AQREVA
Medical Billing & Consulting

# Client Memo
# August 2021

**"Life is like jazz...it is best when you improvise."**
**-- George Gershwin**

***NEWS Update***


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## Public Health Emergency Extended

The U.S. Department of Health and Human Services Secretary Xavier Becerra signed a renewal of determination that extended the current COVID-19 public health emergency by 90 days, effective July 20, 2021. An HHS letter to state governors has indicated that the public health emergency likely will remain in place for the entirety of 2021.

The additional 90 days will come as a relief to many health care professionals and patients, as this extension will allow for continued implementation of policies outlined in existing waivers that have been implemented because of the pandemic, including waivers pertaining to telemedicine. *(AASM*, July 22, 2021, bulletin)

**The COVID-19 Public Health Emergency is now set to end October 18, 2021**

**End Dates by Payers for Relaxed Telehealth Visit Rules**

| INSURANCE PLAN | PROPOSED END DATE |
|---|---|
| Aetna | Until further notice |
| 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 | New 2021 Virtual Care Policy |
| 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 Medicare Advantage | until end of COVID-19 emergency |
| UnitedHealthcare | New 2021 telehealth Reimbursement Policy |

-- Updated 7/20/21

** Cigna's Virtual Care policy went into effect January 1, 2021.

*** United Healthcare's Telehealth Reimbursement policy went into effect January 1, 2021

## CMS 2022 Proposed Rule Heralds Key Changes for Providers -- Stanley Nachimson, MS, *ICD 10 Monitor*, July 26, 2021

Physicians and their organizations can expect to see significant changes to the Part B Physician Fee Schedule (PFS), Quality Payment Program (QPP), and Outpatient Prospective Payment System (OPPS) regulations, writes Stanley Nachimson in his July 26, 2021, article for *ICD 10 Monitor*.

As a reminder, payments under the fee schedule are based on the relative value units (RVUs) applied to each service for work, practice expenses, and malpractice expenses. These RVUs become payment rates through the application of a conversion factor.

In the Part B PFS proposed rule, CMS is proposing a CY 2022 PFS conversion factor of $33.58, a decrease of $1.31 from the CY 2021 PFS conversion factor of $34.89. These changes are based on requirements in the law.

Regarding policy changes, CMS is proposing the following:

- Refining longstanding policies for split (or shared) E&M visits to better reflect the current practice of medicine, the evolving role of non-physician practitioners (NPPs) as members of the medical team, and to clarify conditions of payment that must be met to bill Medicare for these services.
- Refining policies for critical care services, including allowing such services to be furnished concurrently to the same patient on the same day by more than one practitioner representing more than one specialty, and allowing critical care services to be furnished as split (or shared) visits.
- Allowing physician assistants (PAs) to bill Medicare directly for their services and reassign payment for their services.
- Implementing the final part of section 53107 of the Bipartisan Budget Act of 2018, which requires CMS, using new modifiers (CQ and CO), to pay at 85 percent of the otherwise applicable Part B pay-

ment amount for physical therapy and occupational therapy services furnished in whole or in part by physical therapist assistants (PTAs) and occupational therapy assistants (OTAs), for dates of service on and after Jan. 1, 2022.

- Implementing additional policy changes for telehealth for mental health services and opioid treatment payment policies.

## Telehealth Coverage Expanded in Proposed 2022 Physician Fee Schedule

CMS's proposed 2022 Physician Fee Schedule offers some good news for telehealth advocates, reports Eric Wicklund, in his July 14, 2021, article for *Palmetto Care Connections.*

The 1747-page draft proposes to make permanent some provisions enacted to address the coronavirus pandemic, while continuing most until at least Dec. 23, 2023 "so that there is a glide path to evaluate whether the services should be permanently added to the telehealth list following the COVID-19 PHE."

**CMS is proposing to eliminate geographic restrictions on telemental health coverage and to make the patient's home an originating site, as long as the patient and the telemental health provider meet in-person within six months of beginning telehealth services and at least once every six months after.**

As for audio-only telehealth, CMS is proposing to amend its requirements for interactive telecommunications systems, which now focus on real-time, two-way, audio-visual telemedicine technology, to include audio-only telehealth when used for the diagnosis, evaluation or treatment of mental health issues in the patient's home.

CMS is also proposing to require the use of a new modifier for services furnished using audio-only communications, which would serve to certify that the practitioner had the capability to provide two-way, audio/video technology, but instead, used audio-only technology due to beneficiary choice or limitations.

In addition, CMS plans on expanding Medicare coverage for telemental health services delivered by federally qualified health centers (FQHCs) and rural health clinics (RHCs). Neither are designated by CMS as a distant site practitioner for telehealth, but the agency is proposing to allow coverage for mental healthcare services furnished by real-time telecommunication technology, including audio-only telehealth.

As far as remote patient monitoring coverage (RPM) goes, CMS said it is "engaged in an ongoing review of payments for E/M visit code sets." Changes highlighted in the CMS press release don't factor in RPM coverage, and RPM experts are still poring over the document to ascertain whether more coverage is on the horizon.

- allzonems.com

## Advancing the Quality Payment Program – *Medicare Jurisdiction F Part B Update,* July 13, 2021

CMS is taking further steps to improve the quality of care for people with Medicare through changes to the agency's Quality Payment Program.

CMS is proposing to require clinicians to meet a higher performance threshold to be eligible for incentives. This new threshold aligns with the requirements established for the QPP's Merit-based Incentive Payment System (MIPS) under the Medicare Access and CHIP Reauthorization Act of 2015.

To ensure more meaningful participation for clinicians and improved outcomes for patients, CMS is moving forward with the next evolution of the QPP and proposing its first seven MIPS Value Pathways (MVPs). MVPs are subsets of connected and complementary measures and activities, established through rulemaking, used to meet MIPS reporting requirements.

The initial set of proposed MVP clinical areas include:

- rheumatology,
- stroke care and prevention,
- heart disease,
- chronic disease management,
- lower extremity joint repair (e.g., knee replacement),
- emergency medicine, and anesthesia.
- anesthesia

MVPs will more effectively measure and compare performance across clinician types and provide clinicians more meaningful feedback. CMS is also proposing to revise the current eligible clinician definition to include clinical social workers and certified nurse-midwives, as these professionals are often on the front lines serving communities with acute health care needs.

## Medicare Annual Wellness Visits vs Annual Physicals – Ashley Trice, *Chartspan.com,* July 15, 2021

Jam is to jelly, crocodile is to alligator, pill is to tablet, annual physical is to annual wellness visit… right? All of these things are commonly used interchangeably, yet they have fundamental differences that make them absolutely NOT the same.

The only way to ensure the terms are used correctly is to educate on what distinguishes these from each other.

### What is an Annual Wellness Visit?

There's a common misconception in the medical industry that annual wellness visits are the same thing as an annual physical exam. This likely comes with most people being familiar with annual physical exams or checkups, and assuming that an annual wellness visit is the same thing.

### HOWEVER, THEY ARE QUITE DIFFERENT

Medicare's Annual Wellness Visits (AWV) are yearly preventive visits for Medicare patients to create or update a personalized prevention plan. These preventative visits are designed to give the patient the opportunity to explain to their provider how they feel about their health status by filling out a health risk assessment. The provider is then able to use the collected information to identify risk factors, suggest appropriate preventive services, and create a personalized prevention plan for the patient.

These visits are comprised of three main components:

1. **Health Risk Assessment (HRA**) – The first component of an AWV entails patients completing a self-administered questionnaire that addresses all facets of their health and well-being. In order for the HRA to be deemed compliant, patients must self-report information on the following topics:
    - Demographics
    - Self-Assessment of Health Status
    - Behavioral Risks
    - Medical History and Family Health History
    - Psychosocial Risks
    - Activities of Daily Living
    - Instrumental Activities of Daily Living

    The risk-assessment questionnaire may also include questions about advance care planning. Based on the patient's answer to the HRA questions, the provider will be able to identify risk factors, such as cognitive impairment, and create a personalized prevention plan to follow.

2. **Vitals** – The second component is collecting and documenting vitals. These routine measurements include height, weight, and blood pressure which are essential to analyze when discussing risk factors related to cardiovascular disease, stroke and hypertension. Height and weight are used to calculate and report on BMI.

3. **Consultation** – The third component of an AWV consists of translating the HRA results into a five to ten-year care plan. Based on patient responses in the questionnaire, providers are able to identify risk factors and discuss a preventative plan of action geared towards a healthier future.

### The Difference

One of the most significant distinctions is that an **AWV does not require a physical exam, while an annual physical does**. Keeping that in mind, it is easy to understand the other differences since there is no physical touch involved in an AWV but there is during a physical.

For example, you would not perform blood work during an AWV since physical touch is involved.

| | AWV | Annual Physical |
|---|---|---|
| Medical History | X | |
| Physical Exam | | X |
| Review Risk Factors for illness | X | |
| Bloodwork, lab tests | | X |
| Personalized prevention plan | X | |
| Medication Review | X | |
| Address new health problems | | X |
| Vaccinations | | X |

Medicare beneficiaries qualify to receive an Annual Wellness Visit from their provider, completely free of charge on a yearly basis. However, the patient must be enrolled in Medicare Part B, along with Medicare Part A, in order to reap the benefits of preventive health care services.

Patients with Medicare Advantage plans are also eligible to receive preventive services such as AWVs, as long as they are seeing an in-network provider.

Ultimately, eligibility comes down to these two things:

- ✓ The patient has been enrolled in Medicare Part B services for over 12 months;

- ✓ And, the patient has not received an AWV or the Welcome to Medicare preventive visit in the past 12 months.

Since only one AWV can be done per patient, per year, a patient will not be eligible if they have already had their preventive visit with another provider.

**Please note: Recent Medicare audits have been targeting Adult Wellness Visits including Incident-to Billing, which is not allowed for Medicare wellness exams.**

## More on Medicare Annual Wellness Visits – *FPM Journal Blog*, February 4, 2021

Here are some frequently asked questions to help you further navigate the world of AWV billing, as well as a side-by-side comparison of the three types of Medicare wellness visits.

**Q - What is the difference between a Medicare AWV and a preventive visit?**

A - Medicare AWVs consist of three specific visit types statutorily covered by Medicare with no co-pay or deductible. They are the IPPE (the "Welcome to Medicare" visit, G0402), the initial AWV (G0438), and the subsequent AWV (G0439). These visits do not require a comprehensive physical exam. Preventive visits (9938X and 9939X) are covered by commercial/managed care and Medicaid plans and require a comprehensive physical exam.

**Q - Can a Medicare patient receive a preventive visit?**

A - Yes, but traditional Medicare does not cover these visits (9938X and 9939X are statutorily prohibited), so patients with that coverage will have to pay 100% out-of-pocket. However, some Medicare Advantage plans cover both Medicare AWVs (G codes) and non-Medicare (commercial) preventive visits (9938X and 9939X). Medicare Advantage patients would need to check their plan benefits to find out if they have coverage for both.

**Q - Can I perform Medicare wellness visits in skilled nursing facilities or as home visits?**

A - Yes. Just make sure the place of service (POS) on the claim corresponds to the correct location.

**Q - Can I perform a pap smear or pelvic exam during a Medicare AWV?**

A - Yes, and they are both separately billable. Use code Q0091 for the screening pap smear for a Medicare patient. The pelvic exam must be combined with a breast exam and then billed together using G0101. Specific documentation components are required for the G0101.

| | IPPE (Welcome to Medicare G0402) | Initial AWV (G0438) | Subsequent AWV (G0439) |
|---|---|---|---|
| How Often? | Once in a lifetime | Once in a lifetime | Annually |
| Eligibility | Within first 12 months of Medicare Part B enrollment | 12 months after the IPPE (or if patient did not receive an IPPE during 12-month eligibility window) | Every year after the initial AWV |
| Minimum time since previous AWV | Not applicable – first visit | At least 11 full months after G0402 | At least 11 full months after G0438 or G0439 |
| Required physician exam components | Height, weight, BMI, BP, visual acuity screening with documentation | Height, weight, BMI and BP (visual acuity screen not required) | Weight and BP (height, BMI and visual acuity screen not required |
| Electrocardiogram screening covered? | Yes but copay and deductible apply (ECG codes: G0403, G0404, and G0405) | No | No |
| Can Advance Care Planning be billed separately | No. ACP is included as a mandatory component of this visit | Yes, CPT 99497 and 99498 can be billed separately as long as minimum time requirements are met (Use modifier -33 to avoid copay and deductible) | Yes, CPT 99497 and 99498 can be billed separately as long as minimum time requirements are met. (Use modifier -33 to avoid copay and deductible) |

— Vinita Magoon, DO, JD

## How to Choose an ACO Partner

More than one-third of U.S. healthcare payments flow through an advanced payment model (APM), such as shared savings, shared risk or capitated payment.

Accountable care organizations (ACOs) can be a good starting point for an APM journey because this type of model starts with upside risk only, which allows practices to test the waters before wading into more complex arrangements that require them to assume greater risk.

While not the most flexible type of value-based care models, ACOs do offer greater flexibility than fee-for-service, paying providers for things like provider collaboration and care management, while addressing social determinants of health and more.

Here are some key areas to assess:

### Administration

A high-performing ACO must have a dedicated board in place whose members support the payer risk-sharing model, have influence in the local healthcare community and are respected by physician and non-physician peers. Administrative teams should ease the physician burden of ACO management and facilitate communication between all participants.

### Data and analytics

To accomplish its mission, an ACO needs real-time data from across the care continuum that providers can use to identify patients with care gaps and guide interventions to close those gaps. This requires a platform that can automatically capture data from disparate sources and normalize it for use within EHRs, so providers can use it in decision-making without having to toggle between systems.

While accessing and incorporating clinical data into the EHR is essential, an ACO should also have a strategy for collecting, analyzing, and responding to social determinants of health data because these non-clinical factors can account for more than 80% of health outcomes.

### Quality improvement and reporting

Since quality is mission-critical for any ACO, it is essential that quality improvement efforts be done well. When assessing a potential ACO partner, make sure it has a sound quality strategy that spans the organization. Reliable and accurate quality reporting is also key. When an ACO has knowledgeable resources committed to coordinating different quality metrics, it can make sure that what's communicated to CMS is consistent, timely and accurate. (Excerpts taken from Corey Redding's article from *Physicians Practice*, July 7, 2021).

## How to Bill a House Call Visit

Physician house calls are making a comeback as they offer clear benefits for many patients and providers. But physicians making house calls need to know about certain reimbursement and practical considerations, writes Remy Franklin in the June 9, 2021, bulletin from *Mobius MD.*

Here's a quick overview of tips and CPT codes for the next time you need to bill for a house call visit.

- Medicare reimburses providers for home visits only if they are medically necessary. *Healthcare.gov* defines medically necessary services as "services or supplies that are needed to diagnose or treat a medical condition and that meet accepted standards of medical practice."
- In the case of house calls, physicians need to document that the home visit was medically necessary.
- Providers need to document if the home visit is based upon a one-time, ongoing, or permanent need.
- Documentation should prove that the patient is not physically capable of traveling to the office. You may base this assessment on physical or mental issues but not on financial or personal issues.
- Patients receiving care under Medicare's home health benefit must be confined to the home. However, patients don't need to be home-bound for physicians to provide services billed under CPT codes 99341 through 99350.
- The OIG and many CMS contractors regularly audit home services billed to Medicare. Make sure to provide appropriate documentation showing that the house call was medically necessary.

**CPT Home Services Codes --** Physicians use a limited set of CPT codes to bill for house calls. These codes apply to E/M services provided in a patient's home. "Home" can include a private residence, temporary lodging, or short-term accommodation.

#### New patient CPT codes

99341 – Home visit for the evaluation and management of a new patient. This visit requires the following three components:

- A problem-focused history
- A problem-focused exam
- Straightforward medical decision making

99342 – Same as above, but this is a moderate severity problem requiring 30 minutes.

99343 – Moderate to high severity problem requiring 45 minutes.

99344 – High severity problem requiring 60 minutes.

99345 – Patient unstable or significant new problem requiring immediate attention (75 minutes).

#### Established patient CTP codes

99347 – Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- A problem-focused interval history
- A problem-focused examination
- Straightforward medical decision making

99348 – Same as above, with low to moderate severity problem requiring 25 minutes face-to-face time.

99349 – Moderate to high severity problem requiring 40 minutes.

99350 – Patient unstable or significant new problem requiring immediate physician attention (60 minutes).

When making a house call, you may offer additional services such as advanced care planning, diagnosis services, or other minor procedures. These can be documented and billed in addition to the visit code.

## Medicare News

CMS recently issued its proposed policies for the 2022 performance year of the Quality Payment Program (QPP) via the Medicare Physician Fee Schedule Notice of Proposed Rule Making (NPRM).

The following are some of the key QPP policies that have been proposed in the NPRM:

- MIPS Value Pathways (MVPs) begin in 2023 with 7 options for the first year
- The CMS Web Interface extends as a collection type and submission type for quality measure reporting into the 2022 and 2023 performance years for Shared Savings Program Accountable Care Organizations (ACOs) (for other ACOs and registered groups and virtual groups the CMS Web Interface continues for the 2022 performance period only)
- Updates to cost measures and improvement activities inventory
- Revisions to Promoting Interoperability performance category reporting requirements

CMS is also seeking comment on a variety of potential changes in the NPRM, including:

- Traditional MIPS sunsets after the end of the 2027 performance and data submission periods;
- The appropriate number of procedures done or conditions treated at the facility types for which CMS is proposing to add affiliation; and
- The types of utilization data that could be added to Care Compare to inform patients' healthcare decisions.

Feedback on Proposed Changes to the Quality Payment Program must be submitted by September 13, 2021.

Contact the Quality Payment Program at 1-866-288-8292 by e-mail at: qpp@cms.hhs.gov.

**Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities; Updates to the Quality Reporting Program and Value-Based Purchasing Program for Federal Fiscal Year 2022**

On July 29, 2021, CMS issued a final rule (CMS-1746-F) that provides updates to and finalized proposals for the 2022 Skilled Nursing Facility Quality Reporting Program (SNF QRP). This rule includes two new finalized measures:

1. The Skilled Nursing Facility (SNF) Healthcare-Associated Infections Requiring Hospitalization Measure; and
2. The COVID-19 Vaccination Coverage among Healthcare Personnel Measure

It also has as an update to the specifications for the Transfer of Health (TOH) Information to the Patient-Post-Acute Care Quality Measure.

In addition, CMS finalized a modification to public reporting for the SNF QRP quality measures in order to accommodate the exception of 2020 Q1 and Q2 data.

The final rule went on display at the Federal Register and will be available at:
https://www.federalregister.gov/public-inspection

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