"Above all, don't fear difficult moments. The best comes from them." -- Rita Levi-Montalcini

Client Memo August 2020

NEWS Update

COVID-19 Public Health Emergency Extended

On July 23, 2020, HHS Secretary Alex Azar signed the renewal of the COVID-19 national public health emergency declaration which is expected to last another 90 days.

The signing of the declaration extends the national public health emergency period, allowing for COVID-19 regulatory changes, including relaxed telehealth rules and higher payments, to continue.

Revised end dates for Medicare & Medicaid plans as well as commercial insurance companies are provided below:

End Dates by Payers for Relaxed Telehealth Visit Rules	
Insurance Plan	**Proposed End Date**
Aetna	8/4/2020
BCBS No Dakota	Until end of COVID-19 emergency
BCBS So Dakota	8/31/2020
BCBS Oklahoma	8/31/2020
BCBS Federal Plan	until end of COVID-19 emergency
Cigna	7/31/2020
GEHA	6/30/2020
Humana	until end of COVID-19 emergency
Medicare	until end of COVID-19 emergency
Tricare	until end of COVID-19 emergency
UnitedHealthcare	9/30/2020

The COVID-19 national public health emergency period has been extended for another 90 days, up until October 25, 2020.

Repayment of Medicare Loans to Begin

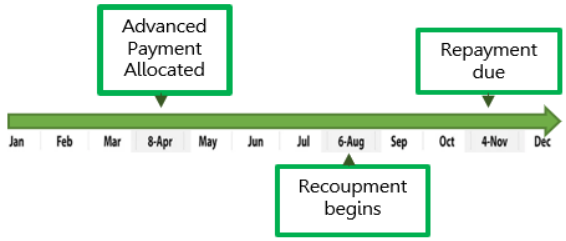
Repayment of the Accelerated and Advance Payment Program loans will begin Monday, August 3, 2020.

CMS will begin recouping the accelerated/advanced loan payments sent to Medicare providers and suppliers in response to the COVID-19 pandemic. CMS provided accelerated/advance payments to any Medicare provider/supplier who submitted a request to the appropriate Medicare Administrative Contractor (MAC) and met the required qualifications.

Providers were allowed to request up to three months of payments with the understanding that the loan would be repaid to Medicare within 210 days. According to the AMA, CMS had extended the repayment of these accelerated/advance payments to begin 120 days after the date of issuance of the payment.

Please refer to the example timeline below which shows an advanced payment issued in the beginning of April, recoupment beginning in August, and repayment due in early November.

Advanced Payment Timeline Example



Physicians can continue to submit claims as usual after the issuance of the accelerated or advance payment; however, recoupment will not begin for 120 days. Physicians will receive full payments for their claims during the 120-day delay period.

At the end of the 120-day period, the recoupment process will begin and every claim submitted by the physician will be offset from new claims to repay the accelerated/advanced payment. Thus, instead of receiving payment for newly submitted claims, the physician's out-standing accelerated/advance payment balance will be reduced by the claim payment amount. This process will be automatic, states the AMA in its bulletins regarding the COVID-19 pandemic.

The AMA also sent a letter on July 31, 2020, to CMS asking for a delay to the start of the Medicare loan repayments. Dr. Madara, the AMA's chief executive, pointed out that providers could see their Medicare payments reduced by 100% at a time when they are already facing financial hardship caused by the COVID-19 emergency.

Provider Relief Program Updates

HHS Extends Application Deadline for Medicaid Providers

On July 31, 2020, the HHS Press Office announced that as part of its ongoing efforts to provide financial relief to healthcare providers impacted by COVID-19, the application deadline for the Phase 2 general distribution to Medicaid, Medicaid managed care, CHIP, and dental providers had been extended.

HHS also plans to allow certain Medicare providers who experienced challenges in the Phase 1 Medicare General Distribution application period a second opportunity to receive funding.

Both groups will have until Friday, August 28, 2020 to apply.

To be considered eligible for funding from the General Distribution (Phase 2), Medicaid, CHIP and Dental providers must have:

- Received no payment from the first $50B general distribution;
- Billed Medicaid/CHIP programs or Medicaid managed care plans for health-related services between Jan. 1, 2018 - Dec. 31, 2019; or billed a health insurance company for oral healthcare-related services as a dental service provider; or be a licensed dental service provider who does not accept insurance and has billed patients for oral healthcare-related services;
- Filed a federal income tax return for fiscal years 2017, 2018, 2019; or be exempt from filing a return;
- Provided patient care after January 31, 2020.

For more detailed information on eligibility, please see Medicaid, CHIP and Dental Distribution FAQs at: https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/faqs/medicaid-distribution/index.html

Second Chance for Certain Medicare Providers

Starting the week of August 10th , HHS will allow Medicare providers who missed the opportunity to apply for additional funding from the $20 billion portion of the $50 billion Phase 1 Medicare General Distribution.

In April, 2020, HHS, utilizing CMS payment information, distributed $30 billion directly to Medicare providers proportionate to their share of 2019 Medicare fee-for-service reimbursements.

This was part one of the $50 billion Phase 1 Medicare General Distribution which sought to offer providers financial relief equal to 2 percent of their annual revenues. Providers that do not submit comprehensive cost reports with CMS were asked to submit revenue information to a portal to receive the balance of their 2 percent payment of General Distribution funds.

HHS is now giving those eligible providers another opportunity to apply for additional funding. They will have until August 28, 2020, to complete an application to be considered for the balance of their additional funding up to 2 percent of their annual patient revenues.

Payments for Providers Who Had a Change in Ownership

As previously noted, HHS relied on 2019 CMS payment data on file to determine automatic payments for $30 billion of the $50 billion Phase 1 Medicare General Distribution. Accordingly, some providers or provider practices that experienced a change in ownership in 2020 missed out on payments as the payments were distributed to the previous owners.

Prior owners are required to return the payments to HHS, if they cannot attest to providing diagnoses, testing, or care for individuals with possible or actual cases of COVID-19 on or after January 31, 2020. For program integrity considerations, previous owners are precluded from transferring funds to new owners who may qualify and can attest to providing care for possible or actual COVID 19 cases.

HHS did not reissue returned payments to the new owners and instead promised to give new owners a separate opportunity to apply for provider relief funding. **That opportunity is now here.** Starting the week of August 10th, providers who experienced change in ownership challenges may submit their revenue information, along with documentation proving a change in ownership, by August 28th for consideration for Provider Relief Fund payments.

HHS is currently working to address relief payments to new providers in 2020 along with those that have yet to receive any funding for a variety of reasons, including the fact that they may only bill commercially, or do not directly bill for the services they provide under the Medicare and Medicaid programs and thus did not receive any funding yet. Future announcements will be provided.

For updated information and data on the Provider Relief Fund, visit: hhs.gov/providerrelief.

COVID-19 Relief Funds Are Taxable

If you received money from the COVID-19 Provider Relief Fund, it will probably be taxed, warns Kent Moore, senior strategist for physician payments at the AM Academy of Family Physicians.

His article in the July 14, 2020 issue of *FPM* states that the IRS has confirmed that Provider Relief Fund payments made available through the federal CARES Act cannot be excluded from taxation under a disaster relief exemption.

Therefore, the payments do constitute gross taxable income, unless otherwise carved out under an existing exclusion, such as if the provider is a 501(c) nonprofit.

The IRS guidance came in response to a question about whether a health care provider that receives a Provider Relief Fund payment may exclude it from gross income as a qualified disaster relief payment under section 139 of the Internal Revenue Code.

The IRS responded "No," and said a payment to a business does not fit the definition of a qualified disaster relief payment under section 139, even if the business is a sole proprietorship. The relief fund payment is therefore included in gross income under section 61 of the code.

This guidance is now reflected in the updated Provider Relief Fund frequently asked questions page on the U.S. Department of Health and Human Services website: https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/faqs/index.html

HRSA COVID-19 Uninsured Program

HHS has contracted with UnitedHealth Group to provide claims reimbursement to health care providers, generally at Medicare rates, for testing uninsured individuals for COVID-19 and treating uninsured individuals with a COVID-19 diagnosis. The process will not involve credentialing or contracting with UnitedHealth Group,

How It Works

As part of the Families First Coronavirus Response Act and the CARES Act, health care providers can request claims reimbursement electronically through the COVID-19 Uninsured Program Portal and receive reimbursement, generally at Medicare rates, for testing uninsured individuals for COVID-19 and treating uninsured individuals with a COVID-19 diagnosis.

Health care providers who have conducted COVID-19 testing or provided treatment for uninsured individuals with a COVID-19 diagnosis on or after February 4, 2020 can request claims reimbursement.

Steps will involve:

1. enrolling as a provider participant,
2. checking patient eligibility,
3. submitting patient information,
4. submitting claims, and
5. receiving payment via direct deposit.

To participate, providers must attest to the following at registration:

- You have checked for health care coverage eligibility and confirmed that the patient is uninsured.
- You will accept defined program reimbursement as payment in full.
- You agree not to balance bill the patient.
- You agree to program terms and conditions.

For more information and instructions, please go to: https://coviduninsuredclaim.linkhealth.com/claims-and-reimbursement.html

CMS to Pay Clinicians for Counseling Patients During COVID-19 Tests

CMS said it will pay eligible clinicians for telling patients to isolate while awaiting results of a test for the novel coronavirus, writes Alicia Ault in her July 30, 2020, article for *Medscape Medical News.*

Doctors and other healthcare providers will be able to bill CMS using existing E/M payment codes when they discuss with patients the immediate need for isolation, and the importance of informing their immediate household members that they should also be tested for COVID-19.

The agency has provided a checklist for clinicians to use. This Counseling Check List, including resource links, can be viewed at: https://www.cms.gov/files/document/counseling-checklist.pdf

Clinicians are also expected to review the signs and symptoms of the disease and discuss services available to patients to help them isolate at home.

Reimbursement is available regardless of where a test is administered, including doctor's offices, urgent care clinics,

hospitals, and community drive-thru or pharmacy testing sites.

If patients test positive, clinicians are expected to counsel them to wear a mask at all times and to tell them they will be contacted by public health authorities who will be seeking information for contact tracing. Clinicians should also counsel COVID-positive patients to inform their immediate household and recent contacts, as they may also need to be tested and to self-isolate.

The Sequela Effects of COVID-19

We are learning more every day about the sequela conditions that might arise as a result of COVID-19. The early studies have found decreased lung function that might not be reversible, as well as potentially permanent damage to the heart, kidneys, and liver, along with GI conditions. Scientists and clinicians typically have focused on the acute phase of COVID-19, but is has become increasingly clear that many patients who have recovered may need continuous monitoring for long-term effects, states Deborah Gride in her article "What we currently know about the sequela effects of COVID-19," *ICD-10 Monitor*, July 28, 2020

A sequela is a residual or late effect (condition-produced) after the acute phase of an illness or injury has terminated. There is no time limit on when a sequela code can be used. The residual effect may be apparent early, such as in cerebral infarction, or it may occur months or years later, such as that due to a previous illness or injury.

How do we code sequelae of COVID-19?

For coding all late effects or sequelae of COVID-19, confirmed by COVID testing or documentation in the practitioner's record indicating the patient had COVID-19:

Code first all the condition(s) being treated related to COVID (e.g., shortness of breath, DVT, etc.). Use the additional code B94.8-Sequelae to identify the late effect.

Coding: Shortness of Breath R06.02
Fatigue R53.83-other fatigue
Sequela: B94.8

When not certain if the condition treated during the encounter is a sequela of COVID-19, but the patient had a confirmed diagnosis of COVID-19 either by testing or confirmation in the practitioner's documentation:

Code first the condition you are treating. Use Z86.19-Personal history of other infectious and parasitic diseases as an additional diagnosis.

Coding: Hypertension-I10
Personal history of other infectious and parasitic diseases-Z86.19

There is no specific timeframe for when a personal history code is assigned. If the practitioner documents that the patient no longer has COVID-19, the personal history code Z86.19 can be assigned as an additional diagnosis.

If a patient is seen in follow-up after completed treatment, and the patient does not have a related sequela condition and/or symptoms, code the following:

Z09-encounter for follow-up examination after completed treatment for other conditions other than malignant neoplasm
Z86.19- Personal history of other infectious and parasitic diseases

It is important that when coding sequela of COVID-19, the practitioner documents that the condition is a late effect of COVID. If the practitioner's documentation indicates multi-system inflammatory syndrome, the practitioner needs to document the affected organs in order to code correctly.

If the patient is experiencing signs or symptoms that are sequelae of COVID-19, code all signs and/or symptoms that are relevant. Be specific, because documentation must include the relationship with COVID-19 in order to code the condition as a sequela. Physicians should also document any patient counseling related to prevention measures to reduce the spread of COVID-19.

Don't Forget Modifier CS

Don't forget to add modifier CS to visits related to COVID-19 testing. By doing this, Medicare and private insurers will pay 100% of the insurance allowable without any patient cost-sharing.

Modifier CS can be used for both in-person visits and visits via telehealth. When using modifier 95 for telehealth services, report the CS modifier first since the 95 modifier is only for informational purposes.

The patient does not have to test positive in order to use the CS modifier.

eCQMs Allow Telehealth Encounters

CMS has released information on the allowance of telehealth encounters for the Eligible Professional and Eligible Clinician electronic clinical quality measures (eCQMs) used in CMS quality reporting programs for the 2020 and 2021 performance periods.

The information applies to eCQMs used in each of the following programs:

- QPP: The MIPS and Advanced APMs
- APM: Comprehensive Primary Care Plus (CPC+)
- APM: Primary Care First (PCF)
- Medicaid Promoting Interoperability Program for Eligible Professionals

CMS has updated the Eligible Clinicians and Eligible Professionals Table of eCQMs to reflect the allowance of telehealth.

To view the full list of the **2020 Performance Period Table of eCQMs , please go to:**
https://ecqi.healthit.gov/sites/default/files/EP-EC-MeasuresTable-2019-05-v3.pdf

Some of the measures that can be met through the use of telehealth are listed below. For a complete list of applicable measures, please go to the website above.

NQF ID	MIPS Quality ID	Measure Name	Measure Description
0418e	134	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Percentage of patients aged 12 years and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the eligible encounter
0419e	130	Documentation of Current Medications in the Medical Record	Percentage of visits for patients aged 18 years and older for which the eligible professional or eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.
0028e	226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user
Not Applicable	318	Falls: Screening for Future Fall Risk	Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period
Not Applicable	001	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period
Not Applicable	309	Cervical Cancer Screening	Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria: *Women age 21-64 who had cervical cytology performed every 3 years *Women age 30-64 who had cervical cytology/human papillomavirus (HPV) co-testing performed every 5 years
Not Applicable	112	Breast Cancer Screening	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the Measurement Period
Not Applicable	111	Pneumococcal Vaccination Status for Older Adults	Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine
Not Applicable	113	Colorectal Cancer Screening	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer

NQF ID	MIPS Quality ID	Measure Name	Measure Description
0041e	110	Preventive Care and Screening: Influenza Immunization	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization
Not Applicable	236	Controlling High Blood Pressure	Percentage of patients 18-85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period

The measures above can also be reported via claims EXCEPT Cervical Cancer Screening and Falls: Screening for Fall Risk

For an updated list of measures that can be submitted via Medicare Part B claims, please click on or go to the following site: https://qpp.cms.gov/mips/explore-measures?tab=qualityMeasures&py=2020#measures

Medicare News

COVID-19: Coverage of Physician Telehealth Services Provided to SNF Residents

The current COVID-19 Public Health Emergency (PHE) does not waive any requirements related to Skilled Nursing Facility (SNF) Consolidated Billing; however, CMS added CPT codes 99441, 99442, and 99443, to the list of telehealth codes coverable under the waiver during the COVID-19 PHE. These codes designate three different time increments of telephone evaluation and management service provided by a physician. You can bill for these physician services separately under Part B when furnished to a SNF's Part A resident.

Medicare Administrative Contractors (MACs) will reprocess claims for CPT codes 99441, 99442 and 99443 with dates of service on or after March 1, 2020, that were denied due to SNF CB edits. You do not have to do anything. If you already received payment from the SNF for these physician services, return that payment to the SNF once the MAC reprocesses your claim.

Influenza Vaccine Payment Allowances – Annual Update for 2020-2021 Season

The Medicare Part B payment allowance limits for seasonal influenza and pneumococcal vaccines are 95% of the Average Wholesale Price (AWP) as reflected in the published compendia except where the vaccine is furnished in a hospital outpatient department. When the vaccine is furnished in the hospital outpatient department, payment for the vaccine is based on reasonable cost.

Annual Part B deductible and coinsurance amounts do not apply for the influenza virus and the pneumococcal vaccinations. All physicians, non-physician practitioners, and suppliers who administer these vaccinations must take assignment on the claim for the vaccine.

The payment allowance limits can be viewed at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing

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