CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11115	**Date: November 16, 2021**
	Change Request 12519

SUBJECT: 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

I. SUMMARY OF CHANGES: This Change Request (CR) provides a summary of the policies in the CY 2022 Medicare Physician Fee Schedule (MPFS) Final Rule and announces the Telehealth Originating Site Facility Fee payment amount. The attached recurring update notification applies to publication 100-04, chapter 12, section 190.5, chapter 13, section 20.2.4, and chapter 18, section 240.

EFFECTIVE DATE: January 1, 2022
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2022

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 11115	Date: November 16, 2021	Change Request: 12519

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I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to provide 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. The Centers for Medicare & Medicaid Services (CMS) issued a final rule that updates payment policies and Medicare payment rates for services furnished by physicians and Nonphysician Practitioners (NPPs) that are paid under the MPFS in CY 2022.The final rule also addresses public comments on Medicare payment policies proposed earlier this year.

B. Policy: CMS issued regulation number CMS-1751-F, Medicare Program: CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements. This CR provides a summary of the payment polices under the MPFS and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in CY 2022.

Medicare Telehealth Services

For CY 2022, CMS is not adding any new Category 1, Healthcare Common Procedure Coding System (HCPCS) codes to the list of Medicare telehealth services. CMS is also not adding any new Category 2, Healthcare Common Procedure Coding System (HCPCS) codes to the list of telehealth services. Codes that were 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 will allow time to gather more evidence and more comment 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 the 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".

Additionally, 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, these services may continue to be offered as telehealth services. The previous telehealth restrictions limiting mental health services to be only available to beneficiaries residing in rural areas will no longer apply. The beneficiary's "originating sites" of a physician's office, a hospital, or other medical care settings, will also expand to include the beneficiary's home, which we clarify to include temporary lodging such as hotels and homeless shelters and nursing homes, located a short distance from the beneficiary's actual home.

Medicare telehealth services require that the services be performed over real-time audio and visual interactive telecommunications. For purposes of diagnosis, evaluation, or treatment of mental health disorders, should the beneficiary not have the technical capacity or the availability of real-time audio and visual interactive telecommunications, or they do not consent to the use of real-time video technology, audio-only communication is permitted 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 six months of the first mental health telehealth services. There is a requirement for an in-person service within 6 months prior to initiating telehealth. For CY 2022, CMS is finalizing that there must be a non- telehealth service every 6 months thereafter, but with exceptions. When a subsequent in-person, face to face, non-telehealth service for mental health service does occur, and original telehealth practitioner is unavailable, CMS will allow the clinician's colleague in the same subspecialty and in the same group practice, to furnish the in-person, face to face, non-telehealth service to beneficiary.

The list of codes that are added to the telehealth services list can be found at: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

For more information regarding telehealth services, please contact Patrick Sartini at (410)786-9252.

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 provided from October 1, 2001, through December 31, 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased 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 percent of the lesser of the actual charge, or $27.59 (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance).

For more information regarding Telehealth Services, contact Patrick Sartini at (410)-786-9252.

Billing for Physician Assistant (PA) Services

For CY 2022, CMS is implementing policy promulgated by section 403 of Division CC of the Consolidated Appropriations Act (CAA) that authorizes the Medicare Part B program to make direct payment to PAs for their professional 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 the professional services of PAs at 85% of what a physician is paid under the Physician Fee Schedule (PFS) can be made directly to a PA who bills the program for their professional services. Additionally, this changed billing construct under the PA statutory benefit category now provides PAs with the option to reassign payment for their professional services and, to incorporate with other PAs and bill the program for PA services.

For more information regarding billing for PA services, please contact Regina Walker-Wren at (410) 786-9160.

Teaching Physician Services

For CY 2022, CMS is 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, program payment can be made to teaching physicians. However, this payment to teaching physicians under the Physician Fee Schedule (PFS) includes only the total time that the physician is present during the visit, not the resident's time.

For the primary care exception, CMS is finalizing 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.

For more information regarding this teaching physician services provision, please contact Regina Walker-Wren at (410) 786-9160.

Split (or shared) Evaluation and Management (E/M) visits

For CY 2022, we are refining our longstanding policies for split (or shared) E/M visits by establishing the following:

- Definition of split (or shared) E/M visits as evaluation and management (E/M) visits 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, medical decision-making, or more than half of the total time (except for critical care, which must be more than half of the total time).
- Split (or shared) visits can be reported 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 ensure program integrity.
- Documentation in the medical record must identify the two individuals who performed the visit. The individual providing the substantive portion must sign and date the medical record.
- Codifying these revised policies in new regulations at 42 CFR 415.140.

For more information regarding split (or shared) E/M visits, contact Ann Marshall at (410)-786-3059.

Critical Care Services

For CY 2022, we are refining and clarifying our longstanding policies by establishing the following:

- Critical care services are defined in the Current Procedural Terminology (CPT) Codebook prefatory language for the code set.
- The CPT listing of bundled services are not separately payable.
- When medically necessary, critical care services can be furnished concurrently to the same patient on the same day by more than one practitioner representing more than one specialty, and critical care services can be furnished as split (or shared) visits.
- Critical care may be paid 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 did not require critical care, the visit was medically necessary, and 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.
- Critical care services may be separately 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 (e.g., trauma, burn cases). We are creating a new modifier that we 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), the appropriate modifiers must also be reported to indicate the transfer of care. Medical record documentation must support the claims.

For more information regarding critical care services, please contact Ann Marshall at (410)-786-3059.

Changes to Beneficiary Coinsurance for Additional Procedures Furnished During the Same Clinical Encounter as a Colorectal Cancer Screening

CMS is finalizing plans to implement Section 122 of the CAA, which amends statute by providing a special coinsurance rule for procedures that are planned as colorectal cancer screening tests but become diagnostic tests when the practitioner identifies the need for additional services (e.g., removal of polyps). At present, the addition of any procedure beyond the planned colorectal screening (for which there is no coinsurance) results in a beneficiary's having to pay coinsurance.

Section 122 of the CAA reduces, over time, the amount of coinsurance a beneficiary will pay for such services. That is, for services furnished on or after January 1, 2022, the coinsurance amount paid for planned colorectal cancer screening tests that require additional related procedures shall be equal to a specified percent (i.e., 20% for CY 2022, 15% for CYs 2023 through 2026, 10% for CYs 2027 through 2029, and zero percent beginning CY 2030) of the lesser of the actual charge for the service or the amount determined under the fee schedule that applies to the test.

The reduction over time of the coinsurance percentage holds true regardless of the code that is billed for establishment of a diagnosis, for removal of tissue or other matter, or for another procedure that is furnished in connection with and in the same clinical encounter as the screening. Thus, beginning CY 2022, the coinsurance required of Medicare beneficiaries for planned colorectal cancer screening tests that result in additional procedures furnished in the same clinical encounter will be gradually reduced, and beginning January 1, 2030, will be zero percent.

For more information, please contact Liane Grayson at (410)-786-6583.

Therapy Services

CMS is implementing the final part of section 53107 of the Bipartisan Budget Act of 2018, which requires CMS, through the use of new modifiers (CQ and CO), to identify and make payment at 85% of the otherwise applicable Part B payment amount for physical therapy and occupational therapy services furnished in whole or in part by physical therapist assistants (PTAs) and occupational therapy assistants (OTAs) ─ when they are appropriately supervised by a physical therapist (PT) or occupational therapist (OT), respectively ─ for dates of service on and after January 1, 2022.

For CY 2022, in response to numerous stakeholder questions and to promote proper therapy care, CMS is revising the policy for the *de minimis* standard established to determine whether services are provided "in whole or in part" by PTAs or OTAs. Specifically, CMS' revised policy will not apply the *de minimis* standard to allow a 15-minute timed service to be billed without the CQ/CO modifier in cases 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 ─ and is also known as the 8-minute rule). Under this finalized policy, any minutes that the PTA/OTA furnishes in these scenarios will not matter for purposes of billing Medicare.

In addition to cases where one unit of a multi-unit therapy service remains to be billed, we identified a limited number of cases where there are two 15-minute units of therapy remaining to be billed for which the *de minimis* standard policy is not applied. For these 13 cases, CMS allows one 15-minute unit to be billed with the CQ/CO modifier and one 15-minute unit to be billed without the CQ/CO modifier in billing scenarios where there are two 15-minute units left to bill when the PT/OT and 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 furnishes a service, or a 15-minute unit of a service "in whole" without the PT/OT furnishing any part of the same service.
- In instances where the service is not defined in 15-minute increments including: supervised modalities, evaluations/reevaluations, and group therapy.
- When the PTA/OTA furnishes eight minutes or more of the final 15-minute unit of a billing scenario in which the PT/OT furnishes less than eight minutes of the same service.
- When both the PTA/OTA and the PT/OT each furnish less than eight minutes for the final 15-minute unit of a billing scenario (the 10 percent standard applies).

Additionally, CMS is 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.

For more information regarding physical or occupational therapy services provided "in whole or in part" by PTAs/OTAs or the KX-modifier thresholds, contact Pamela West at 410-786-2302.

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

Since January 1, 2002, Registered Dieticians (RDs) and nutrition professionals have been recognized 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 nonphysician practitioners (NPPs), we are establishing regulations at §410.72 for their services since they are 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 are finalizing an alternative regulatory text at § 410.72(f) for assignment policy that cross-refers to our assignment regulations at § 424.55 for RDs and nutrition professionals that conveys clearer policy than that which is found in other NPP regulations. To maximize consistency in our regulations, we are adopting this same assignment regulatory text for physician assistants, nurse practitioners, clinical nurse (specialists, and certified nurse mid-wives at §§ 410.74(d)(2), 410.75(e)(2), 410.76(e)(2) and 410.77(d)(2), respectively.

We are also updating the payment regulation for MNT services at §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, since CY 2011 ─ as required by the Affordable Care Act of 2010 that amended 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 received a grade of B.

For more information regarding payment for MNT services or regulatory provisions for services of RDs and nutrition professionals, contact Pamela West at 410-786-2302.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12519.1	Contractors shall be aware of the policies published in	X	X	X						

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	the Medicare Physician Fee Schedule Final Rule (Regulation number CMS-1751-F, Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements), which are summarized with this change request and apply those policies as appropriate.									
12519.2	Contractors shall continue to pay for the Medicare telehealth originating site facility fee as 80 percent of, the lesser of the actual charge or $27.59, as described by HCPCS code Q3014 "Telehealth facility fee", effective for dates of service on and after January 1, 2022.	X	X	X						
12519.3	Contractors shall use the list of telehealth services found on the CMS website at http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.	X	X							
12519.4	Contractors shall use the list of codes that are subject to the CT modifier reduction found on the CMS website at https://www.cms.gov/medicare/physician-fee-schedule/ct-modifier-reduction-list.		X							
12519.5	Contractors shall use the prolonged preventive services G0513 and G0514 as an add-on to the covered preventive services located on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Medicare-PFS-Preventive-Services.html.		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility

		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12519.6	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X	X	X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Kathleen Kersell, 410 786-2033 or Kathleen.Kersell@cms.hhs.gov , Julie Adams, 410-786-8932 or julie.adams@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0