"Mistakes are the portals of discovery."

-- James Joyce

AQREVA Medical Billing & Consulting

Client Memo September 2020

NEWS Update

CMS Proposed Rule for 2021 Physician Fee Schedule

Physician Fee Schedule proposed rule lays the groundwork for payment and policy changes.

CMS released its proposed rule on August 3, 2020, to address changes to the Medicare Physician Fee Schedule and other Medicare Part B payment policies for 2021 and beyond.

The staff from *AAPC.com* presents the good news and bad news in their August 7, 2020, bulletin.

Summary of the 2021 MPFS Proposed Rule

CMS is proposing to establish RVUs for 2021 for the MPFS to ensure that payment systems are updated to reflect changes in medical practice and the relative value of services, as well as changes in the statute.

The bad news is: The proposed 2021 MPFS conversion factor is $32.26 – a decrease of $3.83, or 10.6 %, from last year's $36.09.

The good news is: CMS is proposing to add the following services to the Medicare telehealth services list on a Category 1 basis: services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the Medicare telehealth services list for 2021.

Services CMS is proposing for **permanent** addition to the Medicare telehealth services list are:

- Group Psychotherapy (CPT code 90853)
- Domiciliary, Rest Home, or Custodial Care services, established patients, Levels 1-2 (CPT codes 99334-99335)
- Home Visits, established patient, 15 minutes to 25 minutes, (CPT codes 99347-99348)
- Cognitive Assessment and Care Planning Services (CPT code 99483)
- Visit Complexity Inherent to Certain Office/Outpatient E/M's (HCPCS Level II code GPC1X)
- Prolonged Services (CPT code 99XXX)
- Psychological and Neuro-psychological testing (CPT code 96121)

Services CMS is proposing as **temporary** additions to the Medicare telehealth services list are:

- Domiciliary, Rest Home, or Custodial Care services, established patients (CPT codes 99336-99337)
- Home Visits, established patient (CPT codes 99349-99350)
- Emergency Department Visits, Levels 1-3 (CPT codes 99281-99283)
- Nursing facilities discharge day management (CPT codes 99315-99316)
- Psychological and Neuropsychological Testing (CPT codes 96130- 96133)

CMS is also proposing to allow billing of other communication technology-based services (CTBS) by certain non-physician practitioners who cannot independently bill for E/M services, using two additional HCPCS Level II G codes:

Code	Description
G20X0	Remote assessment of recorded video and/or images submitted by an established patient including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment
G20X2	Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

The proposed rule also includes discussions and provisions regarding several other Medicare Part B payment policies, a few of which are mentioned below.

The proposed rule can be viewed in its entirety at: https://www.cms.gov/files/document/cms-1734-p-pdf.pdf

Care Management Services Code Refinements

To improve payment for care management services, CMS is proposing code refinements related to remote physiologic monitoring (RPM), transitional care management (TCM), and psychiatric collaborative care model (CoCM) services.

Increasing the Value of Services

CMS is proposing to increase the value of many services that are comparable to or include office outpatient E&M visits, such as maternity care bundles, ED visits, and PT and OT evaluation services. CMS has finalized new values for CPT codes 99202 through 99215 and assigned RVUs to the new office/outpatient E&M prolonged visit code 99XXX, as well as the new HCPCS Level II code GPC1X. These valuations were finalized with an effective date of January 1, 2021.

- 99XXX (add on code for prolonged 99205 and 99215 services)
- GPC1X (add on code for use with E&M services to represent the visit complexity)

Scope of Practice and Related Issues

CMS is proposing several policies to modify supervision and other requirements of the Medicare program that limit healthcare professionals from practicing at the top of their license, two of which are mentioned below:

1. Supervision of Diagnostic Tests by Certain Non-Physician Practitioners (NPPs): In the May 1 COVID-19 interim final rule, CMS established a policy to permit PAs, NPs, and certain other NPPs to supervise diagnostic tests. CMS is now proposing to make these changes permanent by:
    - allowing NPs, CNSs, PAs, or certified nurse-midwifes (CNMs) to supervise diagnostic tests on a permanent basis as allowed by state law and scope of practice;
    - specifying that supervision of diagnostic psychological and neuropsychological services can be done by NPs, CNSs, PAs, or CNMs to the extent that they are authorized to perform the tests under applicable state law and scope of practice, in addition to physicians and CPs who are currently authorized to supervise these tests;
    - amending the regulation to specify that diagnostic tests performed by PAs in accordance with their scope of practice and state law do not require the specified level of supervision assigned to individual tests.
2. Pharmacists Providing Services Incident to Physicians' Services: CMS is reiterating that pharmacists fall within the regulatory definition of auxiliary personnel and may provide services under the appropriate level of supervision of the billing physician or NPP, if payment for the services is not made under the Medicare Part D benefit.

2021 E&M Changes Confirmed

CMS announced in the 2019 Final Rule that changes to E&M services would be initiated as an attempt to alleviate the administrative burden the current guidelines presented to providers, writes Shannon DeConda CPC, in excerpts from her August 3, 2020, article for *ICD 10 Monitor.*

Within six months of the CMS announcement, the AMA announced that it would be revising the office/outpatient E&M code set 99201-99215, effective January 1, 2021.

-- outsource strategies

Not all E&M services are impacted by the 2021 E&M changes; however, the code set corresponding with approximately 60 percent of E&M services submitted will be.

This means that any provider seeing patients in an office/clinic setting will be impacted by the changes when submitting codes 99201-99215.

Deletion of 99201: The AMA elected to delete 99201, effective January 1, 2021, making 99202 the lowest office-based E&M service.

MDM: Starting in 2021, the AMA E&M guidance is based on time or MDM only. This means that the history and exam associated with office-based encounters will no longer be scored.

Time: The AMA will be changing the way in which it counts time in 2021 by allowing the sum of the total time related to the encounter on the given date of service. "2021 time" also includes non-face-to-face time for duties such as prep and the actual documentation process.

Updating/revising/deleting templates and macros: As previously discussed, the need to score history and exam is eliminated in 2021; therefore, the need to use a template that already includes a 10-point organ system review, auto-populated PFHS, and a baseline eight-point organ system exam is unnecessary. Templates should be updated to eliminate the need for anything more than what is medically indicated, based on the patient's presenting problem.

Eliminating copy-and-paste functionality: The dreaded fallout of EMR-created documentation has been copying and pasting. In most instances, providers have relied on such functionality to ensure that all associated elements of history and exam are included to prevent down-coding based on documentation requirements. This often ineffective use of copy of paste should not really be needed in 2021.

Documenting complexity: Since 2004, CMS has stated that the overarching decision in appending the E&M level of service should be based on the complexity of the encounter, based on the patient's presenting problem. One of the three defining MDM elements is evaluating the complexity of the diagnoses treated during the encounter, and this should be clearly noted through the documentation.

Joe Ferro and Angela Jordan's article, "2021 E&M Guidelines & Level Changes," for the August 24, 2020, issue of *Physicians Practice*, discusses why **practices should not fear the new coding requirements.**

They state that because providers need a mechanism to be accurately reimbursed for the time and effort that they expend in providing care, the AMA's new set of guidelines for 2021 will help simplify E&M leveling for office and other outpatient services.

For 2021, CMS will move from a points-based system for history, exam and medical decision making, to a medical necessity-based system.

The leveling methodology will change for 2021. The new rules require that documentation be appropriate to support the patient's diagnosis, and CMS will move from a points-based system to a medical necessity-based system.

The 2021 E&M changes to office and other outpatient services were meant to ease the documentation burden on providers. When comparing the changes side by side, the new focus is clearly on medical decision making.

AMA CPT 2020	AMA CPT 2021
99214 - Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Typically, 25 minutes are spent face-to-face with the patient and/or family.	99214 - Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. 30-39 minutes of total time is spent on the date of the encounter.

AAFP & AMA Resources Prepare Members for E&M Coding Changes

Due to significant changes affecting office/outpatient E&M visit coding and payments for 2021, the AAFP and AMA have rolled out resources to assist providers in preparing for these changes.

The AAFP recently launched three new resources to help family physicians ensure they are ready for changes to office/out-patient E&M visit coding and payment that will take effect on January 1, 2021. They can be viewed at: https://www.aafp.org/family-physician/practice-and-career/getting-paid/coding/evaluation-management.html

The three new resources now available on the AAFP website are:

Checklist for Solo and Independent Physicians -- This resource is designed specifically to help small, solo and independent practices understand what steps to take throughout the year to ensure they are ready for 2021.

Checklist for Employed Physicians -- This checklist will assist physicians in evaluating the impact the changes may have on employment contracts and practice workflow and guide their preparations.

Practice Training Outline – This sample training outline will help your practice implement the updated E&M guidelines.

The AMA also has an extensive resource library on their site: https://www.ama-assn.org/practice-management/cpt/em-office-visit-changes-track-2021-what-doctors-must-know

"There is a lot for physician practices to understand before the new E&M office visit guidelines take effect January 1, 2021," said Dr. Susan Bailey, AMA President. "The AMA is helping physician practices prepare now for the transition and offers authoritative resources to anticipate the operational, infrastructural and administrative workflow adjustments that will result from the planned transition."

Some of the covered topics include:

- CPT® Evaluation and Management -- A historical overview and summary of the E&M coding revision for office visits.
- 10 tips to prepare your practice for E&M office visit changes -- A checklist with linked resources to guide physician practices for a smooth transition to the simpler and more flexible E&M office visit documentation-and-coding guidelines.
- Revisions to the CPT E&M Office Visits: New Ways to Report Using Time -- This separate educational module provides detailed information on how the new E&M coding revisions for office visits have clarified and simplified the time component of code selection to reduce administrative burden.

In addition to the changes in coding, the 2021 Medicare physician fee schedule is slated to include a 12% increase for primary care.

2021 Proposed Rule for the QPP

On August 3, 2020, CMS also released its proposed policies for the 2021 performance year of the Quality Payment Program (QPP) via the Medicare Physician Fee Schedule Notice of Proposed Rulemaking.

Note: As with other rules, CMS is publishing this proposed rule to meet the legal requirements to update Medicare payment policies in the PFS on an annual basis.

In recognition of the 2019 COVID-19 public health emergency and the limited capacity of healthcare providers to review and provide comment on extensive proposals, CMS has limited annual rulemaking required by statute to focus primarily on essential policies including Medicare payment to providers, as well as proposals that reduce burden and may help providers in the COVID-19 response.

Key proposals for the 2021 performance year of the QPP include:

- Beginning the MIPS Value Pathways (MVPs) implementation in 2022 instead of 2021.
- ❖ Increasing the performance threshold from 45 points in 2020 to 50 points for 2021.
- Revising performance category weights for Quality (decreases from 45% to 40%) and Cost (increases from 15% to 20%).
- ❖ Removing the CMS Web Interface as a collection and submission type for reporting MIPS quality measures beginning in 2021.
- Sunsetting the APM Scoring Standard and allowing MIPS-eligible clinicians in APMs the option to participate in MIPS and submit data at the individual, group, or APM Entity level.
- ❖ A new APM Performance Pathway (APP) in 2021.

Complex Patient Bonus COVID-19 Update in 2020

In addition to 2021 policies, this NPRM includes a proposal to increase the complex patient bonus from a 5- to 10-point maximum for clinicians, groups, virtual groups, and APM entities for 2020 performance only to offset the additional complexity of their patient population due to COVID-19.

Submit Comments

CMS is seeking comment on a variety of proposals in the NPRM. Comments are due by 5 p.m. (EDT) on October 5, 2020. You must officially submit your comments in one of the following ways:

- Electronically: https://www.regulations.gov
  or
- Regular mail to: CMS, Department of Health and Human Services, Attention: CMS-1734-P, P.O. Box 8016, Baltimore, MD 21244-8016.

CMS Finalizes 2.2% Boost in Skilled Nursing Facility Reimbursement

CMS also finalized 2021 Medicare payment rates for inpatient psychiatric facilities and hospices in addition to the $750M boost in skilled nursing facility reimbursement.

In one of three Medicare payment rules released by CMS, on August 3, 2020, the agency announced that it will increase skilled nursing facility reimbursement by $750 million, or 2.2% for fiscal year 2021, reports Jacqueline LaPointe in her August 3rd article for *RevCycle Intelligence.*

The reimbursement increase is attributable to a 2.2% market basket increase factor, according to the SNF Prospective Payment System final rule. CMS, however, will neither increase nor decrease the productivity factor for skilled nursing facilities next year.

The rule will also apply a 5% cap on any decreases in a skilled nursing facility's wage index from FY 2020 to FY 2021.

Other updates in the SNF PPS final rule include ICD-10 code mapping changes in the PDPM, a new case-mix classification model implemented in FY 2019, and the finalization of updates to the SNF VBP Program.

To view the complete SNF PPS final rule, go to: https://www.cms.gov/newsroom/fact-sheets/fiscal-year-2021-payment-and-policy-changes-medicare-skilled-nursing-facilities-cms-1737-f

The other two final rules updated the prospective payment systems for inpatient psychiatric facilities and hospices:

- Inpatient psychiatric facilities (IPF) will see a 2.2%, or $95 million, increase in Medicare reimbursement for 2021.
- Hospice reimbursement rates are slated to increase by $540 million or 2.4% in 2021.

CMS Proposes 9% Cut to Therapy Rates

CMS is proposing to reduce Medicare reimbursement for various Part B therapy services as part of its 2021 Medicare Physician Fee Schedule, writes Maggie Flynn in her August 4th *Skilled Nursing News* article: "CMS Proposes 9% Cut to Medicare Therapy Rates, Threatening PT, OT, Speech Services in Nursing Homes."

Under the proposed fee schedule, Medicare Part B reimbursement for PT and OT would see an overall reduction of 9% although it's not clear where speech therapists would fall under the proposed changes.

This will affect therapists providing services for patients in skilled nursing facilities who have finished their Medicare Part A coverage and have their services covered by Medicare Part B, while either private pay or Medicaid covers room and board.

The agency proposed the cuts to offset increases to payments for primary care physicians, according to a release from the American Physical Therapy Association (APTA), the American Occupational Therapy Association (AOTA), and the American Speech-Language-Hearing Association (ASHA).

The three groups said they "strongly oppose" the cuts, which are slated to take effect on January 1, 2021, and called on Congress and CMS to implement the increases to primary care in a way that does not reduce payments for other providers.

Operating Windows 7 Increases Cyber Risk to Network Infrastructure

Organizations continuing to operate with Microsoft Windows 7 platforms on the network infrastructure are at an increased risk of cyberattack, according to a private industry notification from the FBI, writes Jessica Davis for *Health IT Security,* August 5, 2020.

Microsoft ended support for Windows 7, Windows Server 2008, and 2008 R2 on January 14, 2020, which meant the platform would no longer receive regularly scheduled security updates.

The tech giant offered an Extended Security Update (ESU) plan to its customers, allowing a "paid-per-device" option for Professional and Enterprise versions, with the price increasing the longer a customer continues to use the option. However, that plan will expire in January 2023!

As time passes, Windows 7 becomes more vulnerable to exploitation due to lack of security updates and new vulnerabilities discovered, according to the FBI alert. Microsoft and other industry professionals strongly recommend upgrading computer systems to actively supported operating systems.

Computer systems must be upgraded to the latest supported version, while anti-virus, spam filters, and firewalls should be checked to determine if it is up to date, properly configured, and secured. Administrators should audit network configurations and isolate computer systems that can't be updated.

Lastly, healthcare organizations will need to first perform a complete inventory of all of the devices on a network. Security researchers have noted that often, healthcare providers are unaware of just how many devices are connected to the network. The process should be automated to ensure accuracy.

MIPS Update

QPP Mandatory Security Update

To increase network security, a mandatory update will be applied to the Quality Payment Program (QPP) systems in the Fall of 2020. As a result, you may not be able to access qpp.cms.gov if you have an outdated:

- Windows operating system (7 or 8.1) and Version 11 of Internet Explorer
- Mac OS and iOS with an outdated version of Safari

- Version of Google Chrome, Mozilla Firefox, or Microsoft Edge

Test your web browser and make any necessary updates to ensure your continued access. Test your browser at the Developer Preview Account webpage to see if it will allow you to access the QPP website after the security update this Fall.

If you experience an error message stating, "This page can't be displayed," we encourage you to update your web browser to one of the following:

- Google Chrome v69 or newer
- Mozilla Firefox v47 or newer
- Internet Explorer with Windows 10
- Microsoft Edge

Now Available: 2019 MIPS Performance Feedback and Final Score

If you submitted 2019 MIPS data, you can now view your final MIPS performance feedback and score on the Quality Payment Program (QPP) website: https://qpp.cms.gov.

Access your 2019 MIPS performance feedback and final score by:

1. Going to https://qpp.cms.gov/login.
2. Logging in using your Health Care Quality Information HCQIS Access Roles and Profile (HARP) system credentials.
3. These are the same credentials that allowed you to submit your 2019 MIPS data.
4. If you do not have a HARP account, refer to the QPP Access User Guide at: https://qpp.cms.gov/login?page=register
5. Once logged into the QPP Portal, you will then navigate to the Performance Feedback section to review your group and individual clinician feedback.

MIPS Targeted Review Period Open

If you believe an error has been made in your 2021 MIPS payment adjustment factor(s) calculation, you can request a targeted review until October 5, 2020 at 8:00 p.m. (EDT).

If you determine that a targeted review is warranted, you may submit a request by accessing the targeted review request form through the performance feedback page after signing in to the QPP Portal: htpps://qpp.cms.gov

MEDICARE NEWS

Renewed ABN: Deadline Extended to January 1

Due to COVID-19, CMS extended the deadline for using the new Advance Beneficiary Notice of Noncoverage (ABN) to January 1, 2021. The renewed form may be used prior to the mandatory deadline and can be obtained at: https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN

MACs Resume Medical Review on a Post-Payment Basis

To protect the Medicare Trust Fund against inappropriate payments, Medicare Administrative Contractors (MACs) are resuming fee-for-service medical review activities. As of August 17, 2020, the MACs are resuming with post-payment reviews of items/services provided before March 1, 2020.

The Targeted Probe and Educate program (intensive education to assess provider compliance through up to three rounds of review) will restart later. The MACs will continue to offer detailed review decisions and education as appropriate.

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