AQREVA Medical Billing & Consulting

Client Memo
February 2021

"Hang in there, as better times are ahead."
-- Steven Magee

NEWS Update

Public Health Emergency Extended

On January 7, 2021, HHS Secretary Alex Azar II renewed the COVID-19 public health emergency, extending it into April 2021. This action marks the fourth time that HHS has extended the public health emergency since its inception on January 31, 2020.

The table below has been updated to reflect the new end dates for Medicare, Medicaid and commercial plans.

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 2/1/2021

The Covid-19 Public Health Emergency is set to end April 20, 2021.

Cigna's and UnitedHealthcare's 2021 telehealth policies have been summarized in previous newsletters or can be reviewed on each plan's website.

2021 Physician Fee Schedule Update

The Consolidated Appropriations Act of 2021 passed by Congress on December 21, 2020, enacted a 3.75% increase in Physician Fee Schedule payments for all providers in 2021 to "support physicians and other professionals in adjusting to changes in payment for physicians' services during 2021," writes Jacqueline LaPointe, in her January 11, 2021 article "CMS Recalculates Medicare Physician Fee Schedule Rates for 2021" for *Revcycle Intelligence.*

Congress also suspended the 2% payment adjustment for the statutory Medicare sequester through March 31, 2021.

The $1.4 trillion COVID-19 stimulus package also delays for at least 3 years, payments for HCPCS code **G2211**, an add-on code for the complexity inherent to E/M visits, which accounted for about $3 billion, or 3% of spending in the Medicare Physician Fee Schedule, according to the AMA.

The funds that were earmarked for it are instead going to be used to increase the conversion factor, which decreased by 10% in the 2021 PFS, states Betsy Nicoletti, in her January 12, 2021, article for *Medscape Medical News:* "How Does the COVID-19 Stimulus Bill Affect Physician Payments?" Removing payments for G2211 will mitigate the decrease in the conversion factor by about 3.5%.

On January 5th, CMS released the updated conversion factor for calendar year 2021. **It is $34.89.** Although this is a decrease from the 2020 conversion factor, which was $36.09, it is a significant increase from the $32.41 rate published in CMS's Final Rule.

Combined with the increased payments for office and outpatient codes, many practices will find their Medicare revenue unchanged or increased from last year. The AMA estimates that, on the basis of these changes, most specialties will now see either a neutral or positive change in fees for 2021. The drastic decreases projected by Medicare in its Final Rule are erased by the provisions enacted by Congress.

Code	2021 Medicare Payment		Code	2021 Medicare Payment
99201	n/a		99211	$ 23.73
99202	$ 74.32		99212	$ 36.56
99203	$114.44		99213	$ 93.51
99204	$172.01		99214	$132.93
99205	$227.13		99215	$185.96

For Medicare, total RVUs are multiplied by the year's conversion factor ($34.89 for 2021) to determine the payment allowance for each code.

MIPS for 2021

MIPS Performance Category weights for 2021:

A MIPS 2021 Quick Start Guide is located at: file:///U:/MACRA%20&%20MIPS/2021%20MIPS%20Overview%20Quick%20Start%20Guide%20(2).pdf

If you are participating in an APM, please refer to the above referenced guide for additional information.

What you need to know about MIPS in 2021

(from Healthmonix webinar "The 2021 Final Rule" by Michael Lewis, January 5, 2021)

This is the year that MIPS finally counts!

There will be no 'easy out' for MIPS reprting and no tricks to avoid the penalty.

Incentives will be at the highest levels since MIPS was introduced.

More providers will be penalized than any other year since the threshold has been raised from 45 to 60 points.

By 2022, CMS must implement MIPS payments adjustments in a budget-neutral manner. This will raise the penalty avoidance threshold to a breakeven point.

Check Your Current Eligiblity

Eligibility is determined by past and current Medicare Part B claims and PECOS data for providers and practices twice each performance year over a 12-month period. It is important to routinely check your eligibility because it can change.

To check eligibility, enter your NPI in the Quality Payment Program (QPP) Participation Status Tool on the QPP website. This tool will show you your current eligibility and indicate if you're considered a small practice. Practices can also sign in to https://qpp.cms.gov to review eligibility for all clinicians in the practice.

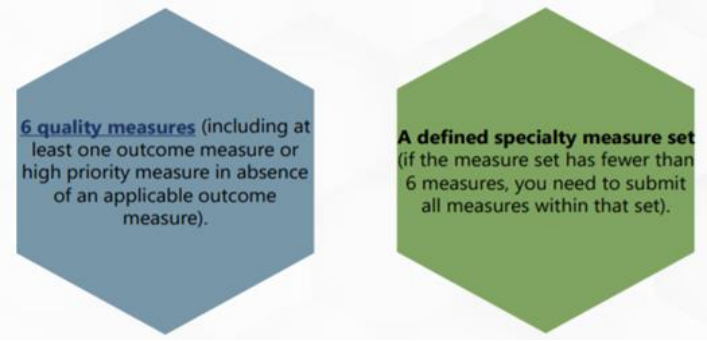
What Stayed the Same

- **Eligibility** –Still $90,000+ in Medicare Part B charges, 200+ Medicare Part B patients, and 200+ covered professional services
- **Eligible provider types**
- **Exceptional performance threshold staying at 85%**
- **Quality data completeness staying at 70%**

What's New with Quality in 2021?

The quality performance category weight has decreased from 45% to 40% for individual MIPS eligible clinicians, groups, and virtual groups participating in Traditional MIPS.

To meet the quality performance category requirements, you have to report:



-- 2021 MIPS Quick Start Guide

8 Medicare Part B claims measures were removed from the 2021 MIPS quality measure set and can no longer be reported:

- **Quality ID #012**: Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
- **Quality ID #048**: Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older
- **Quality ID #052**: Chronic Obstructive Pulmonary Disease (COPD): Long-Acting Inhaled Bronchodilator Therapy
- **Quality ID #146**: Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Screening Mammograms
- **Quality ID #268**: Epilepsy: Counseling for Women of Childbearing Potential with Epilepsy

- **Quality ID #419**: Overuse of Imaging for the Evaluation of Primary Headache
- **Quality ID #435**: Quality of Life Assessment for Patients With Primary Headache Disorders
- **Quality ID #437**: Rate of Surgical Conversion from Lower Extremity Endovascular Revascularization Procedure.
- **Quality ID #458**: All-cause Hospial Readmission

Many measures have substantive changes. Updated information on each measure can be reviewed on the Quality Payment Program website: https://qpp.cms.gov

MEASURES WITH SUBSTANTIVE CHANGES (FULL LIST)			
1	5	6	7
52	65	66	93
116	117	118	119
134	137	143	144
180	181	182	191
220	221	222	226
268	277	279	281
290	291	293	305
331	332	335	336
378	379	382	383
395	400	405	410
431	438	439	444
455	457	459	460
469	470	471	473

MEASURES WITH SUBSTANTIVE CHANGES (FULL LIST)			
8	14	19	47
107	110	112	113
126	127	128	130
145	147	176	178
195	217	218	219
236	238	243	265
282	283	286	288
309	317	318	326
364	370	374	377
386	387	391	394
415	416	418	419
450	451	452	453
461	462	464	468
476	478		

-- Healthmonix

There are 2 new quality measures that will be automatically evaluated and calculated through administrative claims, if the following case minimum requirements are met:

- Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinicians Groups.
- Risk-standardized Complication Rate (RSCR) following Electric Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty (TKA) for MIPS.

What's New with Improvement Activities?

MODIFYING TWO ACTIVITIES

- Engagement of Patients Through Implementation of Improvements in Patient Portal -- Added caregivers as potential users and changed the language to say that the portal's primary use should be clinical and not administrative.
- Comprehensive Eye Exams –Added language to promote access to vision rehabilitation services for individuals with chronic vision impairment

REMOVING ONE ACTIVITY

- CMS Partner in Patients Hospital Engagement Network

FINALIZING THE ADOPTION OF ONE ACTIVITY

- COVID-19 Clinical Trials

What's New with MIPS Cost Category?

20% - Up from 15% in 2020

The move to 30% for the Cost Category is mandated by law for 2022, and CMS reiterated that fact in the Final Rule.

What's New with Promoting Interoperability?

Query of Prescription Drug Monitoring Program (PDMP)

- Bonus increases from 5 to 10 points and will remain an optional measure.

Introduction of a new optional measure - Health Information Exchange (HIE) bi-directional exchange measure

- Bi-directional exchange means that the clinician's EHR is enabled to allow for querying and sharing data by sending, receiving, and incorporating data via an HIE for every patient.

Measure name change

- from Support Electronic Referral Loops by Receiving and **Incorporating** Health Information to Support Electronic Referral Loops by Receiving and **Reconciling** Health Information

Promoting Interoperability Measures for 2021

Objective	Measure
Electronic Prescribing	e-Prescribing
	Bonus: Query of PDMP
Health Information Exchange OR	Support Electronic Referral Loops by Sending Health Information
	Support Electronic Referral Loops by Receiving and Reconciling Health Information
Health Information Exchange (alternative)	HIE Bi-Directional Exchange
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information
Public Health and Clinical Data Exchange	Report to two different public health agencies or clinical data registries for any of the following: • Syndromic Surveillance Reporting • Immunization Registry Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting

Notes: The Security Risk Analysis measure is required, but will not be scored.

Submitting 2020 MIPS Data

CMS has opened the data submission period for MIPS-eligible clinicians who participated in the 2020 performance year of the Quality Payment Program. Data can be submitted and updated from January 4, 2021 through March 31, 2021.

DEADLINE FOR CMS TO RECEIVE 2020 CLAIMS FOR THE QUALITY PERFORMANCE CATEGORY IS MARCH 1, 2021.

How to Submit Your 2020 MIPS Data

Clinicians will follow the steps outlined below to submit their data:

1. Go to the QPP webpage.
2. Sign in using your QPP access credentials (see below for directions).
3. Submit your MIPS data for the 2020 performance year or review the data reported on your behalf by a third party.

How to Sign into the QPP Data Submission System

Clinicians will need to register in the Health Care Quality Information Systems Authorization Roles and Profile (HARP) system. For clinicians who need help enrolling with HARP, please refer to the QPP Access User Guide located on the QPP website: https://qpp.cms.gov

HARP Account Reminders

If you have a HARP account, the following are some tips to keep your account active and how to create a strong password. Passwords must:

- Be changed every 60 days.
- Be changed prior to expiration.
- Be changed by going to portal.cms.gov > My Profile > Click on Change My Profile > Change Password.

MIPS Submission Portal Pointers

Tip #1: Submit early. Do not wait! Make sure your password is still working!

Tip #2: Click the "Print" button at the top of your Reporting Overview, as there is no "Save" or "Submit" button, once you have entered your data.

Tip #3: If you are part of an Alternative Payment Model (APM), such as an Accountable Care Organization (ACO), please confirm with your ACO that they have uploaded the Quality MIPS data on your behalf. Do not forget you are required to submit your own data in the Promoting Interoperability category unless otherwise specified by your ACO.

Using Total Time to Code Office Visits

-- Staff, *AAPC website*

The Time section of the 2021 E/M guidelines will include important information about proper use of the revised office and other outpatient codes.

Here are the major points from the 2021 guidelines for Time:

- You will be able to use time alone to select the correct code from 99202-99205 and 99212-99215. Note that 99211 is not in that list because no time is listed in that descriptor.
- Counseling and/or coordination of care will not need to dominate an office or other outpatient E/M service for you to code the service based on time in 2021. But for other E/M services that you code based on time, you will still need to meet the threshold of counseling and/or coordination of care taking up more than 50% of the visit.
- You will use 99211 if clinical staff members perform the face-to-face visit under the supervision of the physician or other qualified healthcare professional.
- A shared or split visit is when a physician and one or more other qualified healthcare professionals perform the face-to-face and non-face-to-face work for the E/M visit. When you're coding these visits based on time, sum the time spent by the physician and other qualified healthcare professionals to get a total time. Any time that the providers spend together to meet with or discuss the patient should be counted only once (like you're counting the time of one individual).

- A key shift for the office and other outpatient E/M codes is that the time referenced in the 2021 code descriptors is total time.
  - The 2021 Time guidelines explain that for 99202-99205 and 99212-99215, total time on the encounter date includes both face-to-face and non-face-to-face time spent by the provider.
  - The guidelines offer the examples of preparing for the visit (such as reviewing tests); getting or reviewing a history that was separately obtained; performing the exam; counseling and providing education to the patient, family, or caregiver; ordering medicines, tests, or procedures; communicating with other healthcare professionals; documenting information in the medical record; interpreting results and sharing that information with the patient, family, or caregiver; and care coordination.
  - When you start counting time for the 2021 codes, you should not include time spent on services you report separately.
  - The total time also will not include time for activities the clinical staff normally performs.

Services Reported Separately: In particular, watch for this line: *"If a test/study is independently interpreted in order to manage the patient as part of the E/M service, but is not separately reported, it is part of medical decision making."*

Time Spent on the Date of the Encounter	New Patient	Time Spent on the Date of the Encounter	Established Patient
15-29 mins	99202	10-19 mins	99212
30-44 mins	99203	20-29 mins	99213
45-59 mins	99204	30-39 mins	99214
60-74 mins	99205	40-54 mins	99215
75+ mins	See prolonged services 99XXX	55+ mins	See prolonged services 99XXX

-- eClinical Works

Provider Relief Fund Reporting Delayed–

MGMA Bulletin, January 21, 2021

Following changes made by Congress to Provider Relief Fund (PRF) reporting requirements, HHS is delaying the reporting deadline for providers that received over $10,000 in PRF payments. Previously, the reporting period was set from January 15 to February 15, 2021; however, **HHS has removed this deadline altogether for the time being.**

As of January 15, 2021, HHS is encouraging providers who received PRF payments exceeding $10,000 in the aggregate to register through the PRF Reporting Portal at: https://prfreporting.hrsa.gov

The Portal is currently open for registration only but cannot be used to report data elements yet.

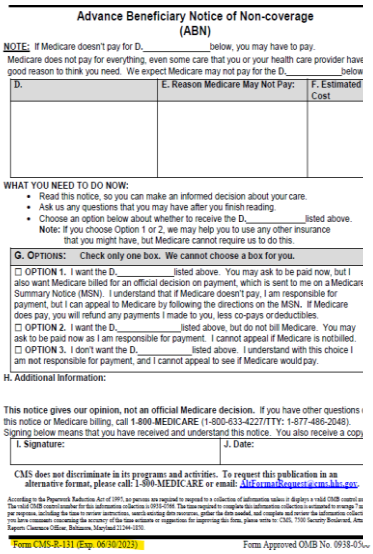
New ABN Form Mandatory for 2021

The Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, is issued by providers (including independent laboratories, home health agencies, and hospices), physicians, practitioners, and suppliers to Original Medicare FFS beneficiaries in situations where Medicare payment is expected to be denied.

The ABN is issued in order to transfer potential financial liability to the Medicare beneficiary in certain instances.

Note: Skilled nursing facilities issue the ABN to transfer potential financial liability for items/services expected to be denied under Medicare Part B only.

CMS has expanded the deadline for use of the renewed ABN, Form CMS-R-131 (exp. 6/30/2023). At this time, the renewed ABN is mandatory. The revised ABN replaces the ABN Form that was last released in June 2017. Although the form appears essentially unchanged, **you must use the form CMS-R-131 (Exp. 06/30/2023).**



Advance Beneficiary Notice of Non-coverage
(ABN)

NOTE: If Medicare doesn't pay for D._____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D._____below

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D._____listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ OPTION 1. I want the D._____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ OPTION 2. I want the D._____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is notbilled.

☐ OPTION 3. I don't want the D._____listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy

I. Signature:	J. Date:

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Form CMS-R-131 (Exp. 06/30/2023) Form Approved OMB No. 0938-05

Don't forget to add modifier 'GA' to your Medicare billing to let Medicare know that a mandatory ABN for a service is on file. The 'GA' modifier is used when both covered and non-covered services appear on an ABN-related claim. Use of this modifier ensures that Medicare will automatically assign the liability to the beneficiary if the service is denied.

The new ABN form and additional information can be found at: https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN

MEDICARE NEWS

New Rule Addresses the Prior Authorization Process – *CMS Bulletin,* January 15, 2021

CMS puts Patients Over Paperwork with a new rule that addresses the prior authorization process. The final rule gives providers access to patient treatment histories and streamlines the prior authorization process to improve patient experience and alleviate burden for health care providers.

The "CMS Interoperability and Prior Authorization" rule builds on the efforts to drive interoperability, empower patients, and reduce costs and burden in the healthcare market by promoting secure electronic access to health data in new and innovative ways.

These significant changes include allowing certain payers, providers and patients to have electronic access to pending and active prior authorization decisions, which should result in fewer repeated requests for prior authorizations, reducing costs and onerous administrative burden to our frontline providers.

This final rule requires the payers regulated under this rule (namely, Medicaid and CHIP managed care plans, state Medicaid and CHIP fee-for-service programs and issuers of individual market Qualified Health Plans on the Federally-facilitated exchanges to implement application programing interfaces (APIs) that will give providers better access to data about their patients, and streamline the process of prior authorization.

Payers would be required to implement and maintain these APIs using the Health Level 7 (HL7) Fast Healthcare Interoperability Resources (FHIR) standard. The FHIR standard is an innovative technology solution that helps bridge the gaps between systems so both systems can understand and use the data they exchange.

While Medicare Advantage plans are not included in and therefore not subject to this final rule, CMS is considering whether to do so in future rulemaking.

The final rule is available to review at:
https://www.cms.gov/files/document/11521-provider-burden-promoting-patients-electronic-access-health-information-e-prior.pdf

Doctors and Clinicians Preview Period is Now Open

The Doctors and Clinicians Preview Period is officially open as of January 25, 2021. 2019 Quality Payment Program performance information can now be previewed before it will appear on clinician and group profile pages on Medicare Care Compare and in the Provider Data Catalog (PDC). You can access the secured Preview through the QPP website at https://qpp.cms.gov.

Please note the 2019 QPP performance information is targeted for public reporting in 2021 and will be added to Care Compare and/or the PDC after all Targeted Reviews are completed. If you have an open Targeted Review request, you will still be able to preview your 2019 Quality Payment Program performance information during the Doctors and Clinicians Preview Period.

If you have any questions about public reporting for doctors and clinicians or the Doctors and Clinicians Preview Period, please contact CMS at QPP@cms.hhs.gov

Accountable Care Organizations (ACOs) can preview their performance information via their 2019 MIPS Performance Feedback Reports.

Be Careful and Stay Safe!

- vectorstock

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