PCG SOFTWARE

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POINTS OF INTEREST

MD LABS AND ITS CO-FOUNDERS AGREE TO PAY UP TO $16 MILLION TO RESOLVE ALLEGATIONS OF FRAUDULENT BILLING

A Nevada-based clinical laboratory, MD Spine Solutions LLC, d/b/a MD Labs Inc., and two of its owners and co-founders have agreed to resolve allegations that MD Labs submitted false claims for payment to Medicare, Medicaid, and other federal health care programs.

MD Labs, along with its owners and co-founders, Denis Grizelj and Matthew Rutledge, will pay up to $16 million to settle this matter. According to the settlement agreement, MD Labs, Grizelj, and Rutledge admit that between 2015 and 2019, MD Labs regularly billed federal health care programs for medically unnecessary urine drug testing (UDT). MD Labs performed and then billed federal health care programs for two types of UDT: presumptive testing, a relatively inexpensive test that quickly provides qualitative results, and confirmatory testing, an expensive test that is designed to confirm quantitatively the results of presumptive UDT.

https://www.justice.gov/usao-ma/pr/md-labs-and-its-co-founders-agree-pay-16-million-resolve-allegations-fraudulent-billing

TWO SENTENCED TO FEDERAL PRISON FOR HEALTH CARE FRAUD

FOR IMMEDIATE RELEASE ***Friday, November 5, 2021***

Tampa, Florida – U.S. District Judge Virginia M. Hernandez Covington has sentenced Michael Nolan (48, Tampa) and Richard Epstein (29, Aurora, CO) for their roles in a conspiracy to defraud federal health benefit programs, Medicare and the Civilian Health and Medical Program of the Department of Veterans Affairs ("CHAMPVA")

Nolan was sentenced to six years and six months in federal prison, followed by three years of supervised release. Epstein was sentenced to five years and three months in federal prison, followed by three years of supervised release. As part of their sentences, the court also entered a money judgment against each defendant in the amount of $2.1 million and $3 million, respectively, which were proceeds of the conspiracy. Nolan and Epstein were also ordered to pay restitution, jointly and severally with each other and other conspirators, in the amount of $29,020,304.

From around October 2016 through around April 2019, Epstein and Nolan ran a telemarketing company in Tampa called REMN Management LLC that targeted the elderly to generate thousands of medically un-necessary physicians' orders for durable medical equipment ("DME") and cancer genetic testing ("CGx"). Epstein and Nolan also created and operated Comprehensive Telcare, LLC, a "telemedicine" company through which they illegally bribed physicians to sign the orders regardless of medical necessity. Epstein and Nolan then illegally sold the signed physicians' orders to client-conspirators for use as support for false and fraudulent claims submitted to Medicare and CHAMPVA. The conspiracy resulted in the submission of at least $134 million in fraudulent claims to the federal health benefit programs, resulting in approximately $29 million in payments.

https://www.justice.gov/usao-mdfl/pr/two-sentenced-federal-prison-health-care-fraud

MEDICARE ADVANTAGE COMPLIANCE AUDIT OF SPECIFIC DIAGNOSIS CODES THAT UPMC HEALTH PLAN, INC. (CONTRACT H3907) SUBMITTED TO CMS

A new HHS-OIG audit recommends Medicare Advantage organization, @upmchealthplan, (University of Pittsburgh Medical Center) refund to the federal government the $6.4 million of estimated net overpayments for the high-risk diagnoses codes in 2015 and 2016. Read more:

https://go.usa.gov/xej2J.

The OIG sampled 280 unique enrollee-years with the high-risk diagnosis codes for which UPMC received higher payments for 2015 through 2016. The OIG limited the review to the portions of the payments that were associated with these high-risk diagnosis codes, which totaled $975,223.

The full OIG report has an interesting list of the high risk diagnosis codes that were investigated in the Compliance Audit. See section Findings on page 8 in the report. For those looking for FWA studies, the audit of high-risk diagnoses codes was well designed.

Under Federal regulations (42 CFR §422.503(b) MA organizations must (vi) adopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with CMS' program requirements as well as measures that prevent, detect, and correct fraud, waste, and abuse.

https://oig.hhs.gov/oas/reports/region7/71901188.asp

NEW AND REVISED TELEHEALTH POS CODES

CMS has updated the current POS code set by revising the description of existing POS code 02 and adding new POS code 10.

The POS code set provides setting information necessary to pay claims correctly. At times, the health care industry has a greater need for specificity than Medicare. While Medicare doesn't always need this greater specificity to appropriately pay claims, it adjudicates claims with the new codes. This eases coordination of benefits and gives other payers the setting information they need. The POS Workgroup is revising the description of POS code 02 and creating a new POS code 10 to meet the overall industry needs, as follows:

- **POS 02: Telehealth Provided Other than in 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.

- **POS 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.

According to the MLN, Medicare hasn't identified a need for new POS code 10. The MACs will instruct their providers to continue to use the Medicare billing instructions for Telehealth claims in Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, Section 190 through the end of this pandemic date designation. The POS for telehealth will use the POS of where the visit would have occurred if there was no pandemic.

At the AMA 2022 Symposium, Dr. Neil Sandler, CMO for CGS Administrators, answered questions regarding the New POS 10 and revision of POS 2. The Effective date of the Change Request is January 1, 2022, while the implementation date is April 4, 2022. The delayed implementation date was according to Dr. Sandler set to allow the MACs "sufficient time for implementation".

CMS will revert to the geographic/originating site requirements for most telehealth services. For traditional Medicare, POS 10 would only apply to tele-mental health services after the PHE. Per the CMS bulletin, the new POS code won't be implemented under traditional Medicare until April 4, 2022, at the earliest.

In the meantime, as of January 1, 2022, Anthem and UnitedHealthcare (UHC) will require commercial and Medicare Advantage plans to use new place of service (POS) code 10 for telehealth provided in the patient's home. POS code 02 should continue to be used when telehealth is provided anywhere other than a patient's home (e.g., a hospital or skilled nursing facility).

See Medicare IOM Chapter 12 Section 190 and Transmittal 11045, October 13, 2021.

https://www.cms.gov/files/document/mm12427-newmodifications-place-service-pos-codes-telehealth.pdf

The full American Academy of Family Physicians article on Anthem and UHC changes in coding policy can be found at:

https://www.aafp.org/journals/fpm/blogs/gettingpaid/entry/telehealth_pos_change.html

The Anthem reimbursement guide is state driven:

https://www.anthem.com/provider/policies/reimbursement/

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APRIL 2022 ICD-10 UPDATES

There are 3 new ICD-10-CM diagnosis codes and 7 new ICD-10-PCS procedure codes for inpatient care. These codes describe introducing or infusing therapeutics, including vaccines for Covid-19 treatment. The new diagnosis codes go into effect on April 1, 2022.

The December updates are found in the CMS web files for ICD-10.

https://www.cms.gov/medicare/icd-10/2021-icd-10-cm

https://www.cms.gov/medicare/icd-10/2022-icd-10-pcs

ICD-10-CM Code	Description
Z28.310	Unvaccinated for COVID-19
Z28.311	Partially vaccinated for COVID-19
Z28.39	Other under immunization status

For ICD-10-PCS, the following new codes should be utilized starting on April 1, 2022:

PCS Code	Description
XW013V7	Introduction of COVID-19 vaccine dose 3 into subcutaneous tissue, percutaneous approach, new technology group 7
XW013W7	Introduction of COVID-19 vaccine booster into subcutaneous tissue, percutaneous approach, new technology group 7
XW023V7	Introduction of COVID-19 vaccine dose 3 into muscle, percutaneous approach, new technology group 7
XW023W7	Introduction of COVID-19 vaccine booster into muscle, percutaneous approach, new technology group 7
XW0DXR7	Introduction of fostamatinib into mouth and pharynx, external approach, new technology group 7
XW0G7R7	Introduction of fostamatinib into upper GI, via natural or artificial opening, new technology group 7
XW0H7R7	Introduction of fostamatinib into lower GI, via natural or artificial opening, new technology group 7

Note that "these are not to be reported for individuals who are not eligible for the vaccines, as determined by the provider," a tabular guideline states.

In addition, you'll find new code **Z28.39** (Other under-immunization status), which may be reported when a patient is delayed

or lapsed in getting other non-COVID vaccines.

Code **Z18.310**, Unvaccinated for COVID-19, may be assigned when the patient has not received at least one dose of any COVID-19 vaccine. Code **Z28.311**, Partially vaccinated for COVID-19, may be assigned when the patient has received at least one dose of a multi-dose COVID-19 vaccine regimen, but has not received the full set of doses necessary to meet the Centers for Disease Control and Prevention (CDC) definition of "fully vaccinated" in place at the time of the encounter.

The ICD-10 MS-DRG Grouper software package to accommodate these new codes, Version 39.1, is effective for discharges on or after April 1, 2022. Assignment of new ICD-10-CM diagnosis code Z28.310, Z28.311, and Z28.39 is as follows:

The ICD-10 MS-DRG V39.1 Grouper Software, Definitions Manual Table of Contents and the Definitions of Medicare Code Edits V39.1 manual will be available at:

www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software.gov

The Index and Tabular Addenda for new diagnosis codes Z28.310, Z28.311, and Z28.39 will be available via the CDC website at:

https://www.cdc.gov/nchs/icd/icd10cm.htm

INPATIENT ONLY LIST

CMS is reversing course on the elimination of the IPO list, explaining that more time is required to evaluate the implications for each service, particularly on patient safety. In the OPPS final rule, the agency finalizes, with modification, its proposal to:

- Halt the elimination of the IPO list;
- Codify in regulation five longstanding criteria for determining whether a service or procedure should be removed from the IPO list; and
- Add back to the IPO list 293 of the 298 services removed in CY 2021. Ultimately, CMS determined that five services met several of the criteria for removal: CPT® codes 22630 (lumbar spine fusion), 23472 (reconstruct shoulder joint), 27702 (reconstruct ankle joint), and their corresponding anesthesia codes.

As a result, CMS is amending the implementation regulation to remove the reference to the elimination of the list — a huge win for hospitals that would have seen lower payments as a result of this policy. Patient safety was a key factor in the IPO designation.

The rule also exempts procedures removed from the IPO list on or after Jan. 1, 2022, from site-of-service claim denials, Beneficiary and Family-Centered Care Quality Improvement Organization (BFCC–QIO) referrals to Recovery Audit Contractor (RAC) for persistent noncompliance with the Two-Midnight rule, and RAC reviews for "patient status" (that is, site-of-service) for a period of two years.

ASC COVERED PROCEDURES LIST

The final rule reinstates patient safety criteria for adding a procedure to the ASC Covered

Procedures List (ASC CPL) that were in place in CY 2020 and removes from the ASC CPL 255 of the 267 procedures added in CY 2021.

CMS is also adopting a new nomination process that, starting March 2022, will allow an external party to nominate a surgical procedure to be added to the ASC CPL in the next applicable rulemaking cycle. CMS will provide sub-regulatory guidance on the nomination process in early 2022. If the agency determines that a surgical procedure meets the requirements for addition to the ASC CPL, it would propose to add it to the ASC CPL for Jan. 1, 2023.

The full Fact Sheet on the CY 2022 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1753FC) Nov 02, 2021, can be found at:

https://www.cms.gov/newsroom/fact-sheets/cy-2022-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center-0

Download the OPPS/ASC Payment System final rule from the Federal Register at:

www.federalregister.gov/public-inspection/2021-24011/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment

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TEAMHEALTH AWARDED $60 MILLION FROM UNITED HEALTHCARE

From Fierce Healthcare, “a Nevada jury has awarded TeamHealth $60 million in punitive damages as part of an ongoing legal spat between the physician staffing firm and health insurance giant UnitedHealthcare.”

A jury ruled late last month that the insurer underpaid emergency physicians at three TeamHealth affiliates in the state and at the time awarded $2.65 million in compensatory damages. The jury reached a decision after two days of deliberation and nearly three weeks of testimony.

Nine additional, similar lawsuits are pending in other states, and TeamHealth is expecting the Nevada results to drive momentum in those other cases.

“Today’s ruling that United must pay $60 million in punitive damages sets a critical precedent that large health insurers can’t underpay frontline doctors for lifesaving care,” said TeamHealth President and CEO Leif Murphy in a statement. We look forward to continuing the fight against United in nine future cases that will be decided on the same set of facts.”

https://www.fiercehealthcare.com/payer/jury-unitedhealth-must-pay-teamhealth-60m-damages-nevada-case

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SEQUESTRATION AND THE PAY AS YOU GO DELAYS

Many of the Medicare Physician Fee Schedule cuts that were planned for 2022 have be pushed out to 2023 by current legislation named Protecting Medicare and American Farmers.

- On December 10, 2021, Congress enacted a temporary one-year increase in the Medicare physician

fee schedule reimbursement of 3% above what was originally proposed for 2022. In real monetary terms, this means that the previously scheduled 3.75% decrease will result only in a .75% decrease in the MPFS. The new 2022 conversion factor is $34.6062. The 2021 conversion factor was $34.8931.

- The same legislation will also move the Statutory Pay-As-You-Go (PAYGO) legislative timeline to 2023. PAYGO will reduce Medicare spending by 4%. The principle underlying PAYGO is a rule of budget neutrality—that is, the government must not enact any new laws that would increase projected deficits.
- Adherence to PAYGO does not by itself reduce projected deficits, but during the 1990s, when the first statutory PAYGO law was in effect, adherence to the principle reinforced- and effectively locked into place- the substantive deficit-reduction measures enacted in 1990 and 1993, helping to lead to surpluses in the last four years of the Clinton Administration.
- Rate reductions to the Medicare Clinical Laboratory Fee Schedule (CLFS) are delayed until 2023. Requirements for certain hospital laboratories to report private payor data are also delayed until 2023. Payment won't be reduced by more than 15% for CYs 2023 through 2025.
- The new Medicare Radiation Oncology Model, which provides for episode-based payments for radiotherapy services, is delayed until 2023.
- Sequestration is back in force in 2022 in a scheduled rollout:
  - January 1. 2022: The Medicare Physician Fee Schedule will be cut by 0.75%. No sequestration this quarter.
  - April 1, 2022: A 1% sequestration cut goes into effect.
  - July 1, 2022: The Medicare sequestration cut increases to 2%.
  - January 1, 2023: The delayed cuts from 2022 will be reviewed and could come back into effect.

https://www.congress.gov/bill/117th-congress/senate-bill/610/text?q=%7B%22search%22%3A%5B%22s+610%22%2C%22s%22%2C%22610%22%5D%7D&r=7&s=1

MODIFIER QW WITH CODE 86328 FOR COVID ANTIBODY TEST

Effective January 3, 2022, 86328 with a modifier QW is payable as a CLIA waived test. While the MACs will not search the claims data base for previously denied claims, any claims brought to the attention of the MAC will be adjusted.

86328 Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single-step method (eg, reagent strip); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]).

For the duration of the emergency declaration, you can perform such tests in a patient care setting that is qualified to have the test

performed there due to operating under a CLIA Certificate of Waiver, Certificate of Compliance, or Certificate of Accreditation.

The full MLN on 86328QW can be reviewed at:

https://www.cms.gov/files/document/mm12557-addition-qw-modifier-healthcare-common-procedure-coding-system-hcpcs-code-86328.pdf?utm_source=newsletter&utm_medium=email&utm_campaign=name_january_compliance_newsletter_early_edition&utm_term=2021-12-31

COVERAGE OF SURGICAL DRESSING

Medicare covers primary or secondary surgical dressings when used to protect or treat a wound and when needed after wound debridement.

Surgical Dressings are covered under the Surgical Dressings Benefit (Social Security Act §1861(s)(5)). The CMS Benefit Policy Manual (IOM 100-02), CH 15, §100 provides interpretive guidance to contractors for the implementation of this provision. The relevant part of the manual section establishes two separate benefit criteria:

- The necessity for and definition of a qualifying wound; and,
- The requirements necessary for any product to be classified as a surgical dressing for purposes of coverage under this benefit.

Surgical dressings are covered when a qualifying wound is present. A qualifying wound is defined as either of the following:

- A wound caused by, or treated by, a surgical procedure; or,
- After debridement of the wound, regardless of the debridement technique.

The surgical procedure or debridement must be performed by a treating practitioner or other healthcare professional to the extent permissible under State law. Debridement of a wound may be any type of debridement (examples given are not all-inclusive):

- Surgical (e.g., sharp instrument or laser)
- Mechanical (e.g., irrigation or wet-to-dry dressings)
- Chemical (e.g., topical application of enzymes) or
- Autolytic (e.g., application of occlusive dressings to an open wound)

Dressings used for mechanical debridement, to cover chemical debriding agents, or to cover wounds to allow for autolytic debridement are covered although the debridement agents themselves are noncovered.

HCPC Modifiers A1 through A9 are helpful in determining the number of surgical dressings applied to wounds. A1 indicates a single surgical dressing and A9 surgical dressings for 9 or more wounds.

The complete LCD 54563 is an excellent guide on surgical dressing coverage and medical necessity criteria:

https://www.cms.gov/medicare-coverage-database/view/article.aspx?arti-cleid=54563&utm_source=newsletter&utm_medi-um=email&utm_campaign=name_january_compliance_newsletter_early_edition&utm_term=2021-12-31

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UPDATE TO THE SOMETIMES THERAPY CODES AND PAYMENT DIFFERENTIALS

CMS is adding 5 CPT© codes and long descriptors as "sometimes therapy" codes effective for dates of service on or after January 1, 2022. The 5 CPT added codes are:

- CPT code 98975 — Remote therapeutic monitoring (RTM) (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment
- CPT code 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
- CPT code 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
- CPT code 98980 — Remote therapeutic monitoring treatment management services, physician/other qualified health care professional time in a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes
- CPT code 98981 — Remote therapeutic monitoring treatment management services, physician/other qualified health care 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)

CMS considers these 5 CPT codes to be remote therapeutic monitoring (RTM) services that physical therapists (PTs), occupational therapists (OTs), and speech-language pathologists can provide, when appropriate. The RTM treatment management services described by CPT codes 98980 and 98981 are provided remotely to patients in their homes by therapists in private practice (TPPs) and facility-based therapists. For example, therapists who work in rehabilitation agencies and comprehensive outpatient rehabilitation facilities would provide these services. The therapist would do the RTM service for the initial set-up and patient education on use of equipment (CPT code 98975) in the office or in the patient's home.

When physicians, NPPs, or therapists do not directly perform the services, they must be

done under direct supervision. Therapists' services under therapy plans of care, RTM services related to a RTM device that is specific to therapy services, such as the ARIA Physical Therapy supply device in CPT code 98977 that includes therapeutic exercises, must be provided under a therapy plan of care when provided by physicians and NPPs. If PTs and OTs delegate the RTM services to physical therapist assistants and occupational therapy assistants, respectively, they are subject to the de minimis standard (with the exception of the 2 CPT codes for the RTM devices).

Effective January 1, 2022, the Physical Therapy Assistant and Occupational Therapy Assistant payment will be reduced by 15%. Modifier CO and CQ will indicate the reduction to be applied.

The reduced PFS payment affects physical therapists (PTs) in private practice (PTPPs) and occupational therapists (OTs) in private practice (OTPPs), including PTPPs and OTPPs who have reassigned their benefits to physician groups or to groups of certain non-physician practitioners (NPPs), including physician assistants, nurse practitioners and clinical nurse specialists when the PTPP/OTPP National Provider Identifier (NPI) appears as the rendering provider on the claim.

The reduced PFS payment for PTA/OTA services also applies to institutional therapy providers, including comprehensive outpatient rehabilitation facilities, with the exception of critical access hospitals and other providers that aren't paid using Medicare Physician Fee Schedule (MPFS). This payment policy is applicable to the following bill types: 12X, 13X, 22X, 23X, 34X, 74X, and 75X.

The full Transmittal can be reviewed at:

https://www.cms.gov/files/document/R11118CP.pdf

The full Medicare Learning Network publication outlines the reductions and coding for billing and payment:

https://www.cms.gov/files/document/mm12397-reduced-payment-physical-therapy-and-occupational-therapy-services-furnished-whole-or-part.pdf

OPIOID TREATMENT PROGRAMS (OTPs) MEDICARE BILLING AND PAYMENT

A new Opioid Treatment Program MLN Booklet was released in November 2021. Included are these new codes:

- HCPCS code G1028 - Take-home supply of nasal naloxone; 2-pack of 8mg per 0.1 mL nasal spray
- HCPCS code G2215 - Take-home supply of nasal naloxone; 2-pack of 4mg per 0.1 mL nasal spray

Important billing information concerning not only medical necessity criteria but also frequency of use guidelines are a focus in the booklet.

In addition, After the conclusion of the PHE, CMS expects OTPs to add the following modifiers on claims for HCPCS code G2080–each additional 30 minutes of counseling in a week of medication assisted treatment, (provision of the services by a Medicare enrolled opioid treatment program); list separately in addition to code for primary procedure.

- Modifier 95: For counseling and therapy provided using audio-video telecommunications
- Modifier FQ: For counseling and therapy provided using audio-only telecommunications

After the end of the COVID-19 public health emergency (PHE), CMS will allow audio-only interactions (such as telephone calls) in cases where audio-video communication isn't available to the patient, including circumstances in which the patient can't or won't agree to the use of two-way audio/video communication.

The full OTP Booklet can be reviewed at:

https://www.cms.gov/files/document/otp-billing-and-payment-fact-sheet.pdf

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PROMPT PAYMENT INTEREST RATES 2022

The prompt payment interest rate for January through June 2022 is 1.625%. The Bureau of the Fiscal Services prompt payment file is available at:

https://fiscal.treasury.gov/prompt-payment/rates.html

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COVID-19 VACCINE AND MONOCLONAL ANTIBODIES (mAb) PART A BILLING

Because there have been so many changes in the billing requirements and new codes, there have been some interesting requests for information regarding the vaccines and mAb administration.

When COVID-19 vaccine and mAb doses are provided by the government without charge, providers should only bill for the vaccine administration. The vaccine codes are not included on the claim when the vaccines are free.

For roster billing and centralized billing, reference the Medicare billing for COVID-19 vaccine shot administration page and Roster billing for Part A providers.

If the patient is enrolled in a Medicare Advantage plan, submit COVID-19 vaccine and mAb infusion claims to Original Medicare for all patients enrolled in Medicare Advantage in 2020 and 2021.

Effective for dates of services on and after January 1, 2022, COVID-19 vaccines and mAbs provided to patients enrolled in a Medicare Advantage plan are to be billed to the Medicare Advantage plan.

These codes will not apply to skilled nursing facility consolidated billing (SNF-CB) edits.

The types of bill to report for the COVID-19 vaccine and mAb infusion on the Part A claim form, or electronic equivalent, are:

Inpatient Part B:

- Hospital—12X
- SNF—22X

Outpatient:

- Hospital—13X
- SNF—23X
- End stage renal disease—72X
- Comprehensive outpatient rehabilitation facility—75X
- Critical access hospital—85X

The full listing of all the COVID Vaccine Code and mAb codes can be reviewed in a new Novitas publication at:

https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00243902

NO SURPRISES

For the time being, only patients without insurance or self-pay are expected to receive a Good Faith Estimate (GFE) although there is an expectation that the rules may be extended to other patients by the end of 2022. The GFE does not apply to individuals insured under Medicare, Medicaid, or other federal health care programs.

www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ.pdf

https://aihc-assn.org/update-on-no-surprises-act-2022/?utm_source=newsletter&utm_medium=email&utm_campaign=name_free_live_webinar_on_authentication_rules_update_on_no_surprises_act_2022&utm_term=2022-01-05

https://www.beckershospitalreview.com/finance/no-surprises-act-takes-effect-jan-1-9-things-for-hospital-leaders-to-know.html?origin=BHRSUN&utm_source=BHRSUN&utm_medium=email&utm_content=newsletter&oly_enc_id=5001F3494678B4J

LAB EXPENDITURES FOR 2020—FROM THE OIG

The rapid #COVID19 test was the top diagnostic lab test, based on spending, that Medicare Part B paid for in 2020. Over $1 billion was paid for 10 million+ uses of it. Find more details on spending and volume among COVID and non-COVID testing: http://go.usa.gov/xtadv.

UPDATE! PRIOR AUTHORIZATION UPDATE FROM CMS

Effective immediately, for claims with dates of service on or after 1/7/2022, the Centers for Medicare & Medicaid Services (CMS) is removing current procedural terminology code 67911 (correction of lid retraction) from the list of codes that require prior authorization as a condition of payment. This service is not likely to be cosmetic in nature and commonly occurs secondary to another condition.

PCG used the First Coast Options weblink for the article review, but please check with the MAC serving your localities:

https://medicare.fcso.com/CMS_e-News/0492588.asp

MEDICARE LIMITS COVERAGE OF COSTLY ALZHEIMER'S DRUG

On January 11, 2022, CMS announced that it will limit coverage of Biogen's costly Alzheimer's disease drug, Aduhelm, to patients enrolled in approved randomized clinical trials. "While there may be the potential for promise with this treatment,

there's also the potential for serious harm to patients," CMS Chief Medical Officer Lee Fleisher said, though Biogen said the decision "will exclude almost all patients who may benefit."

There has been high level of apprehension, not only about the $28,000- per year cost, but the overall effectiveness of Aduhelm in slowing the progression of early dementia as well as its safety. The original cost of the medication was $56,000- per year but was cut in half because of the effectiveness and safety concerns.

If the proposed National Coverage Determination is finalized, CMS will review each submitted clinical trial to determine whether it meets the criteria specified in the proposed National Coverage Determination.

https://www.reuters.com/business/healthcare-pharmaceuticals/future-biogens-aduhelm-hinges-us-medicare-alzheimers-coverage-2022-01-11/

https://www.cms.gov/newsroom/press-releases/cms-proposes-medicare-coverage-policy-monoclonal-antibodies-directed-against-amyloid-treatment

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NORTH CAROLINA PHYSICIAN INDICTED FOR ADULTERATING MEDICAL DEVICES FOR REUSE ON PATIENTS, FABRICATING RECORDS, AND OTHER CHARGES

Anita Louise Jackson ("Jackson") was a licensed North Carolina physician who operated an Ear, Nose, and Throat (ENT) practice in Rockingham, Lumberton, and other locations within the Eastern District of North Carolina. The name of the practice was Greater Carolina Ear, Nose, & Throat, P.A. (GCENT).

Between 2014 and the end of 2018 Jackson, through GCENT, billed Medicare more than $46 Million for allegedly rendering more than 1,200 incidents of "balloon sinuplasty" services to more than 700 patients. GCENT received more than $5.4 Million for the services. In fact, Jackson was the top-paid provider for "balloon sinuplasty" in the US.

Key to Jackson's profitability was the re-use of the sinuplasty balloon which are single use devices. There are not any approvals to reuse or clean these devices which collect patient secretions and blood. During the entire period, Jackson purchased only 30 of the devices.

Jackson also waived copays and caused Medicare to pay all or nearly all of the charges. Operative reports were cloned and did not identify why each patient required a sinuplasty. When audited retrospectively by Medicare, Jackson fabricated, back-dated and forged records to deceive the auditors.

If convicted Jackson faces a maximum term of imprisonment of 20 years for Mail Fraud, 10 years for Paying Illegal Remunerations, and 5 years for Conspiracy and Making False Statements. Aggravated Identity Theft carries a 2-year mandatory prison sentence, consecutive to any other punishment. Jackson also faces fines exceeding $250,000.

https://www.justice.gov/usao-ednc/press-release/file/1460746/download

https://www.justice.gov/usao-ednc/pr/north-carolina-physician-indicted-adulterating-medical-devices-reuse-patients

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MEDICARE TELEHEALTH SERVICES FOR 2022 THROUGH 2023

From the CMS Medicare Learning Network: MM12519 Released 12-2-2021.

For CY 2022, CMS is not adding any new Category 1 HCPCS codes to the list of Medicare telehealth services. CMS is also not adding any new Category 2 HCPCS codes to the list of telehealth services. Codes that are 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.

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.

https://www.cms.gov/files/document/mm12519-summary-policies-calendar-year-cy-2022-medicare-physician-fee-schedule-mpfs-final-rule.pdf

BILLING FOR PHYSICIAN ASSISTANT (PA) SERVICES

Effective January 1, 2022, CMS program payment for Physician Assistant services is 85% of the physician fee under MFPS. The changes under the PA benefit category now allow PAs with two options:

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

https://www.cms.gov/files/document/mm12519-summary-policies-calendar-year-cy-2022-medicare-physician-fee-schedule-mpfs-final-rule.pdf

NEW E/M MODIFIERS

MODIFIER FS—SPLIT (OR SHARED) EVALUATION AND MANAGEMENT (E/M) VISITS

New CMS revisions to the Split or Shared E/M visits make many changes to the billing and payment for these services. The following are key points to the regulations:

- Definition of split (or shared) E/M visits as E/M visits that are provided 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 – see below.
- 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.

Modifier FS will be required on claims to identify split/shared visits and to help ensure program integrity.

CMS indicated the "FS" modifier should be appended to E/M services to indicate they are a split/shared service. CMS did clarify that split/share applies to a facility based setting and does not apply in an office practice setting. Split/shared can be reported for new, as well as established patients, and initial and subsequent visits as **well as prolonged services.** The final rule includes a table defining what the substantive portion would reflect as well as billing for prolonged service in a split/share visit. All of these policies will be contained in the Code of Federal Regulations, 42 CFR 415.140.

www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf

Modifier FT—Unrelated E/M visit during a Postoperative Period

The full description and use of Modifier FT is (Unrelated evaluation and management [E/M] visit during a postoperative period, or on the same day as a procedure or another E/M visit. The modifier is reported when an E/M visit is furnished within the global period but is unrelated, or when one or more additional E/M visits furnished on the same day are unrelated.)

The modifier FT is used when there is an unrelated E/M visit during the postoperative period or on the same day as a procedure or another E/M. This includes Critical Care services 99291 through 99292 when performed during the global surgical period for care unrelated to the procedure. A provider can report a critical care service and an E/M on the same date of service if the critical care service is the subsequent care and the other E/M service was first. In those cases, the critical care service would be billed with a Modifier 25.

The primary example in the Change Request is a transfer of care from the surgeon to an intensivist and the intensivist would bill both the Modifier 55 for postoperative care only and the FT modifier.

There are a few examples in the Change Request 12519 and more is called for but until that comes out, the final rule is our guide. In December, Medicare clarified some aspects of the FT modifier and stated "The "on the same day as a procedure or another E/M visit" portion of the descriptor does not have a practical application."

https://www.cms.gov/files/document/r11146cp.pdf

Modifier FQ—Audio-Only Communication Technology

Modifier FQ (The service was furnished using audio-only communication technology) was designed to identify mental health telehealth services that are provided to a member in the home using audio-only communication such as a phone. A practice that uses the Modifier FQ is certifying that although they have "technical capability at the time of service to use an interactive telecommunications system or service that

includes video. The audio-only is used because the member could not or would not use a video connection for the telehealth visit.

Modifier FR—Supervising Physician Present during Audio/Video Communication

Modifier FR is used to indicate that (The supervising practitioner was present through two-way audio/video communication technology) and that virtual supervision is included in the definition of direct supervision.

Of interest again is the lack of information, such and good examples and codes, that will be applicable during either the PHE or after the expiration of the PHE.

MODIFIER 93—AMA LATE ADDITION TO 2022 CPT® CODES

Modifier 93 was released to the AMA website on December 30, 2021, and did not make it into Appendix A. The effective date is January 1, 2022 and will be included in the 2023 CPT code Manual.

SYNCHRONOUS TELEMEDICINE SERVICE RENDERED VIA TELEPHONE OR OTHER REAL-TIME INTERACTIVE AUDIO-ONLY TELECOMMUNICAITONS SYSTEM

Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located away at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.

PCG staff will continue to review the AMA publications for additional information on the new Modifier 93 as there seems to be overlap with the CMS Modifier FQ.

https://www.ama-assn.org/system/files/cpt-appendix-a-modifier-93.pdf

1st QUARTER 2022 VE UPDATES AND CHANGES

- CCI Version: 28.0
- APC Version: 86
- New NCCI edits: 93,673
- New CPT Codes: 183
- New Dx Codes: 3

PCG PROGRAM VERSIONS

- Virtual Examiner®: 7.4
- Virtual AuthTech®: 1st Quarter 2022
- Virtual Reporter®: 1.12.9.2
- VEWS: 3.3

PCG APPLICATION VERSIONS/ ENHANCEMENTS/REVISIONS

- VR: Ability to Mark and log claims form main work queue screen.
- VR: Updated VE Knowledgebase with RSN Code to CARC/RARC crosswalk.
- VR: Added configurable TLS protocol.
- VE: E&M codes including Medi-Cal stored in table.
- VE: OPPS version updated,
- VE: New support debug “step” statements added.
- VE: Code added to provide error checking prior to .log and .ini file loads.
- VE: Added configurable TLS protocol.

RE-PURPOSED HCPCs

CMS is reusing deleted codes and re-assigning them with new descriptions. However, claim and authorization systems have encounter history, benefit matrix categories and fee schedules configured using the old code descriptions. Below is a cross-reference list of repurposed HCPC codes:

CPT	NEW DESCRIPTION	ORIGINAL DESCRIPTION
G0030	Pt scr tob & cess int	PET imaging prev PET single
G0031	Pall serv during meas	PET imaging prev PET multiple
G0032	2+ antipsy schiz	PET follow SPECT 78464 single
G0033	2+ benzo seiz	PET follow SPECT 78464 multiple
G0034	Pall serv during meas	PET follow SPECT 76865 single
G0035	Pt ed pos 23	PET follow SPECT 78465 multiple
G0036	Pt/ptn decln assess	PET follow cornry angio single
G0037	Pt not able to participate	PET follow cornry angio multiple
G0038	Clin pt no ref	PET follow myocard perf single
G0039	Pt no ref, rn spec	PET follow myocard perf multiple
G0040	Pt phys/occ therapy	PET follow stress echo single
G0041	Pt/ptn decln referral	PET follow stress echo multiple
G0042	Ref to therapy	PET follow ventriculogm single
G0043	Pt mech pros ht valv	PET follow ventriculogm multiple

CPT	NEW DESCRIPTION	ORIGINAL DESCRIPTION
G0044	Pt mitral stenosis	PET following rest ECG single
G0045	Mrs 90 days post stk	PET following rest ECG multiple
G0046	No mrs 90 days post stk	PET follow stress ECG single
G0047	Ped blunt hd traum	PET follow stress ECG multiple
G0050	Pt w/ lmted life expec	Residual urine by ultrasound
G0051	Pt hospice mnth	Destruc any methd-1st ben/premalig les incl anes
G0052	Pt peri dialysis dur mo	Destruc any methd 2-14 ben/premal les incl anes
G0053	Adv rheum pt care mvp	Destruc any methd 15/> ben/premal les incl anes
G0054	Strk cr prev pos outcme mvp	Blood cholesterol test
G0055	Adv care heart dx mvp	Glucose post dose measure
G0056	Opt chronic dx mang mvp	Glucose tolerance 3 specimen
G0057	Best pct pt safety em mvp	Glucose tolerance>3 specimen
G0058	Imprv care le jnt repr mvp	Auto multichannel test; 20 tests
G0059	Pt sfty pos exp w aneth mvp	Auto multichannel test; 21 tests
G0060	Allergy/immunology ss	Auto multichannel test; 22 tests
G0061	Anesthesiology ss	Lung volume reduction surg
G0062	Audiology ss	Peripheral skel-bone mineral density studies
G0063	Cardiology ss	Central skel-bone mineral density studies
G0064	Cert nurse midwife ss	Phys superv-pt undr care hha-tx plan 30 min />/month
G0065	Chiropractic ss	Phys suprv-hospice pt-tx plan/adj tx 30 min />/month
G0066	Clinical social work ss	Phys suprv-nurs facil pt-tx plan 30 min />/ month

As always, if you have any comments, questions or require further documentation, please call me.
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