provide During the Same Clinical Encounter as a Colorectal Cancer Screening

We're finalizing plans for a special coinsurance rule for procedures that are planned as colorectal cancer screening tests but become diagnostic tests when the practitioner finds the need for additional services (for example, removal of polyps). At present, the addition of any procedure beyond the planned colorectal screening (for which there's no coinsurance) results in a patient's having to pay coinsurance.

Section 122 of the CAA reduces, over time, the amount of coinsurance a patient will pay for such services. For services provided on or after January 1, 2022, the coinsurance amount a patient pays for planned colorectal cancer screening tests that require additional related procedures must be equal to a specified percent (20% for CY 2022, 15% for CYs 2023 through 2026, 10% for CYs 2027 through 2029, and 0% beginning CY 2030) of the lesser of the actual charge for the service or the amount decided under the fee schedule that applies to the test.

The reduction over time of the coinsurance percentage holds true regardless of the code that's billed for:

- Establishment of a diagnosis
- Removal of tissue or other matter
- Another procedure that's provided in connection with and in the same clinical encounter as the screening

Thus, beginning CY 2022, the coinsurance for Medicare patients for planned colorectal cancer screening tests that result in additional procedures done in the same clinical encounter will be gradually reduced, and beginning January 1, 2030, will be 0%.

Therapy Services

We're implementing the final part of Section 53107 of the Bipartisan Budget Act of 2018. The law requires us to identify and make payment at 85% of the otherwise applicable Part B payment amount for physical therapy and occupational therapy services that physical therapist assistants (PTAs) and occupational therapy assistants (OTAs) provide in whole or in part. This applies when they're properly supervised by a physical therapist (PT) or occupational therapist (OT), respectively. This is effective for dates of service on and after January 1, 2022. We do this through the use of new modifiers (CQ and CO).

For CY 2022, we're revising the policy for the de minimis standard to decide whether PTAs or OTAs provide services "in whole or in part." Specifically, the revised policy won't apply the de minimis standard to allow a 15-minute timed service to be billed without the CQ/CO modifier. This applies when a PT/OT and a PTA/OTA participate in providing care to a patient, independent from one another, but the PT/OT meets the Medicare billing requirements for the timed service on their own, by providing more than the 15-minute midpoint (that is, 8 or more minutes. This is also known as the 8-minute rule). Under this finalized policy, any minutes that the PTA/OTA provides in these scenarios won't matter for purposes of billing Medicare.

In addition to cases where 1 unit of a multi-unit therapy service remains to be billed, we identified a limited number of cases where there are 2 15-minute units of therapy remaining to be billed for which the de minimis standard policy isn't applied. For these 13 cases, we allow 1 15-minute unit to be billed with the CQ/CO modifier and 1 15-minute unit to be billed without the CQ/CO modifier in billing scenarios where:

- There are 2 15-minute units left to bill when the PT/OT
- The PTA/OTA each provide between 9 and 14 minutes of the same service
- When the total time for the service is at least 23 minutes and no more than 28 minutes

Overall, the *de minimis* standard would continue to be applicable in the following scenarios:

- When the PTA/OTA independently provides a service, or a 15-minute unit of a service "in whole" without the PT/OT providing any part of the same service
- In instances where the service isn't defined in 15-minute increments including: supervised modalities, evaluations/reevaluations, and group therapy
- When the PTA/OTA provides 8 minutes or more of the final 15-minute unit of a billing scenario in which the PT/OT provides less than 8 minutes of the same service
- When both the PTA/OTA and the PT/OT each provide less than 8 minutes for the final 15-minute unit of a billing scenario (the 10% standard applies)

Also, we're announcing that the KX-modifier threshold amounts for CY 2022 are $2,150 for occupational therapy services and $2,150 for physical therapy and speech-language pathology services combined.

Payment for Medical Nutrition Therapy (MNT) Services and Related Services

Since January 1, 2002, Registered Dieticians (RDs) and nutrition providers have been able to provide and bill for MNT services, meaning nutritional diagnostic, therapeutic, and counseling services. For CY 2022, in response to stakeholder concerns about parity with other types of NPPs, we're setting up regulations at 42 CFR 410.72 for their services since they're the only NPP types listed at Section 1842(b)(18)(C) of the Act without a regulatory provision in this section of 42 CFR subpart B. We're finalizing an alternative regulatory text at Section 410.72(f) for assignment policy that cross-refers to our assignment regulations at 42 CFR 424.55 for RDs and nutrition providers. This will give clearer policy than what is in other NPP regulations. To maximize consistency in our regulations, we're adopting this same assignment regulatory text for physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse mid-wives at Sections 410.74(d)(2), 410.75(e)(2), 410.76(e)(2) and 410.77(d)(2), respectively.

We're also updating the payment regulation for MNT services at 42 CFR 414.64 to clarify that MNT services are, and have been, paid at 100% (instead of 80%) of 85% of the PFS amount, without any cost-sharing. This has been a requirement of the Affordable Care Act of 2010 since CY 2011. That law revised the statute to except the coinsurance and deductible for preventive services defined under Section 1861(ddd)(3) of the Act that have a grade of A or B from the United States Preventive Services Task Force and MNT services have a grade of B.

More Information

We issued CR 12519 to your MAC as the official instruction for this change.

For more information, find your MAC's website.

Document History

Date of Change	Description
December 3, 2021	We revised this Article due to a revised CR 12519. In the Article, we added language to show that the originating site facility fee doesn't apply to Medicare telehealth services when the originating site is the patient's home. For mental telehealth services, we show there must be a non-telehealth service every 12 months (instead of 6 months) after initiating telehealth. These changes are in dark red font on page 2. We also changed the CR release date, transmittal number, and the web address of the CR. All other information is the same.
November 17, 2021	Initial article released.