PROVIDENCE Health Plan

Coding Policy Alerts

March/April 2022

This is the March/April 2022 issue of Providence Health Plan's Coding Policy Alerts. The focus of this update is to communicate to providers new or revised payment policies and coding policies, as well as general billing and coding information.

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CODING POLICY UPDATES

(REPEAT ARTICLE) Location/Place of Service Codes for Telemedicine Services in 2022	The description for place of service (POS) code 02 was changed for services on or after January 1, 2022, and a new location code, POS 10, was published. For dates of service on or after January 1, 2022, POS 02 is to be used when the patient is located in a hospital or other facility when receiving telemedicine services, and POS 10 is to be used when the patient is located in their place of residence (location other than hospital or other facility) when receiving telemedicine services. • **02**: The location where health services and health related services are provided or received through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology. • **10**: The location where health services and health related services are provided or received through telecommunication technology. Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology. PHP telemedicine coding policies (Coding Policies 67.0.A, 67.0.B, 67.0.C, and 67.0.D) have been updated to show that PHP will accept only POS 02 or POS 10 for telemedicine services for dates of service on or after January 1, 2022. For codes with a site-of-service differential, services billed with POS 02 will be paid at the facility rate, and services billed with POS 10 will be paid at the non-facility rate. Modifiers GT and 95 are not required but will not affect payment if used. For additional information, providers are referred to PHP's telemedicine coding policies for specific lines of business (Medicare, Oregon Commercial plans, OHP, and Washington Commercial plans), all of which are available on ProvLink.
(REPEAT ARTICLE) Modifiers 93 and FQ for Telemedicine Services in 2022	The Centers for Medicare and Medicaid Services (CMS) published modifier FQ effective January 1, 2022, to identify telemedicine services performed using audio-only communication technology. The American Medical Association (AMA) published modifier 93 effective January 1, 2022, for the same purpose. • Modifier FQ: The service was furnished using audio-only communication technology • Modifier 93: Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system PHP telemedicine coding policies (Coding Policies 67.0.A, 67.0.B, 67.0.C, and 67.0.D) have been updated to show that either modifier 93 or modifier FQ is required for all telemedicine services performed on or after January 1, 2022, using audio-only communication technology. For additional information, including a list of telemedicine services that are eligible for audio-only communication technology, providers are referred to PHP's telemedicine coding policies for specific lines of business, all of which are available on ProvLink.

Coding Policy 90.0 "Chemotherapy Administration Codes"	PHP follows Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS) guidelines for use of chemotherapy administration codes. The policy was updated to include the CPT guidelines for use of these codes. CPT guidelines state, "The highly complex infusion of chemotherapy or other drug or biologic agents requires physician or other qualified health care professional work and/or clinical staff monitoring well beyond that of therapeutic drug agents (96360-96379) because the incidence of severe adverse patient reactions are typically greater. These services can be provided by any physician or other qualified health care professional. Chemotherapy services are typically highly complex and require direct supervision for any or all purposes of patient assessment, provision of consent, safety oversight, and intraservice supervision of staff. Typically, such chemotherapy services require advanced practice training and competency for staff who provide these services; special considerations for preparation, dosage, or disposal; and commonly, these services entail significant patient risk and frequent monitoring. Examples are frequent changes in the infusion rate, prolonged presence of the nurse administering the solution for patient monitoring and infusion adjustments, and frequent conferring with the physician or other qualified health care professional about these issues." To report infusions that do not require this level of complexity, see CPT codes 96360-96379.
Coding Policy 85.0 "Documentation Guidelines for Rehabilitation Therapy Services (Physical, Speech, and Occupational Therapy Services)"	In the calendar year (CY) 2019 PFS final rule (83 FR 59654 through 59660), CMS created 2 new modifiers for services furnished by therapy assistants: • CQ Modifier: Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant (PTA) • CO Modifier: Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant (OTA) For dates of service on or after January 1, 2022, PHP requires these modifiers to be appended to codes for therapy services, along with GP and GO therapy modifiers, for services in which the PTA or OTA performs more than 8 minutes of a 15-minute unit of timed therapy. Presence of these modifiers will not affect payment.

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GENERAL CODING INFORMATION

Multiple Physicians Billing Critical Care for the Same Patient	Critical care is reported with a base code (CPT code 99291) for the first 30-74 minutes of critical care, and an add-on code (CPT code 99292) for each additional 30 minutes. Critical care services less than 30 minutes total on a given date are not reported with CPT code 99291 but may be reported with the appropriate evaluation and management code based on the site of service. CPT code 99291 may be reported only once per day by providers of the same specialty within the same provider group. Generally, an add-on code may never be billed without a parent code, but PHP makes an exception in the case of CPT code 99292 when multiple physicians of the same specialty in the same group practice are providing critical care for the same patient. If two or more physicians of the same specialty in a group practice provide critical care services to the same patient on the same date of service, only one physician of the same specialty in the group practice may report CPT code 99291. The other physician(s) must report their critical care services with CPT code 99292 alone, without reporting CPT code 99291. In this scenario, PHP will allow payment for CPT code 99292 even though it is billed without a parent code.