November 18, 2021

AACVPR Health Policy & Reimbursement Update

Medicare Final 2022 Regulations

CMS (Centers for Medicare & Medicaid Services) has released final 2022 regulations for physicians (Physician Fee Schedule or PFS) and for hospital outpatient services (Hospital Outpatient Prospective Payment System or HOPPS). Both sets of regulations address aspects of cardiac, intensive cardiac, and pulmonary rehabilitation (CR/ICR/PR) services.

Your program should be familiar with Medicare's CY 2022 rules that take effect January 1, 2022. Some of the new regulations were made final as proposed by CMS in July, some rules were modified based on provider feedback, and some regulations were not altered despite recommendations by providers and the medical community.

Virtual Direct Supervision

The definition of direct supervision is that a physician (MD or DO) is physically present and immediately available at all times to respond to emergencies when a service is in operation (42 CFR 410.27). CR/ICR/PR are outpatient services under direct supervision. During the public health emergency (PHE), CMS expanded the definition to include immediate availability of a physician via virtual presence through audio-video real-time communications technology (excluding audio-only).

This definition allows for the virtual option to be temporarily extended and will remain in effect through the end of the calendar year in which the PHE ends. Because the PHE is currently extended to January 16, 2022 (and perhaps beyond that date), this means virtual direct supervision will be in place at least until December 31, 2022.

Virtual Delivery of Hospital Outpatient Services

During the PHE some hospital outpatient CR/ICR/PR programs expanded to provide virtual sessions (audio-video real-time communications technology) to beneficiaries in their homes during the PHE. This has been possible through the Hospitals without Walls waivers that were put into effect in March of 2020 in response to the PHE. These waivers will expire at the conclusion of the PHE. This means virtual delivery will no longer be an option for hospital outpatient CR/ICR/PR programs after the PHE ends. AACVPR will continue to provide timely updates on any extension of the PHE and consequent impact on virtual delivery of CR/ICR/PR services.

Virtual Delivery of Telehealth for Physician Services

CR/ICR/PR services provided in physician offices were added to the CMS list of temporary telehealth services during the PHE and have been extended until December 31, 2023. Physician telehealth services, using virtual delivery (audio-video real-time interactive communication), will need to provide sufficient evidence of clinical benefit to be permanently added to the Medicare telehealth services list. Note that these temporary ("Category 3") telehealth codes are available only to physician-owned CR/ICR/PR services and are not billable by hospital outpatient programs.

Initial Individualized Treatment Plan

While physicians are an integral part of a comprehensive hospital outpatient CR/ICR/PR service, they are not eligible for separate financial compensation for the physician work that is required of CR-ICR-PR. CMS acknowledges this, so starting in January, a physician will be able to separately bill (under the PFS) an

evaluation and management (E/M) service for establishing and signing the initial ITP. This is a professional code that is not billable by the CR-ICR-PR department.

CMS further clarifies that any physician involved in a patient's care may establish, review, and sign the initial Individualized Treatment Plan (ITP) on or before (but not later than) the first CR/ICR/PR session. This could be the referring physician, one of the patient's other MDs, a physician in the rehab department, or the medical director. The medical director does not have to also sign the initial ITP if it was completed by another physician. CMS has added this new flexibility to reduce delays in beneficiaries starting the CR/ICR/PR program earlier in their recovery process.

Pulmonary Rehabilitation Regulation Changes

Expanded Pulmonary Rehabilitation Coverage for COVID-19

CMS will cover pulmonary rehabilitation for individuals who have had confirmed or suspected COVID-19 and experience **persistent symptoms that include respiratory dysfunction for at least four weeks**. The proposed rule was expanded to include beneficiaries with or without hospitalization prior to PR referral. A positive COVID test is not required. PFTs are not a requirement for this non-COPD diagnosis to be eligible for PR.

New CPT Codes for Pulmonary Rehabilitation

- **CPT code 94625:** Outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)
- **CPT code 94626:** Outpatient pulmonary rehabilitation; with continuous oximetry monitoring (per session)

These code definitions are similar to the two long-standing CR CPT code definitions that provide the options of a session with or without continuous ECG monitoring. CPT 94626 would be used for beneficiaries who require continuous oximetry monitoring. CPT 94625 would be the code to use when oximetry monitoring is intermittent or not necessary for that patient.

Like G0424 and the two CR CPT codes, each new PR code represents a 60-minute session. If one session is delivered, session duration (NOT exercise duration) must be at least 31 minutes to bill for that session. If two PR sessions are provided, CMS views it as cumulative time and considers the first 60 minutes to equal the first session and a second session that would require a minimum of 31 minutes in duration to bill for a second session (i.e., a total of 91 minutes or greater).

Direct Patient Contact Requirement Removed

This PR-specific requirement will be removed from the PR provision, 42 CFR 410.47. CMS agreed that this language is redundant to the definition of a medical director's role. Medical directors already oversee patients, review 30-day ITPs, and provide direct patient (face-to-face) contact as needed. Furthermore, PR staff track patients' progress at every session and identify the need for direct contact when appropriate.

Final 2022 Hospital Outpatient Payment Rates

The following table outlines reimbursement rates are for hospital outpatient CR/ICR/PR services. Payment rates for physician-owned CR/ICR/PR are calculated using a different formula.

Service	Procedure Code	APC	National Average	Patient/Secondary Insurance Amount
Cardiac Rehabilitation w/o Monitor	93797	5771	$118.55	$23.71
Cardiac Rehabilitation w/ Monitor	93798	5771	$118.55	$23.71
Intens Cardiac Rehab w/o Exerc	G0423	5771	$118.55	$23.71
Intens Cardiac Rehab w/ Exerc	G0422	5771	$118.55	$23.71
Pulmonary Rehabilitation w/o Continuous Oximetry Monitoring	94625	5733	$56.85	$11.37
Pulmonary Rehabilitation w/ Continuous Oximetry Monitoring	94626	5733	$56.85	$11.37
Peripheral Vascular Rehab	93668	5733	$56.85	$11.37
Therapeutic Respiratory	G0237	5731	$25.23	$5.05

Procedures				
Therapeutic Respiratory Procedures – Individual	G0238	5731	$25.23	$5.05
Therapeutic Respiratory Procedures – Group	G0239	5732	$34.57	$6.92

More details about both regulations and the consequent impact on CR/ICR/PR services will be covered in an AACVPR webinar on December 7, 2021.

Register Now

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