New Year, New Medicare Payment Questions From Provider-Based Departments and Therapists

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This month's installment of *Payment Strategies* will address various questions this author has received from readers about Medicare payments. For ease of reading, the questions have been divided into questions from provider-based departments (PBDs) and therapists.

Questions from PBDs

Q: Is the site-neutral Medicare payment still in effect for Excepted Off-Campus PBD clinic visits? If so, what is the appropriate claims reporting process?

A: Yes, the site-neutral Medicare payment is still in effect, which means Excepted Off-Campus PBDs will be paid 40% less than on-campus ones. The reduction only applies to the clinic visit code G0463, and the excepted on-campus PBDs will continue to be paid at 100% of allowable rates. To indicate that they are excepted off-campus PBDs, they should append the PO modifier to every code reported on their Medicare claims.

Q: Have any new cellular- and/or tissue-based products (CTPs) for skin wounds received Healthcare Common Procedural Coding System (HCPCS) codes since January 2020? If so, are they assigned to the low- or high-cost Outpatient Prospective Payment System (OPPS) package?

A: Yes. The Table lists the CTPs that received HCPCS codes since January 2020 and their 2021 OPPS package assignment.

Q: Do any of the CTPs for skin wounds have 2021 OPPS pass-through status?

A: No. When CTPs are applied in PBDs, Medicare payment for all current CTPs is packaged into the OPPS payment for the procedure.

Q: Is it true that the Current Procedural Terminology (CPT)* code for new office/outpatient visits, 99201, has been deleted from the CPT manual? If so, how does that impact PBDs?

A: Yes. 99201 has been deleted from the CPT manual. Therefore, PBDs should revise their clinic visit mapping tools, which should now map to 99202-99205 for new visits and 99211-99215 for established visits.

Q: Is it true that procedures reported on the same OPPS claim with 11044 *Debride bone 20 sq cm or less* will be packaged into the OPPS payment for 11044?

A: Yes. 11044 is assigned status indicator "J1" *Hospital Part B services paid through a comprehensive ambulatory payment classification (C-APC).* Comprehensive APCs provide a single payment for a primary service. With few exceptions, all other services reported on a hospital outpatient claim in combination with the primary service are considered related to the delivery of the primary service and packaged into a single payment. Therefore, the following items and services will be packaged into the payment for 11044:

- Major OPPS procedure codes with status indicators "P," "S," "T," and "V"
- Lower-ranked comprehensive APC procedure codes with status indicator "J1"
- Non-pass-through drugs and biologics with status indicator "K"
- Blood products with status indicator "R"
- Durable medical equipment with status indicator "Y"
- Therapy services (HCPCS codes with status indicator "A" reported on therapy revenue centers)

The following are some of the services that might pertain to wound/ulcer management and are excluded from the "J1" comprehensive APC packaging:

- Physical therapy services reported on a separate facility claim for recurring services
- Pass-through drugs, biologics, and devices with status indicators "G" or "H"
- Self-administered drugs, that is, those that do not function as supplies in the provision of the comprehensive service.

Q: I noticed that G0463 *Hospital outpatient clinic visit* is assigned status indicator "J2" *Hospital Part B services that may be paid through a C-APC*. Does that mean that a hospital outpatient clinic visit would be considered part of the payment for 11044?

A: Yes, that is correct. When a "J1" service and a "J2" service are reported on the same claim, the single payment is based on the rate associated with the "J1" service.

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Table. CELLULAR AND/OR TISSUE-BASED PRODUCTS THAT HAVE RECEIVED CODES SINCE JANUARY 2020

Code	Product Description	2021 Package Assignment
C1849	Skin substitute, synthetic	High
Q4227	Amniocore, per sq cm	High
Q4228	Bionextpatch, per sq cm	Low
Q4229	Cogenex amnio memb, per sq cm	Low
Q4232	Corplex, per sq cm	High
Q4234	Xcellerate, per sq cm	High
Q4235	Amniorepair or altiply, per sq cm	Low
Q4236	Carepatch, per sq cm	Low
Q4237	Cryo-cord, per sq cm	High
Q4238	Derm-maxx, per sq cm	High
Q4239	Amnio-maxx, per sq cm	High
Q4247	Amniotext patch, per sq cm	Low
Q4248	Dermacyte amn mem allo, per sq cm	Low
Q4249	Amniply, per sq cm	High
Q4250	AmnioAMP-MP, per sq cm	Low
Q4254	Novafix dl, per sq cm	Low
Q4255	Reguard, topical use, per sq cm	Low

Q: Several procedures (eg, 97602, 97605, 97606, and 97610) commonly performed in PBDs have the status indicator of "Q1." What impact does that have on PBDs' Medicare payment?

A: If the PBD reports a procedure with a "Q1" status indicator on the same Medicare claim as a procedure with the status indicator "S," "T," or "V," those payments will be packaged together.

Question from Therapists

Q: I am confused about whether Medicare will pay therapists to perform Communication Technology-Based Services (CTBSs). Will you shed some light on this topic?

A: The confusion is understandable. Prior to the novel coronavirus 2019 (COVID-19) public health emergency (PHE), the CTBSs were not included on the list of therapy codes that are described as "sometimes" or "always" therapy services. Once the COVID-19 PHE began limiting Medicare beneficiaries' in-person access to their healthcare providers, the CMS changed many codes and regulations, including the CTBSs, as explained below.

In 2020, Change Request 11791[1] added the following CTBSs as "sometimes therapy" codes, which became effective March 1, 2020: 98966, 98967, and 98968 for telephone assessment and management services; and G2010, G2012, G2061, G2062, and G2063 for remote evaluation of patient images/videos, virtual check-ins, and online assessments (e-visits). Therefore, therapists could perform these CTBSs, when medically necessary, for the duration of the COVID-19 PHE. When the CTBSs were provided by therapists in private practice or institutional providers of therapy service, the CTBSs had to be provided under a therapy plan of care, and reported with the appropriate modifier. Because these codes were designated as "sometimes therapy" codes, physicians and nonphysician practitioners could provide the CTBSs when medically necessary outside a therapy plan of care.

Effective January 1, 2021, Change Request 12126[2] updated the therapy code list and associated policies.

- For the duration of the COVID-19 PHE, the three telephone assessment codes remain on the list as "sometimes therapy" codes. Therefore, therapists in private practice and those who work for institutional providers may furnish these services until the PHE ends. **NOTE:** The COVID PHE was extended until April 21, 2021.
- The five codes added to the therapy list in 2020 for remote evaluation were removed and replaced with five other codes effective January 1, 2021. The good news is that the new codes will not end when the COVID-19 PHE ends.
- Code 2010 was replaced with G2250 *Remote assessment of recorded video and/or images submitted by an established patient (eg, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment.*
- Code 2012 was replaced with G2251 *Brief communication technology-based service, eg, virtual check-in, by a qualified healthcare professional who cannot report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available.*
- The three e-visit codes (G2061, G2062, and G2063) were replaced with 98970 qualified nonphysician healthcare professional online *digital E/M service, for an established patient, for up to 7 days, cumulative time during the 7 days: 5 to 10 minutes*; 98971 *11 to 20 minutes*; and 98972 *21 or more minutes.*

Considering these 2021 CTBS changes, this author reminds therapists to update their charging systems with the new permanent codes. ●

REFERENCES

1. Centers for Medicare & Medicaid Services. MLN Matters 11791: Therapy Codes Update. May 26, 2020. www.cms.gov/files/document/MM11791.pdf. Last accessed January 13, 2021.
2. Centers for Medicare & Medicaid Services. MLN Matters 12126: 2021 Annual Update to the Therapy Code List. December 31, 2020. www.cms.gov/files/document/MM12126.pdf. Last accessed January 13, 2021.