Questions and Answers from Open Door Forum: Physicians-January 27, 2021

1. We're new to anesthesia billing and I did review the anesthesia manual out online, but it didn't contain any information regarding any limitations for billing on the same claim. I wanted to find out if claims are - if a claim say a single claim is required to be billed for anesthesia and CRNA services, whether the CRNA is under medical direction or not, is there a requirement for such a thing?
    a. We are still actually looking at those questions that you sent in about that. In general, we would say that to the extent that services are provided for the same patient, for the same procedure and the same date of service by providers who are going to be billing through the same entity, those should generally be billed on the same claim. However, we are looking into the specifics of the questions that you sent in.
2. My question is I heard about the ambulance service. So you're saying that if we do summons an ambulance in emergent care that it probably will be rejected and we have to fill out paperwork to get it covered. Is that right?
    a. The announcement was only for non-emergent ambulance that's scheduled in advance. Not emergent.
3. Our organization is in North Dakota and we had a prior requirement of submitting post-op CPT code 99024 on our claims for the past several years and we did search the CMS Web site for 2021 and are not seeing - it's actually not quite clear if we still need to submit post-op (sort of) visits on our claims going forward, in 2021. Does anybody know if that's still a requirement for North Dakota?
    a. Hi there North Dakota. Absolutely. This is definitely a topic that CMS is very interested in. This is a global services policy issue. So please continue to submit the 99024 because that information is crucial to how we think about the policy going forward.
        i. Will there be a time where that's no longer needed?
            1. I suspect that when that time comes we'll be telling the world about it. So I would stay tuned.
4. My question is related to the COVID vaccine and particularly, you all have noted in the Interim 4th Final Rule that you expected the COVID-19 vaccine to be placed categorically, in the same place as the flu and pneumonia. And since this interim final rule, the Federal Register that addresses this section, Section 410.57, has been updated to include this. If we go to the Medicare Benefit Policy Manual Chapter 15 and 16, each of these discuss that flu and pneumonia are not - do not require an order nor do they follow the Incident 2 requirements. And my question is whether or not we can make that same assumption for the COVID-19 vaccine considering it's in the same category. And the manuals have not been updated and many of our institutions across the states, are trying to do large vaccination centers and we really need to understand and have documentation from CMS related to orders and supervision for these services.
    a. I think that's right. You can assume the same rules apply in the sense that there is no order that's required and the incident too as well too, is similar to how we would be treating the flu vaccine. There should be some information coming out or at least

answers to questions that will be put out maybe through FAQs or other media. But that is a way to think about it.

5. This is actually regarding the 2021 E&M guidelines adopting by both CPT and CMS. The CPT editorial panel has stated that a provider who orders a diagnostic test of any kind may not receive medical decision-making credit for that order if they are also separately reporting a code for that test. This logic represents a significant departure from the past 25 years in terms of how diagnostic data credit is allocated for the medical decision-making component of E&M services. So I'd like to know if A, CMS shares CPT's understanding of this guideline. And B, if CMS does share it, what about situations where another provider under the same Tax ID reports the test? For example, a lab in a hospital system that employs the ordering physician separately, reports the test. In such scenarios, would the ordering provider then be able to get medical decision-making credit for their E&M service?
    a. In the Physician Fee Schedule Final Rule, we finalized the proposed rule and thus adopted the AMA guidelines for Medical Decision Making for Office/Outpatient visits. If you have questions about the AMA's intent for any specific guidelines, please direct your questions and comments to the AMA. If you believe there is a contradiction between CMS policy and the AMA guidelines, please provide us with citations of the specific CMS policy and a clear description of how that policy conflicts with the AMA guidelines. If verified this could inform future rulemaking. Concerning the "same Tax ID" part of the question, please contact your Medicare Administrative Contractor, as they're best able to help you sort through particular circumstances.
6. I have two questions I hope you'll allow me to ask, both related to time based billing. So the first is related to CPT codes 99358 and 59, the prolonged non-face to face service codes. So I understand and it makes sense that we can no longer bill those on the same date of service as the outpatient E&M codes, 99202 through 99215 as we can now include non-face to face time on the same date of service. But in the final rule it was very unclear - it wasn't clearly stated whether we can still bill the 99358 and 59 on the date of service other than an outpatient E&M if we provide a prolonged non-face to face service on those days.
        i. In the Physician Fee Schedule final rule we discontinued the use of the 99358-9 codes to report prolonged time associated with Office/Outpatient E/M visits. While those codes are used for other settings, 99358-9 should not be used for any Office/Outpatient E/M visits.
            1. And then if I can quickly, hopefully, ask a second question that's also time related, and this has to do with resident time. So when billing on the outpatient side now, with the new outpatient E&M guidelines, in a GC or a GE clinic, can the resident's time be counted?
                a. There isn't a national policy on counting resident time, so providers are encouraged to seek guidance from their Medicare Administrative Contractors.
7. So I'm just now learning about all of the Medicare benefits and rules. And so with that being said, I read an article that showed a system's success with the RN, traditional registered nurse leading the AWVs, the annual wellness visits. So I'm wondering is there a conference call or recording that I can listen to get more information about that, like how to bill, if the RN does it versus a traditional provider or APRN?
    a. Look to our Medicare Learning Network for information about working with CMS. You can find a preventive services fact sheet at: https://www.cms.gov/Outreach-and-

Education/Medicare-Learning-Network-MLN/MLNProducts/preventiveservices/medicare-wellness-visits.html. For detailed guidance, please consult the Medicare Claims Processing Manual at

b. https://www.cms.gov/files/document/medicare-claims-processing-manual-chapter-12 . Per Section 30.6.1.1B, The IPPE may be performed by:
c. •a doctor of medicine or osteopathy as defined in Section 1861(r) (1) of the Social
d. Security Act, or
e. a qualified nonphysician practitioner (nurse practitioner, physician assistant or
f. clinical nurse specialist).
g. The AWV may be performed by a health professional, which is defined as:
h. • a doctor of medicine or osteopathy as defined in Section 1861(r)(1) of the Social
i. Security Act,
j. a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in
k. section 1861(aa)(5) of the Social Security Act), or
l. • a medical professional (including a health educator, registered dietitian, nutrition
m. professional, or other licensed practitioner) or a team of such medical
n. professionals, working under the direct supervision of a physician (doctor of
o. medicine or osteopathy).
p. For further information, please contact your Medicare Administrative Contractor

8. My question relates to the primary care exception rule (unintelligible) the public health emergency, as noted in the calendar year 2021 physician fee schedule updates. We're a little confused as to what code set will be applicable outside of the MSA. In particular, level four and five (UN) established patients, transitional care management. And we can certainly submit this question through email as well, but does anyone on the call have guidance on what particular code sets (clarity) will be applicable to the primary care exception setting and the rural health areas outside of the public health emergency?
    a. For the duration of the PHE, the services included under the primary care exception for all resident training sites include CPT codes 99201-99205, 99211-99215, 99495-99496, 99421-99423, 99452, and HCPCS codes G0402, G0438, G0439, G2012 and G2010. After the PHE expires, the services included under the primary care exception for all resident training sites include CPT codes 99202-99203 (CPT code 99201 has since been deleted), 99211-99213, 99421-99423, 99452, and HCPCS codes G0402, G0438, and G0439, G2010 and G2012. We also added to the primary care exception, for residency training sites that are located outside of an MSA, Medicare telehealth services that are furnished by residents.
9. My question relates to the Most Favorite Nation Model. As I understand it, based on the - CMS's page on that, that this was supposed to become effective January 1st but there was a temporary restraining order which delayed it through January 20. But then there was also an interim comment period which was supposed to end yesterday, January 26. I'm just not clear on what the current status is for this model and how, you know, when we should look forward to more information and if it'll be updated on this - the CMS page for the Most Favorite Nation Model or if there'll actually be like a change request sent out on it.
    a. There is now an update at: https://innovation.cms.gov/innovation-models/most-favored-nation-model. The MFN Model was not implemented on January 1, 2021 and will not be implemented without further rulemaking.

10. We received a question about vaccine administration. We understand that the reimbursement rates are on the Web site. But is there any requirement if a provider says they'd rather skip the paperwork; there's no cost sharing for the patient of course; is the provider required to bill Medicare for vaccine administration, or could they just administer and not submit a claim at all?
    a. To the extent that the provider wants to be paid then a claim does need to be submitted. However, if the provider does not for whatever reason, wish to submit a claim and wishes to administer the vaccine without charging the beneficiary and that's an important thing to underline, right, without charging the beneficiary then the provider is free to do so.