"Research is creating new knowledge."

-- Neil Armstrong

Client Memo November 2020

NEWS Update

Public Health Emergency Period Extended Through January 23, 2021.

End Dates by Payers for Relaxed Telehealth Visit Rules	
Insurance Plan	**Proposed End Date**
Aetna	12/31/2020
BCBS No Dakota	until end of COVID-19 emergency
BCBS So Dakota	until further notice
BCBS Oklahoma	until end of COVID-19 emergency
BCBS Federal Plan	until end of COVID-19 emergency
Cigna	12/31/2020
GEHA	until further notice
Humana	until end of COVID-19 emergency
Medicare	until end of COVID-19 emergency
Tricare	until end of COVID-19 emergency
UnitedHealthcare	12/31/2020

FBI, HHS warn of 'increased and imminent' cyber threat – CISA website

In a joint alert sent October 29, 2020, The Cybersecurity and Infrastructure Security Agency (CISA), the FBI, and the US Department of HHS said they have 'credible information' that cybercriminals are taking new aim at healthcare providers and public health agencies as the coronavirus pandemic reaches new heights. The agencies are sharing this information to provide warning to healthcare providers to ensure that they take timely and reasonable precautions to protect their networks from these threats.

CMS Announces New Repayment Terms for Medicare Loans

CMS announced amended terms in its October 9, 2020, bulletin for payments issued under the Accelerated and Advance Payment (AAP) Program.

Providers were required to make payments starting in August of this year, but with this action, repayment will be delayed until one year after payment was issued. After that first year, Medicare will automatically recoup 25% of Medicare payments otherwise owed to the provider or supplier for eleven months. At the end of the eleven-month period, recoupment will increase to 50% for another six months.

If the provider or supplier is unable to repay the total amount of the AAP during this time-period (a total of 29 months), CMS will issue letters requiring repayment of any outstanding balance, subject to an interest rate of 4%.

The letter will also provide guidance on how to request an Extended Repayment Schedule (ERS) for providers and suppliers who are experiencing financial hardships.

An ERS is a debt installment payment plan that allows a provider or supplier to pay debts over the course of three years, or up to five years in the case of extreme hardship. Providers and suppliers are encouraged to contact their Medicare Administrative Contractor (MAC) for information on how to request an ERS.

To allow even more flexibility in paying back the loans, the $175 billion issued in Provider Relief funds can be used towards repayment of these Medicare loans. CMS will be communicating with each provider and supplier in the coming weeks as to the repayment terms and amounts owed as applicable for any accelerated or advance payment issued.

Providers Request Medicare Sequester Cuts For 2021.

Congress paused the Medicare sequester cuts to provide relief during the COVID-19 public health emergency. Now, leading provider groups are calling for an extension.

Major provider groups are asking Congress to extend a congressionally-enacted moratorium on the application of the Medicare sequester cuts into 2021, writes Jacqueline LaPointe in her article "Providers Want Congress to Pause Medicare Sequester in 2021, Too" for *RevCycle Intelligence*, October 27, 2020.

The AHA, AMA, the American Health Care Association, and the National Association for Home Care & Hospice all signed a letter to House Speaker Nancy Pelosi and Congressional Leaders Mitch McConnell, Kevin McCarthy, and Chuck Schumer asking for the extension.

"Given that the PHE is certain to continue into 2021, it is a safe assumption that America's health care providers will continue to face the overwhelming financial challenges and pressures associated with higher overhead costs due to personal protective equipment and other safeguards, lost revenue due to delayed elective procedures and/or forgone routine visits, and hazard pay to staff," the letter stated.

Resuming the Medicare sequester cuts would exacerbate the financial challenges providers are already facing, the AHA and others told congressional leaders.

AMA Calls for Changes to the Proposed 2021 Fee Schedule

Referring to the proposed Medicare fee schedule for 2021, the AMA warned in its October 5, 2020, press release that some proposed regulations would hurt many physician practices already besieged by the pandemic.

The AMA's comments are intended to ensure physicians can continue providing the highest quality care for Medicare beneficiaries during and after this public health emergency, the bulletin stated.

To achieve this, the AMA recommends that CMS prevent the steep budget neutrality cuts that are pending and continue the forward-looking changes for telehealth patients," said AMA President Susan R. Bailey, M.D.

Other comments include:

1. The AMA strongly supports the CMS's implementation of a new office visit policy on January 1, 2021, believing it will significantly reduce administrative burdens and better describe and recognize the resources involved in office visits.

2. The AMA is deeply concerned about the corresponding budget neutrality cuts. The proposal, drafted before the pandemic, would result in a 5.5% cut to physician payment, and additional CMS proposals would lead to an escalation of this cut to almost 11%.

The AMA urges CMS to use its authority to waive budget neutrality and avert the cuts.

3. The AMA recommends that CMS treat all physicians fairly by implementing the office visit increases into the surgical global payments. The AMA supports the RUC recommendations that post-operative visits should be valued equivalent to stand-alone visits.

4. The AMA also recommends postponing implementation of the office visit add-on code until it can be better defined by the CPT Editorial Panel.

5. CMS improved patient access during the pandemic by offering flexibility for telehealth policies, enabling patients to get much-needed care. Consequently, the AMA urges CMS to:
    a) make permanent several telehealth services,
    b) remove geographic and site-of-service barriers,
    c) continue covering services through the end of the year following the year in which the pandemic ends, and
    d) services should include audio only visits.

6. CMS should implement and pay for the new **CPT code 99072.** The additional supplies and clinical staff time needed to perform safety protocols described by this code allow for the provision of evaluation, treatment or procedural services in a setting where extra precautions are taken to ensure the safety of patients as well as health care professionals.

7. CMS has introduced much-needed flexibility to the Medicare Quality Payment Program during the pandemic. CMS should continue the policies introduced during the pandemic through next year as the public health emergency is ongoing and disrupts any fair evaluation of physician performance.

-- *Medical Economics*

DELETED 2021 ICD-10 CODES

The complete list of deleted 2021 ICD-10 Codes for the fiscal year 2021, effective October 1, 2020 through September 30, 2021 can be reviewed by going to the following site: https://icdlist.com/icd-10/deleted-codes

A few of the deleted codes are listed below:

- D84.8 - Other specified immunodeficiencies
- G96.0 - Cerebrospinal fluid leak
- G96.19 - Other disorders of meninges, not elsewhere classified
- G96.8 - Other specified disorders of central nervous system
- K20.8 - Other esophagitis
- K20.9 - Esophagitis, unspecified
- K21.0 - Gastro-esophageal reflux disease with esophagitis
- K59.8 - Other specified functional intestinal disorders
- M92.50 - Unspecified juvenile osteochondrosis of tibia and fibula
- M92.51 - Juvenile osteochondrosis of proximal tibia
- M92.52 - Juvenile osteochondrosis of tibia tubercle
- N18.3 - Chronic kidney disease, stage 3 (moderate)
- R51 – Headache

Legal Risks Posed by COVID-19

Doctors have enjoyed more than a decade of relatively affordable medical malpractice premiums. But for many, those good times are ending.

The investment management firm Conning found that after peaking in 2006, premiums dropped 20% between 2007 and 2013, then remained fairly steady before increasing by 5% in 2019, writes Jeff Bendix for *Medical Economics*, in his October 13, 2020, article "What's happening with cost and claims in the wake of COVID-19."

Still unknown is how the COVID-19 pandemic will affect the medical malpractice market. The answer to that question won't become clear for several years, says Robert E. White Jr., executive vice president for medical professional liability at The Doctors Company, a malpractice insurance provider.

As for the legal risks to doctors posed by COVID-19, experts say these could take several forms.

A. One stems from the prohibitions on elective surgeries most states imposed at the start of the pandemic. "If a doctor deemed something to be nonemergent during the elective surgery ban and (it) turned out they were wrong, they could be sued," White says.

B. A second category of risks is from patients claiming they contracted COVID-19 at a physician's office. Some practices are trying to protect themselves by requiring patients to sign an "exculpatory clause" agreement, limiting the patient's ability to sue if they experience any harm while being treated. But White warns that relying on exculpatory clauses for protection is dangerous…because they generally aren't viewed with favor by the courts."

   Doctors can take heart from the difficulty inherent in proving that a person contracted COVID-19 in a particular place, says Frederick M. Cummings, J.D., a health law attorney with Dickinson Wright in Phoenix, Arizona.

   Practices are urged to follow the CDC's COVID-19 safety guidelines as a way of defending themselves in the event of a patient lawsuit. "'We followed the standard of care, what else could we have done?' That will be the best defense," White says.

C. Probably the greatest potential danger, however, comes from the exponential growth in the number of remote visits caused by the pandemic. As the use of telehealth increases, so does the possibility of a doctor missing a change in a patient's health status or not following up with the patient in person, thereby leading to a malpractice suit.

But despite doctors' best efforts at remote diagnosing, attorney Cummings notes, the number of deaths from causes other than COVID-19 and unexplained causes increased substantially after the pandemic started.

(According to results from a July study in *JAMA Internal Medicine*, there were approximately 122,000 more deaths between March 1st and May 30th than would normally be expected during those months, which was 28% higher than the number of COVID-19–related deaths.)

"The big issue for many of my clients is not whether they recognized COVID (-19), it's whether they paid attention to any of the other health issues that were lurking in those patients."

In addition to his statement above, Cummings adds that doctors can defend themselves in a lawsuit stemming from a remote diagnosis by thoroughly documenting the encounter. This is especially the case for patients who have

missed in-person visits because of concerns over COVID-19. One of the most common malpractice charges primary care doctors face is failure to diagnose.

Open Notes Deadline Extended from November 2, 2020 to April 5, 2021

On October 30, 2020, the US Department of Health and Human Services extended the deadline for healthcare groups to provide patients with immediate electronic access to their doctor's clinical notes as well as test results and reports from pathology and imaging, writes Nick Mulcahy in his October 29th article for *Medscape Medical News.*

The mandate, called "Open Notes" by many, is part of the 21st Century Cures Act, and will now go into effect April 5, 2021. The announcement comes just 4 days before the previously established November 2nd deadline and gives the pandemic as the reason for the delay.

"We are hearing that while there is strong support for advancing patient access…stakeholders also must manage the needs being experienced during the current pandemic," Don Rucker, MD, National Coordinator for Health Information Technology at HHS, said in a press statement.

"To be clear, the Office of the National Coordinator is not removing the requirements advancing patient access to their health information," he added.

The staff at *Family Practice Management,* offers suggestions on how to make your clinical notes more patient friendly in its October 26, 2020, article "Patients will soon have expanded rights to read your clinical notes."

Although the new law does not require physicians to change their note-writing style, some small modifications can be helpful, particularly when documenting potentially sensitive topics such as mental health, obesity, substance use disorder, sexual history, or spousal abuse.

Here are four tips for writing patient-friendly notes in an "open notes" world:

1. **Be transparent.** Your communication with the patient in the office should reflect what you put in the note. There should be no surprises.

2. **Minimize jargon and abbreviations**. If there are medical terms that patients might easily misinterpret, briefly define or simplify them, such as "short of breath," rather than SOB or dyspneic.

3. **Highlight the patient's strengths and achievements in addition to the patient's problems.** This can be particularly helpful for patients with mental health issues because it gives them a more balanced perspective of their illness as they tackle difficult behavioral changes.

4. **Describe behaviors rather than labeling the patient or making judgments.** For example, consider these alternatives:
    - "Patient could not recall" instead of "Poor historian,"
    - "Patient is not doing X" instead of "Non-compliant,"
    - "Patient prefers not to" or "Patient declines" instead of "Patient refuses."

From the November-December 2016 issue of *FPM*, research showed:

Patients report that by reading visit notes, they:

- Remember better what was discussed during visits,
- Feel more in control of their care,
- Are more likely to take medications as prescribed,
- Can share notes with their caregivers and better equip them.

Doctors and other clinicians report that by sharing visit notes, they:

- Promote patient communication and education,
- Can help patients be better prepared for visits,
- Can help patients' family and caregivers optimize care,
- Can meet patients' desire for access to their notes.

Medicare Audits to Resume

The ongoing COVID-19 pandemic and resulting public health emergency has brought about massive and quick changes in the healthcare industry, notably among them the temporary suspension of Medicare Fee-For-Service audits.

CMS announced it resumed program integrity audits, on Aug. 3, 2020. In doing so, the agency acknowledged the continuing public health emergency but emphasized the importance of (and need to) resume medical review activities.

According to CMS, auditors will be "applying" any waivers and flexibilities in place during the emergency period as they conduct their claims reviews, which otherwise will follow statutory and regulatory provisions and billing and coding requirements.

A provider may be selected for a **targeted probe-and-educate (TPE) review** based on high utilization of particular billing codes or some other abnormality identified by CMS in its data analytics. The provider will typically receive notice by mail with a request for medical records associated with 20-40 previously submitted claims.

Pre-payment and RAC audits consist of records requests and notification of any identified audit findings, but do not have the education component that TPE reviews have.

UPIC audits are often generated through data analysis or by review of consumer complaints, and most often target specific healthcare providers. Currently, telehealth claims are part of the UPIC targeted audits, as more and more providers have moved to a telehealth platform during the PHE.

The agency also indicated that if providers selected for medical review believe that responding to a request for documentation would create a hardship situation, they should discuss response options with the contractor performing the review. CMS recognizes that staffing and resources necessary to respond to audits may be limited.
-- Terry Fletcher, BS, CPC, CCC, *ICD 10 Monitor*, October 5, 2020

MIPS Bulletin

QPP Participation Status Tool Includes Second Snapshot of 2020 Qualifying APM Participant and MIPS APMs Data

CMS updated its Quality Payment Program (QPP) Participation Status Tool based on the second snapshot of data from Alternative Payment Model (APM) entities. The second snapshot includes data from Medicare Part B claims with dates of service between January 1, 2020 and June 30, 2020. The tool includes 2020 Qualifying APM Participant (QP) and Merit-based Incentive Payment System (MIPS) APM participation status.

How Do I Check My QP or APM Participation Status?
To view your QP or APM participation status at the individual level:

- Visit the QPP Participation Status Tool. https://qpp.cms.gov/participation-lookup
- Enter your 10-digit National Provider Identifier (NPI).

To learn more about how CMS determines QP and the APM participation status for each snapshot, please visit the Advanced APMs webpage on the QPP website.

Virtual Group Election Period for MIPS 2021 Performance Year Now Open

If you are interested in forming a virtual group for the 2021 MIPS performance year, the election period has started. A virtual group must submit an election to CMS for each performance year that it intends to participate in MIPS as a virtual group (as required by statute).

If your virtual group was approved for the 2020 MIPS performance year and intends to participate in MIPS as a virtual group for the 2021 MIPS performance year, your virtual group is still required to submit an election to CMS for the 2021 MIPS performance year between October 1, 2020 and December 31, 2020 (11:59 p.m. Eastern Time).

Download the 2021 Virtual Group Guide at: (https://neqpp.org/virtual-group-election-period-for-mips-2021-performance-year-now-open/) for further information regarding virtual group participation in MIPS, virtual group reporting requirements, the election process, checklists for virtual groups to consider, and sample templates.

CORRECTED VERSION: CMS Releases Preliminary 2019 Performance Year Quality Payment Program Results

CMS is pleased to share that despite the challenges caused by the COVID-19 Public Health Emergency, clinicians still overwhelmingly engaged in QPP and submitted 2019 data.

Key findings include the:

- **97.44%** of MIPS eligible clinicians engaged in QPP **(correction)**.
- Overall, MIPS engagement rose from 871,838 clinicians in 2018 to 930,219 clinicians in 2019.
- MIPS APM participation rose from 356,546 clinicians in 2018 to 416,281 clinicians in 2019.
- **6.83%** of MIPS eligible clinicians received reweighting of one or more MIPS performance categories **(correction)**.

- The number of Qualifying Advanced Payment Model Participants (QPs) rose from 183,306 clinicians in 2018 to 195,564 in 2019.

Reminder: Applications for the 2020 Promoting Interoperability Hardship and Extreme and Uncontrollable Circumstances Exception are Due December 31, 2020

If you are interested in applying for a MIPS Promoting Interoperability Hardship Exception or Extreme and Uncontrollable Circumstances Exception for the 2020 Performance Year of MIPS, you must submit your application to CMS by **Thursday, December 31, 2020 at 8:00 p.m. ET**.

Once you register for a HARP account, sign in to qpp.cms.gov, select 'Exceptions Applications' on the left-hand navigation, select 'Add New Exception,' and select 'Extreme and Uncontrollable Circumstances Exception' or 'Promoting Interoperability Hardship Exception.'

How do I Know if I'm Approved?
If you submit an application for either of the exceptions, you will be notified by email if your request was approved or denied. If approved, this will also be added to your eligibility profile on the QPP Participation Status Tool, but may not appear in the tool until the submission window is open in 2021.

Questions?
Contact the Quality Payment Program at 1-866-288-8292 or by e-mail at: QPP@cms.hhs.gov. To receive assistance more quickly,

MEDICARE NEWS

Reimbursement Rate for COVID-19 Vaccine Set

A new interim final rule with comment period released on October 29, 2020, ensures Medicare reimbursement for the administration of a COVID-19 vaccine.

Medicare will pay providers $28.39 for the administration of a single-dose COVID-19 vaccine. In the event an approved COVID-19 vaccine requires multiple doses, CMS will reimburse providers $16.94 for the initial doses and $28.39 for the administration of the final dose in the series.

The reimbursement rate will be available under Medicare Part B unless the patient is an inpatient. CMS is working with the AMA to finalize billing codes for the use of a COVID-19 vaccine. The federal agency is also requiring Medicare, Medicare Advantage, Medicaid, and most private plans to waive cost-sharing for an approved vaccine, while ensuring providers will be reimbursed via the Provider Relief Fund for administering vaccines to the uninsured. (*RevCycle Intelligence*, October 29, 2020)

Pay Your CLIA Certification Fees Online

You now have the option to pay CLIA certification fees through a secure platform hosted by the Treasury Department. Online payments process overnight.

For more Information regarding CLIA , visit the website at: https://www.cms.gov/Regulations-andGuidance/Legislation/CLIA/index

Get online payment information at: https://www.cms.gov/files/document/paygov-banner-fact-sheet.pdf

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