"We shall draw from the heart of suffering itself the means of inspiration and survival."

-- Winston Churchill

Client Memo October 2020

NEWS Update

Aetna and United Healthcare Extend End Dates for Relaxed Telehealth Rules

Aetna has extended its relaxed coverage of telemedicine services due to the COVID-19 Public Health Emergency until December 31, 2020. United Healthcare has also extended its deadline to December 31, 2020.

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

The Covid-19 public health emergency is still scheduled to end on October 22, 2020.

ICD-10 Updates for 2021 – staff, *RT Welter & Associates*, September 16, 2020

For the upcoming year, the FY 2021 ICD-10-CM Official Guidelines have made over 500 significant changes.

Updates that are set to take effect October 1st, 2020, include: 490 new codes, 47 revised codes and 58 codes deemed invalid, additional instructtions on reporting manifestations of COVID 19, as well as new guidance on acute kidney failure, insulin use, and social determinants of health, among several other changes.

Below is a summary for some of the anticipated FY 2021 ICD-10-CM Updates by Chapter:

Chapter 1: Certain Infectious & Parasitic Disease brings a new section 1.g for reporting Coronavirus infections.

Chapter 3: Diseases of Blood & Blood-forming organs has eighteen new, detailed codes available for sickle cell anemia. These new codes describe complications associated with sickle- cell and hemoglobin-C (Hb-C) diseases. For example, a note for new sickle-cell thalassemia code D57.418 (Sickle-cell thalassemia, unspecified, with crisis with other specified complication) instructs the coder to code any identified complications such as cholelithiasis (K80.-) or priapism (N48.32).

Chapter 4: Endocrine, Nutritional & Metabolic Disease includes new coding instructions to follow for diabetic patients treated with insulin, oral hypoglycemics and injectable non-insulin drugs.

- For example, if the patient is taking both insulin and an injectable non-insulin antidiabetic drug, assign both Z79.4 (Long term [current] use of insulin) and Z79.899 (Other long term [current] drug therapy).
- If the patient is taking oral hypoglycemic drugs and an injectable non-insulin antidiabetic drug, assign code Z79.84 (Long term [current] use of oral hypoglycemic drugs) in addition to code Z79.899.

Chapter 5: Mental, Behavioral and Neurodevelopmental Disorders contains twenty-one new codes that describe withdrawal from substances including alcohol, cocaine, and opioids. For example, F10.932 (Alcohol use, unspecified with withdrawal with perceptual disturbance).

Chapter 9: Diseases of the Circulatory System contains many revisions to the 'includes and excludes' notes for existing codes. For example: Atherosclerosis of native arteries of the legs with ulceration (I70.2-) now includes both critical and chronic ischemia of native arteries with ulceration. Hypertensive Heart Disease (I11) has been revised to exclude Takotsubo Syndrome (I51.81), also known as "broken heart" syndrome.

A new hypertension guideline provides instruction that when a patient has hypertensive chronic kidney disease and acute renal failure, code both conditions and sequence the codes based on the reason for the encounter.

Chapter 10: Diseases of the Respiratory System now has 'code also' instructions for cases of acute laryngitis and tracheitis (J04) and acute obstructive laryngitis (croup) and epiglottitis (J05). Coders are instructed to 'code also' influenza if present, including influenza due to identified novel influenza A virus with other respiratory manifestations (J10.1). This chapter also has a new section 10.e specifically for vaping-related disorders.

Chapter 13: Musculoskeletal System found several updates this year including twelve new codes to capture other pathological fractures (M80.8AX- and M80.0AX-).

Updates include an expanded list of codes for rheumatoid arthritis, as well as primary and secondary arthritis, and arthritis caused by trauma as well as new codes in the M24 category for other articular cartilage disorders, disorders of ligament, pathological dislocation, recurrent dislocation, contracture and ankylosis.

Chapter 14: Disease of Genitourinary brings two new sub-stages to Stage 3 chronic kidney disease (CKD).

1. N18.30 (Chronic kidney disease, stage 3 unspecified),
2. N18.31 (Chronic kidney disease, stage 3a) and N18.32 (Chronic kidney disease, stage 3b).

Chapter 18: Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified contains several changes. Code R51 (Headache) will be split into two codes:

1. R51.0 (Headache with orthostatic component, not elsewhere classified) or
2. R51.9 (Headache, unspecified).

Another source of new headache coding will come from five new codes for intracranial hypotension – the severe orthostatic headache that is a common symptom of a cerebral spinal fluid (CSF) leak:

- For example, G96.810 (Intracranial hypotension, unspecified),
- G97.83 (Intracranial hypotension following lumbar cerebrospinal fluid shunting), and
- G97.84 (Intracranial hypotension following other procedure).
- Five new codes for CSF leaks can now be found in place of the current code G96.0 (CSF leak).

Chapter 19: Injury, poisoning & certain other consequences holds 128 additions that include new codes for adverse effects and poisoning by fentanyl and tramadol as well as other synthetic narcotics.

New Chapter 22: Codes for Special Purposes (U00-U85) includes just two codes:

U07.0 Vaping- related disorder
U07.1 COVID-19

These codes took effect earlier this year.

Deletions from the 2021 ICD-10-CM code set include the entire code family of T40.4X- (Poisoning by the adverse effect of and underdosing of other synthetic narcotics).

The CDC released 23 files for the final FY 2021 ICD-10-CM code set. The full list of updates can be found at: https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2021.pdf

AMA releases 2021 CPT code set

In its September 1, 2020, press release, the AMA announced that the first major overhaul in more than 25 years to the codes and guidelines for office and other outpatient E/M services was included in the September 1 release of the 2021 CPT® code set published by the AMA.

The changes to CPT codes ranging from 99201-99215 are proposed for adoption by CMS on January 1, 2021. They include:

- ❖ Eliminating history and physical exam as elements for code selection.
- ❖ Allowing physicians to choose the best patient care by permitting code level selection based on medical decision-making (MDM) or total time.
- ❖ Promoting payer consistency with more detail added to CPT code descriptors and guidelines.

The AMA has developed an extensive online resource library that includes a checklist, videos, modules, guidebooks, and other tools to help transition to the revised E/M office visit codes and guidelines on their website: https://www.ama-assn.org/practice-management/cp t/cpt-evaluation-and-management

The CPT code set continues to see growth in new and novel areas of medicine, with the majority (63%) of new codes this year involving new technology services described in Category III CPT codes.

The revised E/M office visit codes are among 329 editorial changes in the 2021 CPT code set, which includes 206 new codes, 54 deletions, and 69 revisions

Among this year's important additions to the CPT code set are new medical testing services sparked by the public health response to the COVID-19 pandemic.

The CPT code set continues to be modified to respond to the fast pace innovation among digital medicine services that can improve access to health care and improved health outcomes for patients across the country. This is illustrated by new codes for retinal imaging and external extended electrocardiogram (ECG) monitoring.

Technological advances in the field of continuous cardiac monitoring and detection have prompted the addition of codes 93241, 93242, 93243, 93244, 93245, 93246, 93247, 93248, along with associated guideline revisions. These codes will replace Category III codes 0295T, 0296T, 0297T and 0298T, which were deleted.

AMA Releases New CPT Code 99072

The AMA has just added a new code to cover the expenses associated with providing a safe in-person visit during the COVID 19 public health emergency.

CPT ® code 99072 was released September 8, 2020, to cover additional practice expenses related to activities required to provide safe in-person medical services to patients during a public health emergency. These activities and supplies are over and above those usually included in a medical visit or service.

This new code should only be reported when the service is rendered in a non-facility place of service.

99072 encompasses the following:

- Time over what is included in the primary service of clinical staff (RNs, LPNs, MTAs)
  - o Pre-visit phone call to screen patients (symptom checks)
  - o Provide instructions on social distancing during the visit
  - o Check patients for symptoms upon arrival Apply and remove PPE
  - o Perform additional cleaning of the exam/procedure/imaging rooms, equipment, and supplies.
- Three surgical masks
- Cleaning supplies- additional quantities of hand sanitizer, disinfecting wipes, sprays, and cleansers

The code should only be used during a declared public health emergency and is different from code 99070, which is typically reported for supplies and materials that may be provided to patients during a normal office visit, the Association also pointed out.

CPT code 99072 should be reported only once per in-person visits per provider identification number (PIN), regardless of the number of services performed during the visit.

CMS has not yet announced whether it will cover 99072 for Medicare services. Providers should check with state Medicaid programs and commercial insurers, as it may take payers some time to implement the new code for payment.

HHS Releases Reporting Requirements for COVID-19 Relief Payments

New guidance details reporting requirements for providers who received COVID-19 relief payments of $10K or more from the Provider Relief Fund

HHS recently released an updated guidance document on reporting requirements for healthcare organizations that received COVID-19 relief payments of $10,000 or more, writes Jacqueline LaPointe in her September 23, 2020, article for *RevCycle Intelligence.*

According to the document, healthcare organizations that meet the reporting criteria will need to submit information on any healthcare-related expense attributable to the virus that has not been reimbursed by another source (e.g., insurance, patients, and other government agencies) and does not need to be reimbursed.

This includes expenses for treating confirmed or suspected cases of COVID-19, preparing for possible or actual COVID-19 cases, and maintaining healthcare delivery capacity, HHS clarified.

Organizations should report on the expenses in two categories:

1. general and administrative (G&A) expenses attributable to COVID-19 and
2. healthcare-related expenses attributable to COVID 19

Other healthcare-related expenses attributable to COVID-19, the guidance clarifies, include:

- supplies and equipment used for COVID-19 response efforts, including personal protective equipment;
- expenses paid for IT or interoperability systems to preserve or expand care delivery during the reporting period; and
- facility-related costs, such as the lease or purchase of new structures or modifications to facilities to accommodate revised treatment practices.

Healthcare organizations will also need to submit information on any COVID-19 relief payments from the Provider Relief Fund that were not fully expended on healthcare-related expenses attributable to COVID-19.

Additionally, if organizations do not expend all relief payments from the Provider Relief Fund in full by the end of 2020, HHS will give them another six months to use the remaining amounts for expenses attributable to COVID-19.

Organizations that have fully expended the payments before the end of the year can submit a single final report any time from Oct. 1, 2020, but no later than Feb. 15, 2021.

The new guidance document can be reviewed at: https://www.hhs.gov/sites/default/files/post-payment-notice-of-reporting-requirements.pdf

The reporting portal will be available starting October 1, 2020.

Medicare Loan Repayments Delayed

Action applies to the Medicare Accelerated and Advanced Payment Loan Program.

A bill to keep the federal government running through December 11 was signed on October 1, 2020. This "continuing resolution" (CR), which was approved by the Senate Wednesday on an 84-10 vote, according *to The New York Times,* includes provisions to delay repayment by physicians of pandemic-related Medicare loans and to reduce the loans' interest rate, writes Ken Terry for *Medscape Medical News* in his October 1, 2020, article.

In an earlier news release, the AMA reported that Congress and the White House had agreed to include the provisions regarding the Medicare loans in the CR.

Under the Medicare Accelerated and Advance Payments (AAP) program, CMS advanced money to physicians who were financially impacted by the pandemic. The repayment terms, however, were harsh according to the AMA's September 21, 2020, press release. Physicians would have 100 percent of their Medicare claims withheld to repay the loans on a short timeline, and after a few months any outstanding balances, would be subject to a 10.25 percent interest rate.

The new loan repayment terms which appear in the CR are as follows:

- Postpones the recoupment of disbursed funds until 365 days after the advance payment has been issued to a physician practice, with the balance due by September 2022.
- Reduces the amount to be recouped from each claim from 100% to 25% of the claim for the first 11 months and to 50% of claims withheld for an additional 6 months. If the loan is not repaid in full, the interest rate goes into effect.
- Lowers the interest rate from 10.25% to 4%.

"Members of Congress and the Administration have settled on a bipartisan response to the economic sword hanging over physician practices," said Susan Bailey, MD, president of the AMA, in the news release. "This relief will be felt across the country as physicians will be able to continue providing health care during the pandemic."

QPP Advanced APM Bonus Payments

On September 18, 2020, Erin Solis, Manager of Practice & Payment for the American Academy of Family Physicians, explained that while physicians who qualified for the Advanced Alternative Payment Model (AAPM) bonus for the Quality Payment Program's 2018 performance period will be receiving their payments soon, **some will have to verify their billing information to ensure they get their bonus.**

CMS started distributing payments to qualified participants (QPs) in September. CMS also sent letters to QPs for whom the agency could not verify current Medicare billing information.

CMS also published a list of those physicians' NPIs, which is available at: qpp-cm-prod-content.s3.amazonaws.com

If you received a letter and/or are on the list, you will need to provide your information to CMS by Nov. 13, 2020.

CMS provided instructions and the required form in the letter, but providers can also find them by going to: qpp-cm-prod-content.s3.amazonaws.com

Forms MUST be submitted to the QPP Help Desk at QualityPaymentProgramAPMHelpdesk@cms.hhs.gov.

Other QPs can log in to the QPP portal to see the details of the payment and the organization that received the payment.

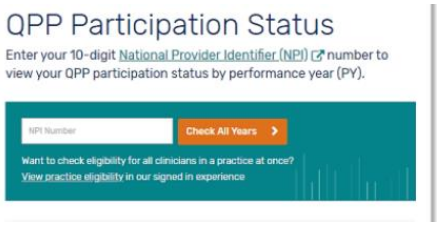
Eligible clinicians with sufficient participation in an AAPM are considered QPs and eligible for a 5% bonus payment. Payments are made two years after the performance period (e.g., 2020 bonus payments are based on the 2018 performance period).

The AAPM bonus is based on the paid amounts for Medicare Part B covered professional services provided by QPs across all their TIN/NPI combinations during the base period. The base period for 2018 bonus payments was Jan. 1-Dec. 31, 2019.

If you have questions about the submission requirements, you can contact the QPP Help Desk at 866-288-8292.

MIPS Bulletin

Eligibility requirements may have changed since the beginning of the year. Providers are urged to check their eligibility again on the QPP website https://qpp.cms.gov.



CMS is reminding participants that October 3rd is the last day to begin the program's 90-day EHR reporting period for the Promoting Interoperability category.

Important things to remember for this category are:

- it counts for 25% of the MIPS final score;
- must use 2015 CEHRT;
- only 4 objectives to meet for 2020:

Objectives	Measures
e-Prescribing	e-Prescribing
	Bonus: Query of Prescription Drug Monitoring Program (PDMP)
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information
	Support Electronic Referral Loops by Receiving and Incorporating Health Information
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information
Public Health and Clinical Data Exchange	Immunization Registry Reporting
	Electronic Case Reporting
	Public Health Registry Reporting
	Clinical Data Registry Reporting
	Syndromic Surveillance Reporting

- **Don't forget the Security Risk Analysis!!**

  You must conduct or review a security risk analysis on an annual basis. This includes addressing the security of ePHI data created or maintained by CEHRT, implement security updates as necessary, and correct identified security. The **Security Risk Assessment (SRA) Tool** which assists small- and medium-sized healthcare organizations assess their security risks has been updated. View updates and download the SRA Tool from: https://www.healthit.gov/topic/privacy-security-and-hipaa/security-risk-assessment-tool

MIPS Scoring for 2020

Final Score 2020	Payment Adjustment 2022
≥85 points	• Positive adjustment greater than 0% • Eligible for additional payment for exceptional performance —minimum of additional 0.5%
45.01-84.99 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
45 points	• Neutral payment adjustment
11.26-44.99	• Negative payment adjustment greater than -9% and less than 0%
0–11.25 points	• Negative payment adjustment of -9%

Virtual Group Election Period for MIPS 2021 Performance Year Now Open

Providers interested in forming a virtual group for the 2021 MIPS performance year must submit an election to CMS via e-mail between October 1, 2020 and December 31, 2020 (11:59 p.m. Eastern Time).

If a 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, the virtual group is still required to submit an election to CMS for the 2021 MIPS performance year.

What Is a Virtual Group?

A virtual group is a combination of 2 or more Taxpayer Identification Numbers (TINs) consisting of the following:

- Solo practitioners who are MIPS eligible (a solo practitioner is defined as the only clinician in a practice); and/or
- Groups that have 10 or fewer clinicians (at least one clinician within the group must be MIPS eligible).

What Are the Advantages of Participating in a Virtual Group?

Participating in MIPS as a virtual group has the following advantages:

- Can increase performance volume in order to be reliably measured; and
- Provides an opportunity for members of a virtual group to collaborate, share resources, and potentially increase performance under MIPS.

What Is the Virtual Group Election Process?

The following outlines the elements that need to be included in an election:

- Acknowledgement that a formal written agreement has been established between each TIN within the virtual group.
- The name and contact information for the official virtual group representative.
- The name and TIN for each practice, and all associated NPIs under each TIN.
- Once complete, the virtual group must submit the election via e-mail to CMS at MIPSVirtualGroups@cms.hhs.gov by 11:59 p.m. Eastern Time on December 31, 2020.

If you have any questions, please contact the Quality Payment Program at 1-866-288-8292 or by e-mail at: QPP@cms.hhs.gov.

Medicare News

CMS Care Compare Empowers Patients

On September 3, 2020, CMS launched Care Compare, a streamlined redesign of eight existing CMS health care compare tools available on Medicare.gov.

Care Compare provides a single user-friendly interface that patients and caregivers can use to make informed decisions about health care based on:

- cost,
- quality of care,
- volume of services,
- and other data.

With just one click, patients can find information that is easy to understand about doctors, hospitals, nursing homes, and other health care services instead of searching through multiple tools. Please tell your patients to go to: https://www.medicare.gov/care-compare/

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