Curbside Consultations Medicare Pearls

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Disclosers

- I have no disclosures to make.

Objectives

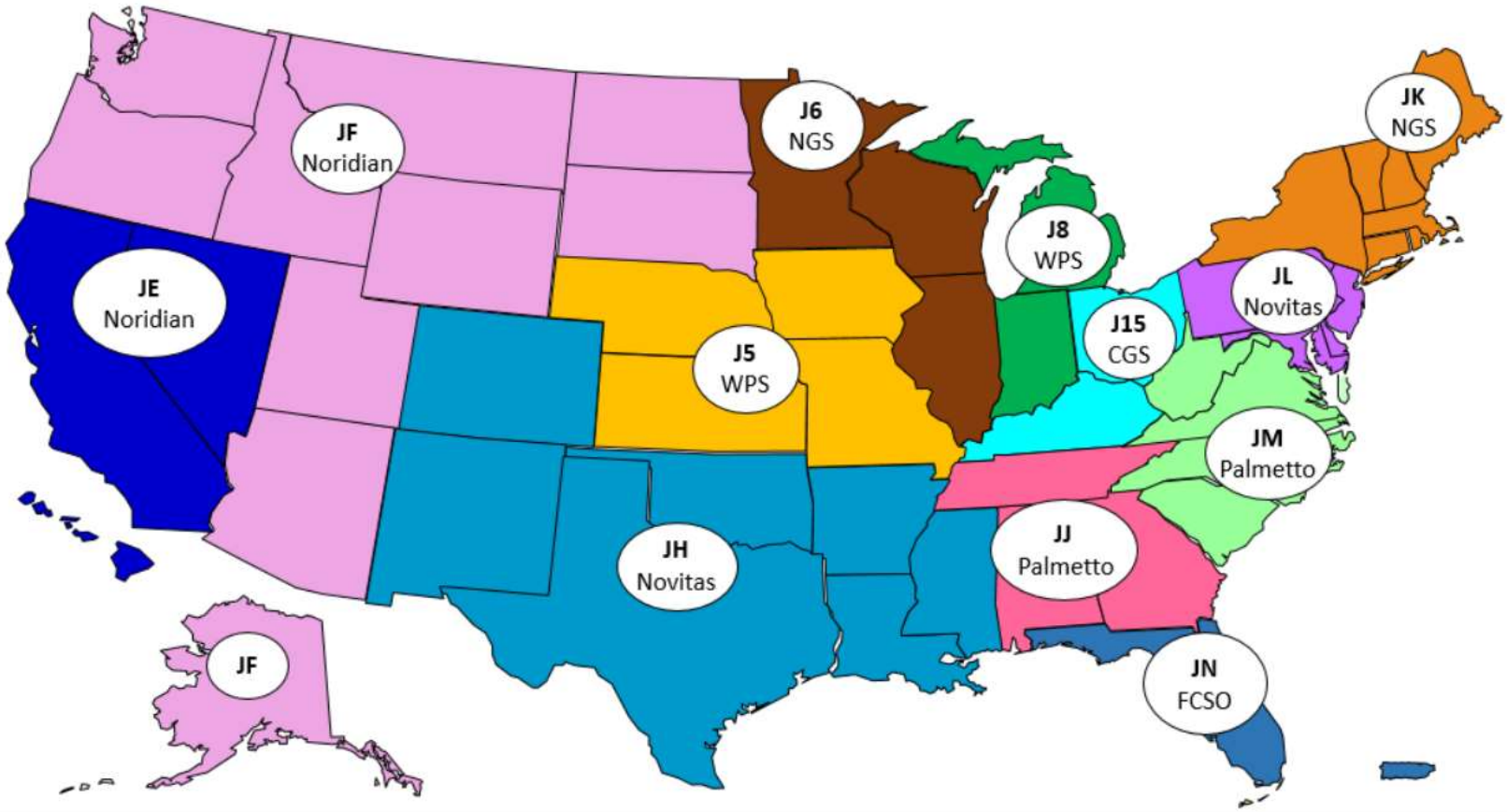
- What is a Medicare Administrative Contractor (MAC)?
- What's a Contractor Medical Director (CMD) and what do I do all day?
- Submitting claims correctly
  - Multiple visits in one day in hospital
  - Split-shared Services in CCU and the FS modifier
  - Billing correctly for Advanced Care Planning in hospitalized patients

What is a MAC?

- In short, there are 7 private companies that process claims for Medicare A and B as well as DME.
- In addition, the MACs
  - Make and account for Medicare FFS payments
  - Enroll providers in the Medicare FFS program
  - Handle provider reimbursement services and audit institutional provider cost reports
  - Handle redetermination requests (1st stage appeals process)
  - Respond to provider inquiries
  - Educate providers about Medicare FFS billing requirements
  - Establish local coverage determinations (LCD's)
  - Review medical records for selected claims
  - Coordinate with CMS and other FFS contractors

A/B MAC Jurisdictions

as of June 2021



Some numbers for A/B MACs

- Represents 36 Million beneficiaries in fee for service Medicare
- Processed 1.1 Billion Claims for those beneficiaries
- Paid out 424 Billion Dollars for those claims

What's a CMD doing all day?

- Comes down to policy and education on all things clinical for the MAC.
- Frequent questions from providers are about changes in E&M codes, questions about National Coverage Determinations coverage and fraud concerns.
- Less frequent questions are related to pricing, medical review and first level of appeals.

Let's talk about CR 12543

- Published March 4, 2022, and effective date is January 1, 2022.
- Updated the IOM to conform to changes published in the final rule for 2022.
- Topics include critical care services, split/shared services, teaching physicians and physician assistants.

Physician Assistant changes

- Direct billing and payment for PA services may be made to the PA.
- Must accept assignment for PA services

Clarifications to practitioners

- Remember
  - MACs pay physicians for one hospital visit per day for the same patient. The billing should reflect ALL of the services provided for that day.
  - If physician A sees patient in morning and Physician B in coverage of Physician A sees the patient in the evening they can't bill separately for the patient's care that day.

Critical Care Visits-definitions

- Medicare adopted the definition of critical care services in the CPT codebook, and the CPT listing of bundled services unless otherwise specified.
- Bundled services are not separately payable.
- Time spent in separately reportable services should not be included in the time reported for critical care

Critical Care by a Single Physician or NPP

- Medicare is adopting CPT's reporting rules for payment of a single physician or NPP.
- Report CPT code 99291 for 30-74 minutes of critical care services to a given patient on a given date. This code is used only once per date even if time spent by practitioner is not continuous on that date.
- Report CPT code 99292 for additional 30 minute time increments provided to the same patient.

Critical Care by Same Specialty and Group

- If a practitioner furnishes initial critical care in its entirety and reports CPT code 99291, any additional practitioner in the same specialty and same group can use CPT code 99292.
- If a practitioner furnishes initial critical care service but does not meet time required to report CPT codec 99291, another practitioner can continue to deliver critical care to the same patient on the same date and aggregate the time requirement to bill CPT code 99291. CPT code 99292 can only be billed when an additional 30 minutes of critical care services have been furnished to the patient.
- The aggregated time must be medically necessary and each visit must meet the definition of critical care to add the times for meeting coding requirements.

Definition of Split (or Shared) Visits

- A split (or shared) visit is an evaluation and management if furnished in the facility setting that is performed in part by both a physician and a nonphysician practitioner who are in the same group, in accordance with applicable law and regulations such that the service could be billed by either the physician or NPP if furnished independently by only one of them.
- Payment is made to the practitioner who performs the substantive portion of the visit.
- Facility setting means an institutional setting in which payment for service and supplies furnished incident to a physician practitioner‘s professional services is prohibited under our regulation.

Split (or Shared) Critical Care Visits

- The billing practitioner bills the initial service CPT code 99291 and any add-on codes for additional time such as CPT code 99292. The substantive portion for critical care services is defined as more than half the total time spent by the physician and NPP.
- For critical care, the practitioner who provided the substantive portion of the cumulative critical care time reports the critical care services.
- The modifier FS must be appended to the critical care CPT codes on the claim.
- Consistent with all split (or shared) visits any time the practitioners spend jointly meeting with or discussing the patient as part of the critical care service, the time can only be counted once for the purpose of reporting that critical care visit.

Definition of Substantive Portion

- 2022 is a transition year for split/shared visits other than for critical care services.
- Other split/shared visits the substantive portion is determined by who did all of the history, or the exam or the medical decision making or more than ½ the total time.
- in 2023, substantive portion will only be determined by more than ½ of the total time.

Advanced Care Planning in the Hospital

- Advanced care planning CPT codes 99497 and 99498.
- CPT code 99497-Advanced care planning including the explanation and discussion of advance directives such as standard forms(with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate.
- CPT code 99498-Each additional 30 minutes.
- These can be done as part of Medicare Welcome Visit.
- These can be done in facility or non-facility setting. Can't be billed with critical care services.

Advanced care planning

- If not doing as part of MWV, make sure patient is willing to pay deductible and copay on services.
- Count time as separate from other services.
- Use diagnosis reported should be the condition that provider is counseling patient.
- To bill CPT Code 99497, must be at least 16 minutes of total time involved.
- To bill CPT Code 99498, must be at least 46 minutes of total time involved.
- CPT code 99497 is @$78 on PFS and CPT Code is @$73 on PFS.

References

- Change Request 12543. Subject: Internet-Only Manual (IOM)Updates for Critical Care, Split/Shared Evaluation and Management, Teaching Physician, and Physician Assistants.
- IOM 100-02, Chapter 15, Section 190
- IOM 100-04, Chapter 12, Section 30.6.9 and 30.6.12
- Medicare Learning Fact Sheet – Advanced Care Planning
- CPT 2022 Professional Edition