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Medical Billing & Consulting

"Science and technology will and should be the heart of modern medicine, but you must add the soul." **-- Paul Farmer, MD, PhD**

Client Memo
June 2021

NEWS Update

North Dakota Makes Expanded Tele-health Care Options Permanent

A bill that makes permanent the expansion of pandemic rules that enabled telehealth medicine to take off in North Dakota was among the last bills to get signed by Governor Doug Burgum for this biennium, writes Renee Jean in her May 17, 2021, article for the *Williston Herald.*

The bill was one of two telehealth-related bills the legislature considered. A second bill, which aimed to ensure payment parity between telehealth and live visits was defeated, as was a study into the issue.

Commissioner Jon Godfread opposed the latter bill, and said he believes the legislature chose the right thing for consumers. Consumers should continue to have the same access to telehealth services that they had during the pandemic, he added.

"The bill that was originally introduced was all about payments," Godfread told the *Williston Herald.* "And the bill that we ultimately passed is all about access."

The state's insurance commissioner acknowledged that negotiations between providers and insurance companies is likely to continue. But he believes that might ultimately be a good thing, to the extent it puts downward pressure on prices for medical services.

South Dakota Permanently Extends Te-lehealth Coverage -- Eric Wicklund, *mHealth Intelligence*, March 11, 2021

Following through on a pledge made in January, 2021, South Dakota Governor Kristi Noem has signed into law a bill that allows providers to use telehealth without first needing an in-person exam.

SB 96, which includes some emergency measures included in executive orders 2020-07 and 2020-16, is the first of what may be several attempts to permanently extend connected health access and coverage beyond the coronavirus pandemic.

"COVID-19 challenged us in new, unforeseen ways, and those challenges provided us an opportunity to adapt and find innovative ways to deliver healthcare in South Dakota," Noem said in a press release. "We greatly expanded telehealth in 2020. Going forward, we will build on these technological advancements and continue to find ways to remove government red tape in healthcare."

In January, Noem announced that she would introduce at least two bills aimed at extending telehealth in the state. Along with eliminating the in-person requirement for telehealth treatment, she also wants to allow providers to prescribe medications via telehealth, permit the use of audio-only telehealth platforms (such as phones) and allow the state to recognize medical licenses from states included in the Uniform Emergency Management Assistance Compact (EMAC), a mutual aid agreement that allows states to share resources during natural and man-made emergencies.

SB 96 also revises the state's definition of telehealth to cover "interactive audio-video, interactive audio with store and forward, store-and-forward technology, and remote patient monitoring."

Incident-To Billing Not Allowed for IPPE and AWV

Please note that Medicare RAC audits are targeting in-cident-to billing for Adult Well Visits (AWV's).

Providers are reminded that the IPPE and AWV are Medicare-covered services within their own benefit category. As such, they are not subject to standard "incident to" billing guidelines and **must be billed by the performing provider,** whether this is a physician or NPP. *National Government Services Bulletin*, February 20, 2020.

The Evolution of "Incident to' Billing

'Incident to' billing has been a challenging topic since its creation by Medicare, writes Elizabeth Woodcock in her February 2021 article for *SVMIC.com.*

The rules – which allow advanced practice providers (APPs) to be reimbursed at the full physician rate by Medicare when seeing patients in an office and directly supervised by a physician – are complex and, arguably, subject to interpretation. There have been a bevy of practices found in non-compliance with the rules, which has resulted in expensive paybacks.

The Medicare Payment Advisory Commission (MedPAC) issued their recommendation to eliminate the provision. Although Medicare did not move forward with the 2019 recommendation, there are signs that other insurers are. United Healthcare, for example, announced a new policy titled: "Advanced Practice Health Care Provider Policy, Professional," with an effective date of March 1, 2021.

For some practices, this policy change won't matter as they have already transferred their APPs to independent status. This indeed is the trend, as practices have assessed the cost/benefit of this manner of billing. At issue is the loss of 15% of revenue, as an independent APP is paid by most insurers at 85% of the fee schedule.

UHC Advanced Practice Health Care Provider Policy -- *Commercial Reimbursement Policy Number 2021R5009A*, effective March 1, 2021

This policy sets forth the requirements for reporting the services of Advanced Practice Health Care Providers and other Nonphysician Providers, within a medical or other healthcare practice.

An Advanced Practice Health Care Provider must report services rendered, within the scope of their licensure or certification, pursuant to applicable state laws and regulations, using the Advance Practice Health Care Provider's own NPI number, unless the Advanced Practice Health Care Provider is ineligible for their own NPI number and the "Incident to" guidelines described in this policy, are met.

For Advanced Practice Health Care Providers ineligible for their own NPI number, services that meet the "Incident-to" criteria above should be **reported under the supervising physician's NPI number with the SA modifier appended.**

Unless otherwise contracted with a Medical Group Nonphysician Provider fee schedule, UnitedHealthcare applies a reduction of 15% to the applicable fee schedule or allowed amount for the reimbursement of the following Advanced Practice Health Care Providers: Physician Assistants (PA), Nurse Practitioners (NP), and Clinical Nurse Specialists (CNS).

AHCCCS Policy Regarding Billing for Mid-Level Practitioners – March 16, 2018

This communication serves as a reminder of the AHCCCS Rules and Policy regarding billing for Arizona Physicians and Mid-Level Practitioners. In accordance with AHCCCS's guidelines, all rendering providers must bill under their own NPI number. As a result, **incident-to billing is not permissible for mid-level practitioners.** (A rendering provider is defined as the individual who provided care to the client and needs to be reported as such in box 24J of the CMS 1500 claim form.)

Per the AHCCCS participating Provider Agreement General Terms and Conditions: "**No provider may bill with another provider's ID number, except in locum tenens situations.** Locum Tenens provider must submit claims using the AHCCCS provider ID number of the physician for whom the Locum Tenens provider is substituting or temporarily assisting." Locum Tenens arrangements will be recognized and restricted to the length of the Locum Tenens registration with the AMA.

Failure to Adhere to Incident-to Rules Can be Costly – Health Law Offices of Anthony Vitale, November 9, 2020

The U.S. Department of Justice recently announced that two physicians and their family medicine practices located in Tennessee will pay $341,690 to resolve allegations that they violated the False Claims Act by knowingly charging Medicare for services rendered by nurse practitioners at the higher reimbursement rate for physician services.

The providers are alleged to have violated what is known as the "incident-to" rule. Under that rule, Medicare pays 85% of the physician fee schedule (PFS) when a service is billed under the NP's or PA's own National Provider Identifier (NPI).

Medicare pays 100% of the PFS rate when the same service provided by an NP or PA is billed "incident to" a supervising physician. It is important to note that the physician must be present in the office suite while the

services are being provided and immediately available to provide assistance if needed.

In addition to the direct supervision provision, the incident-to rule only allows physicians to bill Medicare at the full physician fee schedule amount for the services that are performed by a non-physician practitioner, if the services are:

- Included in a treatment plan for an injury or illness where the physician performs an initial service and is involved actively in the course of treatment.
- The Medicare-credentialed physician must initiate the patient's care. If the patient has a new or worsened complaint, a physician must conduct an initial E/M service for that complaint and must establish the diagnosis and plan of care.
- The physician must see the patient at a frequency that reflects his/her active involvement in the patient's case.

Justice Department Cracks Down on COVID-Related Fraud Cases

The Justice Department has made fighting COVID-related fraud cases a priority, especially with the passing of the CARES Act last year.

The CARES Act, which included $2.2. trillion in economic aid, was intended to provide financial assistance to Americans and their businesses struggling under the economic hardships caused by the COVID-19 pandemic.

Within weeks of the CARES Act's passage, the Department of Justice immediately began efforts to investigate and prosecute related fraud. The Department focused initially on the most egregious instances of COVID-19 related wrongdoing, but it has since cast a wider net, warns Marissa Koblitz and Matthew Lee with Fox Rothschild, LLP in its April 21, 2021 news bulletin.

By the end of March 2021, the Department of Justice had charged over 470 defendants with criminal offenses based on fraud schemes connected to the COVID-19 pandemic. The Justice Department's Criminal Division Fraud Section has prosecuted approximately 120 defendants charged with PPP fraud. The accused include:

- those who lied about payroll costs, employees or even having a business;
- individuals who misappropriated loan proceeds by using the money to purchase cars, boats and houses;
- fraudsters who applied for EIDL advances; and
- over 140 defendants charged and arrested for federal offenses related to UI fraud.

The government has also prosecuted or secured civil injunctions against dozens of defendants who sold products such as fake vitamin supplements and silver ointments, making false claims about the products' abilities to prevent or treat COVID-19 infections.

On May 26, 2021, Rich Mendez of *CNBS.com* reported that the DOJ had charged 14 people — including a medical doctor and owners of laboratories, pharmacies and a home health agency — in multiple fraud schemes that allegedly bilked consumers and insurers out of $143 million.

In addition, the Center for Program Integrity at CMS announced it took administrative action against more than 50 medical providers for their involvement in health-care fraud schemes relating to Covid-19.

The law enforcement actions involved the Justice Department's criminal division, the FBI, seven U.S. attorney's offices in six states, as well as the HHS inspector general's office and other agencies.

Billing for Novavax

The AMA has created unique CPT codes for the Novavax COVID-19 vaccine and its administration.

The vaccine from Novavax Inc. has yet to receive authorization for use in the US by the FDA. The vaccine called NVX-CoV2373 is currently undergoing two Phase 3 clinical trials, one of which recently expanded to include pediatric patients.

- **91304:** Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine
- **0041A**: Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (corona-virus disease [COVID-19]) vaccine, first dose
- **0042A:** Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (corona-virus disease [COVID-19]) vaccine, second dose

Adding House Calls to Your Practice

As payment rates for house calls increase, technology improves, and the population ages, interest in home-based primary care is growing.

Under Medicare rules, house call patients are *not* required to meet the homebound definition required for receiving skilled nursing and therapy services in the home.

And as of January 2019, Medicare no longer requires documentation of medical necessity for every home visit, describing why a house call was needed in "lieu of an office visit."

In the May/June 2021 issue of *Family Practice Management,* Thomas Cornwell, MD, and Brianna Plencner, CPC, write that the best candidates are patients with complex or high-risk conditions who have difficulty getting to the office, as well as:

- Frail older adults with multiple (often five or more) chronic conditions and deficiencies in activities of daily living (ADL).
- Younger homebound patients, usually with one principal neuromuscular condition such as multiple sclerosis, amyotrophic lateral sclerosis, or cervical spine injuries (some on ventilators).
- Patients with high-risk diagnoses like congestive heart failure and chronic obstructive pulmonary disease.
- Patients with high hospital and emergency department (ED) utilization in the past six to 12 months.

Here are four tips for getting started with home visits.

1. **Set geographical limits** -- A geographic radius should be determined for home visits based on driving time (e.g., no more than 20 minutes from the physician's office or home).

   For more distant patients, telehealth may be the better option for providing care, at least while it is allowed under the public health emergency.

   If you also offer house calls to patients in domiciliary settings (e.g., assisted living facilities or group homes), you can realize economies of scale by seeing multiple patients in the same location on the same day.

2. **Follow scheduling best practices** -- Efficient scheduling is critical, and can be achieved through the following steps:
   - Start with a half day or one full day of house calls per week. Then increase that time as volume demands.
   - Schedule patients in close proximity by assigning days to specific geographic areas and using mapping/routing software.
   - Call when enroute to the visit so the patient is ready.
   - Have staff record special instructions on the schedule (e.g., "enter through side door").

3. **Complete certain tasks before the visit** -- Make sure that clerical tasks are done by staff ahead of time, including obtaining signed forms and medical records (e.g., HIPAA forms, consent for treatment, or medical history forms) when possible.

   Also, review charts before the home visit to see if fasting blood work or any unique supplies, such as injections or immunizations, are needed. It's also a good idea to review charts for complex, new, and transitional care management patients ahead of the visit and start pre-charting.

4. **Have your black bag ready to go** -- Unlike in the office, you cannot walk down the hall to a supply closet if you run out of something during a home visit. Have your "black bag" stocked and ready.

Detecting and Diagnosing Cognitive Impairment

Medicare covers a separate visit for a cognitive assessment so providers can more thoroughly evaluate cognitive function and help with care planning explains the staff at Healthcentric Advisors in *QPP Quick Bits*, May 18, 2021.

Detecting cognitive impairment is a required element of Medicare's Annual Wellness Visit (AWV). Providers can also detect cognitive impairment as part of a routine visit through direct observation or by considering information from the patient, family, friends, caregivers, and others.

If a patient shows signs of cognitive impairment at an Annual Wellness Visit or other routine visit, the provider may perform a more detailed cognitive assessment and develop a care plan.

Details on Medicare coverage requirements and proper billing can be viewed at: https://www.cms.gov/cognitive.

99483: Cognitive Assessment & Care Plan Services

- Replaces HCPCS code G0505
- If cognitive impairment is detected during the AWV or other routine visit, a more detailed cognitive assessment and care plan can be performed.
- Typically start with a 50-minute face-to-face visit.
- Assessment of and care planning for patients with cognitive impairment like dementia, including Alzheimer's disease, at any stage of impairment.
- Any clinician eligible to report E/M services can offer this service.
- Can be billed separately from the AWV.

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

Elements of a Cognitive Assessment

Spend 50 minutes face-to-face with the patient and independent historian to perform the following elements during the cognitive assessment;

- ❖ Examine the patient with a focus on observing cognition;
- ❖ Record and review the patient's history, reports, and records;
- ❖ Conduct a functional assessment of Basic and Instrumental Activities of Daily Living, including decision-making capacity;
- ❖ Use standardized instruments for staging of dementia like the Functional Assessment Staging Test (FAST) and Clinical Dementia Rating (CDR);
- ❖ Reconcile and review for high-risk medications, if applicable;
- ❖ Use standardized screening instruments to evaluate for neuropsychiatric and behavioral symptoms, including depression and anxiety;
- ❖ Conduct a safety evaluation for home and motor vehicle operation;
- ❖ Identify social supports including how much caregivers know and are willing to provide care; and
- ❖ Address Advance Care Planning and any palliative care needs.

MIPS UPDATE

2021 MIPS Promoting Interoperability Hardship Exception and Extreme and Uncontrollable Circumstances Exceptions Are Now Open

Applications are now open for the MIPS Promoting Interoperability Performance Category Hardship Exception and Extreme and Uncontrollable Circumstances Exception for the 2021 performance year. Those interested must submit their applications to CMS by December 31, 2021.

Applications can be downloaded or completed on the QPP website: https://qpp.cms.gov

MIPS Tips for Small Specialty Practices

HSAG has released new MIPS Tips, adding Mental/ Behavioral Health, Dermatology, and Chiropractic Medicine, to its list, which already includes:

Cardiology	Chiropractic Medicine
Dermatology	Endocrinology
Family Medicine	Gastroenterology
Nephrology	Ophthalmology
Pulmonology	Rheumatology

Skilled Nursing Facility

Visit the HSAG QPP Tools and Resources webpage to download these tips and share with your MIPS reporting team. They are located under "MIPS Tips for Small Specialty Practices."
https://www.hsag.com/en/quality-payment-program/tools-and-resources/#MIPS_Tips_for_Small_Specialty_Practices

If you would like a Specialty MIPS Tip resource created for your specialty, please let them know via email at: HSAGQPPSupport@hsag.com.

2020 MIPS Cost Performance Category

CMS is reweighting the cost performance category from 15% to 0% for the 2020 performance period. The 15% cost performance category weight will be redistributed to other performance categories in accordance with §414.1380(c)(2)(ii)(D). 2020 Final scores will be out in July 2021.

Analysis of the underlying data for the 2020 performance year, in comparison to prior years' data, shows that the volume of data available to calculate the scores for the cost measures has significantly decreased overall.

As a result, CMS does not believe it can reliably calculate scores for the cost measures that would adequately capture and reflect the performance of MIPS eligible clinicians.

Clinicians do not need to take any action as a result of this decision because the cost performance category relies on administrative claims data.

2021 MIPS Promoting Interoperability

Objectives and Measures for 2021 reporting:

Objectives	Measures
e-Prescribing	e-Prescribing
	Bonus: Query of Prescription Drug Monitoring Program
Health Information Exchange	*Complete A and B or C:* A: Support Electronic Referral Loops by Sending Health Information
	B: Support Electronic Referral Loops by Receiving and Reconciling Health Information
	C: Health Information Exchange Bi-Directional Exchange
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information
Public Health and Clinical Data Exchange	*Choose two of the following:* Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Syndromic Surveillance Reporting

MEDICARE NEWS

Signature Requirements

Documentation must meet Medicare's signature requirements. Medicare claim reviewers look for signed and dated medical documentation meeting Medicare signature requirements. If entries aren't signed and dated, they may deny the associated claims.

Even if a scribe dictates the entry on the provider's behalf, the provider must sign the entry to effectively authenticate the document and the care provided or ordered. It's unnecessary to document who transcribed the entry.

If a provider relies on a medical student's documentation, it's unnecessary to redocument the E/M service, but the provider must review and verify (sign and date) the student's medical record entry.

The medical review guidelines for using an electronic signature are:

- Systems and software products must include protections against modifications and should apply administrative safeguards that meet all standards and laws.
- The individual's name on the alternate signature method and the provider accept responsibility for the authenticity of attested information.
- Part B medications, other than controlled substances, should be ordered through a qualified e-prescribing system.

Providers should check with their attorneys and malpractice insurers before using alternative signature methods.

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