AQREVA Medical Billing & Consulting

Client Memo
July 2021

"Normal is nothing more than a cycle on a washing machine."
-- Whoopi Goldberg

NEWS Update

The COVID-19 Public Health Emergency is set to end July 20, 2021

Speculation has it that the Public Health Emergency will be extended another 90 days and may just continue until the end of 2021. No official announcement has yet been made.

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

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

United Healthcare's Telehealth Reimbursement policy went into effect January 1, 2021: https://www.ahip.org/health-insurance-providers-respond-to-coronavirus-covid-19/#C

Revised Provider Relief Fund Rules

HHS has revised the Provider Relief Fund (PRF) Post-Payment Notice of Reporting Requirements that was issued on January 15, 2021. The new reporting requirements are now available on HHS's website along with other reporting resources. Please review the revised notice for detailed information. A summary of key updates is listed below:

- The period of availability of funds is based on the date the payment is received (rather than requiring all payments be used by June 30, 2021, regardless of when they were received).
- Recipients are required to report for each Payment Received Period in which they received one or more payments exceeding, in the aggregate, $10,000 (rather than $10,000 cumulatively across all PRF payments).
- Recipients will have a 90-day period to complete reporting (rather than a 30-day reporting period).
- The reporting requirements are now applicable to recipients of the Skilled Nursing Facility and Nursing Home Infection Control Distribution in addition to General and other Targeted Distributions.
- The PRF Reporting Portal will open for providers to start submitting information on July 1, 2021.

Period	Pymt Received	Deadline to Use Funds	Reporting Time Period
1	4/10/20- 6/30/20	6/30/21	7/1/21 - 9/30/21
2	7/1/20-12/31/20	12/31/21	1/1/22 – 3/31/22
3	1/1/21 – 6/30/21	6/30/22	7/1/22-9/30/22
4	7/1/21 – 12/31/21	12/31/22	1/1/23 – 3/31/23

Action Needed: Reporting Registration

Recipients who received one or more payments exceeding, in the aggregate, $10,000 during a Payment Received Period are required to report in each applicable Reporting Time Period as outlined in the table above.

Providers are encouraged to register in the PRF Reporting Portal in advance of the relevant Reporting Time Period dates. The registration process will take approximately 20 minutes to complete and must be completed in one session. The entire registration form must be completed for it to be saved.

What is needed to register?

Before starting the registration process, recipients should have the following on hand:

- Tax ID Number (TIN) [or other number submitted during the application process (e.g., Social Security Number, Employer Identification Number [EIN])
- Business name of the reporting entity (as it appears on IRS Form W-9)
- Contact information (i.e., name, phone number, email) of the person responsible for submitting the report
- Address (i.e., street, city, state, five-digit zip code) of the Reporting Entity as it appears on IRS Form W-9)
- TIN(s) of subsidiaries (if a provider is reporting on behalf of subsidiary(ies) - in a list delimited by commas, (e.g.,123456789, 987654321, 135791357)
- Payment information (for any of the payments received)
    - TIN of entity that received the payment
    - Payment amount
    - Mode of payment
    - Check number or ACH settlement date

New SNF PRF Reporting Requirements and Rumors of Future Disbursements

Maggie Flynn's article, "HHS Issues New PRF Reporting Requirements, While Rumors Swirl of Future Disbursement to SNFs," which appears in the June 11, 2021, edition of *Skilled Nursing News*, discusses the possibility of skilled nursing providers receiving some financial aid from the federal government to help address the ongoing costs from COVID-19.

The speculation comes as the government issued new reporting requirements and deadlines for the federal aid SNFs received over the course of the pandemic, Ms. Flynn writes.

Executives at both Sabra Health Care REIT and CareTrust REIT told attendees at the June 7, 2021, Nareit REITWeek investor conference that they expect $10 billion of the remaining roughly $24 billion in CARES Act funds to be disbursed.

Mark Parkinson, the president and CEO of the American Health Care Association (AHCA), told the Synergy Summit 2021 gathering on June 9th that "there will be some positive news on the PRF in the next seven days and possibly sooner than that."

The original deadline for providers to report on how funds were used – and to return any unused PRF dollars – was June 30, 2021. Both the AHCA, which primarily represents for-profit nursing homes, and LeadingAge, the trade group representing nonprofit senior housing and care providers, have been advocating for an extension.

On Friday, June 11, 2021, the Department of Health and Human Services issued new reporting requirements that changed the deadline. The availability of PRF funds is now based on the date the payment was received, superseding the mandate that all payments be used or returned by June 30, according to HHS.

As mentioned in the above article, recipients are required to report for each Payment Received Period in which they received one or more payments exceeding, in the aggregate, $10,000 and will also have a 90-day period to complete reporting.

The reporting requirements also now apply to SNFs that received funds from the SNF and Nursing Home Infection Control Distribution, HHS noted.

2022 ICD-10-CM Codes Now Available

Highly anticipated, the fiscal year 2022 ICD-10-CM codes have been released by the CDC. They new codes are effective October 1, 2021, writes Laurie Johnson for *ICD 10 Monitor*, June 25, 2021.

Still to be released are the 2022 Official Coding and Reporting Guidelines which were not included in the package of new codes but, when released, will comprise the 2022 Inpatient Prospective Payment System (IPPS) Final Rule.

The CDC release on June 23, 2021, contains 159 new codes, along with the Tabular and Index Addenda.

Examples of some upcoming changes are:

A77.49	New Code for Ehrlichiosis
D75.83	Expansion of Thrombocytosis
F32.--	Expansion of Depression
G92.--	Expansion of Toxic Encephalopathy
K31.A-	New subcategory Gastric Intestinal Metaplasia
L24.1-, L24.B-	New subcategories for Irritant Dermatitis
M35.0-	Expansion of Sjogren Syndrome
M54.5-	Expansion of Low Back Pain
R05.--	Expansion of Cough
R63.3-	Expansion of Feeding Difficulties
U09.9	New Code Post-Covid 19 Condition
Z5-.--	Additions to Factors Influencing Health Status Codes

New codes are effective October 1, 2021.

Just for fun.....

ICD 10 Codes for Summer

Here are some of the ICD-10 codes for the summer that Keith Martin put together in his June 29, 2021. article of *Medscape Medical News*:

L55	Sunburn
R21	Rash
T67.01	Heatstroke/Sunstroke
T75.3XX	Motion sickness
V91.16	Injury involving an inflatable craft/floatie
W39	Discharge of firework
W89.1	Exposure to tanning bed for burns
Y92.813	Airplane as place of occurrence
Y92.832	Beach as a place of occurrence
Y93.0	Activity, walking and running
Y93.G2	Activity, grilling and smoking food
Y93.6A	Activity, physical games as the cause of an injury

Using Scribes in Your Practice – *Healthcare Compliance Association - Resource library.*

If you use a scribe in your practice, certain regulatory rules apply.

A scribe is someone who records on behalf of another person. Scribe situations in health care are those in which the physician utilizes the services of staff to document work performed by him or her, in either an office or a facility setting.

The scribe does not act independently, but merely documents the physician's dictation and/or activities during the visit. The physician who receives the payment for the services is expected to be the person delivering the services and creating the record, which is simply "scribed" by another person.

Physicians using the services of a "scribe" must:

- Adhere to E/M guidelines for the place of service of that visit.
- Provide documentation that supports both the medical necessity of the level of service billed and the level of the Key Components required of the service in the E/M guidelines.
- Provide documentation that meets the Current Procedural Terminology (CPT) definition of the level of E/M billed.
- Ensure that the medical record entry notes the name of the person acting as the scribe (e.g., "**acting as a scribe for Dr. Smith**.")
- Co-sign the note indicating the note is an accurate record of both his/her words and actions during that visit.

Under the above circumstances, "scribe" situations are appropriate and can be a part of the physician's billing of services to Medicare. It is important, however, to be certain that the "scribe's" services are used and documented appropriately, and that the documentation is present in the medical record to support that the physician actually performed the E/M service at the level billed.

EEOC Releases Updated COVID-19 Guidance for Employers

On May 28, 2021, the U.S. Equal Employment Opportunity Commission (EEOC) updated its Technical Assistance Questions and Answers guide in relation to COVID-19, writes Rachel Rose, JD, MBA, in her June 3, 2021 article for *Physicians Practice*.

There are a few notable items, some of which seemingly intersect with the Health Insurance Portability and Accountability Act (HIPAA).

First, the EEOC Guidance serves as a reminder that the Americans with Disabilities Act "applies to private employers with 15 or more employees. It also applies to state and local government employers, employment agencies, and labor unions. All nondiscrimination standards under Title I of the ADA also apply to federal agencies under Section 501 of the Rehabilitation Act."

Second, it answers the question regarding how much information an employer may request from an employee who calls in sick in order to protect the rest of its workforce.

The EEOC's answer:
"[d]uring a pandemic, ADA-covered employers may ask such employees if they are experiencing symptoms of the pandemic virus. For COVID-19, these include symptoms such as fever, chills, cough, shortness of breath, or sore throat. Employers must maintain all information about employee illness as a confidential medical record in compliance with the ADA."

This is sage advice, regardless of the size of an organization -- treat all sensitive medical information as if it were a patient's protected health information. Even though HIPAA's Privacy Rule does not apply to employment records, the Privacy Rule does apply to medical or health plan records if a workforce member is a patient of their provider-employer or a member of a health plan.

In light of various state laws, as well as general privacy considerations, employers should always remember not to mention an individual employee by name, even if other workforce members need to be tested as a result of a potential exposure.

As far as COVID-19 vaccinations are concerned, as indicated in the EEOC Guidance, "federal EEOC laws do not prevent an employer from requiring all employees physically entering the workplace to be vaccinated for COVID-19, subject to the reasonable accommodation provisions of Title VII and the ADA and other EEOC considerations."

This notion applies whether or not the employer administers the vaccine, or the employee gets the vaccine elsewhere. The critical considerations for employers are:

- to require the vaccine of ALL employees in order to avoid a discrimination suit;
- to have a process defined in a policy and have procedures in place to address potential accommodations;
- to expressly state that the accommodation may be granted so long as it "does not pose an undue hardship on the operation of the employer's business."

In sum, these items are particularly notable in a healthcare setting and providers are encouraged to consult outside counsel if a situation arises that cannot be reasonably accommodated.

UHC Notice: Web browser Compatibility

On Aug. 17, 2021, Internet Explorer 11 will no longer be supported for Microsoft's online services like Office 365, OneDrive, Outlook and more. As UHC continuously upgrades its online tools, those who use Internet Explorer may experience web compatibility issues on the new UnitedHealthcare Provider Portal and other online platforms.

To get the best user experience with UHC's online platforms, reduce web load time and enhance how items appear, please update your web browser. UHC recommends using either Microsoft Edge, Google Chrome or Apple Safari.

MIPS Update

CMS Suppressing 2 Diabetes Quality Measures on Medicare Part B Claims submissions for the 2021 Performance Period

CMS will suppress the Medicare Part B claims-based submission of the following measures for the 2021 performance period:

- Quality ID 001: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) and
- Quality ID 117: Diabetes: Eye Exam

In January 2021, new CPT Category II Quality Data Codes were introduced as numerator options within the measure specification but were not activated within CMS systems and therefore not usable for the 2021 performance period.

***** These measures will not be scored *****

For each suppressed measure that's submitted for the 2021 performance period, the total available measure achievement points will be reduced by 10 points*.

CMS encourages eligible clinicians and groups to choose different quality measures to report for the 2021 performance period.

MIPS eligible clinicians do not need to submit any additional documentation or resubmit rejected claims solely for the purpose of adding a quality data code for the 2021 performance period.

For any questions related to this policy, please contact the Quality Payment Program at 1-866-288-8292 or by e-mail at: QPP@cms.hhs.gov (Monday-Friday 8 a.m.- 8 p.m. ET).

To receive assistance more quickly, please consider calling during non-peak hours—before 10:00 a.m. and after 2:00 p.m. ET. Customers who are hearing impaired can dial 711 to be connected to a TRS Communications Assistant.

*Please refer to the scoring equations on page 43 of the 2021 MIPS Quality User Guide:

https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1432/2021%20MIPS%20Quality%20User%20Guide.pdf

2019 Quality Payment Program Performance Information Now Available on Care Compare

CMS has added new Quality Payment Program performance information for doctors, clinicians, groups, and Accountable Care Organizations (ACOs) to the Doctors and Clinicians section of Medicare Care Compare and in the Provider Data Catalog (PDC).

CMS is required to report MIPS eligible clinicians' Final Scores, MIPS eligible clinicians' performance under each MIPS performance category, names of eligible clinicians in Advanced APMs and, to the extent feasible, the names and performance of such Advanced APMs.

Performance information for doctors and clinicians is displayed using measure-level star ratings, percent performance scores, and checkmarks.

Medicare patients and caregivers can use the Care Compare website to search for and compare doctors, clinicians, and groups who are enrolled in Medicare.

Visit the Care Compare: Doctors and Clinicians Initiative page for details or if you have any questions about the 2019 QPP performance information:

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Compare-DAC

2021 APM Incentive Payment Details

CMS has published 2021 Alternative Payment Model (APM) Incentive Payment details on the Quality Payment Program (QPP) website. To access this information, clinicians and surrogates can now log in to the QPP website using their HARP credentials.

Eligible clinicians who were Qualifying APM Participants (QPs), based on their 2019 performance, will begin receiving their 2021 5% APM Incentive Payments this month.

Providers can now log in to the QPP website to see the amount and both the NPI numbers and the organizations that were paid.

Providers will not need to do anything to receive their payment, unless CMS is unable to verify a provider's Medicare billing information. For providers who do not receive a payment, they can find their names on this public notice, which indicates if they will need to verify their Medicare billing information.

If Medicare billing information is not verified by **November 1, 2021,** then CMS will not be able to issue an APM Incentive Payment. For instructions on how to verify your Medicare billing information, please review the public notice or contact the Quality Payment Program at: QPP@cms.hhs.gov or call 1-866-288-8292.

July Reminders

- The QPP Exception applications window opens
- Targeted Review Period Opens for 2020 MIPS Performance Year
- Performance Year 2020 Final Feedback Available

Please go to the QPP website to access the Exception applications and for further information: https://qpp.cms.gov

2021 Telligen's QPP Resource Center

For assistance with the Quality Payment Program and MIPS, don't forget Telligen's Quality Payment Program Resource Center. Physicians, their practice managers, and other key office staff can use this site to submit QPP-related questions, stay on top of the latest policy updates & events, and access helpful tools and resources.

Telligen is 1 of 11 organizations awarded by CMS as a QPP Technical Assistance Support Contractor. Telligen's goal is to ensure that small practices in Iowa, Nebraska, South Dakota and North Dakota have the iformation, support and resources necessary to survive and thrive under the CMS's Quality Payment Program.

Please visit their website at: https://telligenqpp.com

MEDICARE NEWS

CMS Increases Medicare Payments for At-Home COVID-19 Vaccinations

Medicare payments will increase by $35 per dose for providers who administer at-home COVID-19 vaccinations for Medicare beneficiaries, CMS announced. In alignment with President Biden's goal of ensuring vaccine accessibility, this increase will incentivize providers and allow beneficiaries who cannot leave their homes the opportunity to receive the vaccine.

Prior to this announcement, at-home vaccine administration warranted a $40 reimbursement for providers per dose; providers will now receive $75 per dose, or $150 for a two-dose vaccine.

The increase in payment covers any costs associated with at-home vaccinations and accounts for the time a provider needs to monitor the beneficiary after the shot. The payment rates will be adjusted geographically.

"In light of CMS's increased Medicare payment rates, CMS will expect health insurance issuers and group health plans to continue to ensure their rates are reasonable when compared to prevailing market rates," the CMS announcement stated.

Cognitive Assessment: What's in the Written Care Plan?

The Cognitive Assessment & Care Plan Service (**CPT code 99483)** typically starts with a 50-minute face-to-face visit that includes a detailed history and patient exam. Use information gathered from the exam to create a written care plan. The resulting written care plan includes initial plans to address:

- Neuropsychiatric symptoms
- Neurocognitive symptoms
- Functional limitations
- Patient or caregiver referrals to community resources, as needed, with initial education and support

Effective January 1, 2021, Medicare increased payment for these services to $282 (may be geographically adjusted) when provided in an office setting, added these services to the definition of primary care services in the Medicare Shared Savings Program, and permanently covers these services via telehealth.

Get details on Medicare coverage requirements and proper billing at: https://cms.gov/cognitive

UPDATE: 2021 Quality Benchmarks File

Through its ongoing quality assurance efforts, CMS has identified and corrected an error with the decile outputs affecting the 2021 historical quality measure benchmarks file. This issue affected every measure in the benchmarks file. As a result of the correction, the range of performance rates for a given decile have shifted down one decile.

CMS realizes this may affect your understanding of your current performance on your selected quality measures; however, CMS is committed to ensuring that clinicians are assessed accurately. CMS has also put additional safeguards in place to prevent this issue from recurring in the future.

Artist and Clinician -- Jaleesa Baulkman, *Medscape Medical News*, June 23, 2021

As the COVID-19 pandemic reached its apex, Saira Malik Rahman, MD, an Indiana-based pediatrician, wanted to portray the immense burdens carried by overstretched physicians. "In many ways, this piece is a reflection of a broken healthcare system," she explains.

Sharon Madanes, MD, a psychiatry resident at New York University, says her paintings and drawings "focus on the rituals, aesthetics, and ethics of medicine, as contextualized within the banal institutional surroundings where doctors treat patients, and patients wait."

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