AQREVA Medical Billing & Consulting

Client Memo March 2021

"All human wisdom is summed up in two words: wait and hope." -- Alexandre Dumas

NEWS Update

MIPS 2020 Data Submission Deadline is March 31, 2021

The data submission period for MIPS eligible clinicians who participated in the 2020 performance year of the Quality Payment Program ends at 8:00 p.m. EDT on March 31, 2021.

How to Submit Your 2020 MIPS Data
Clinicians will follow the steps outlined below to submit their data:

1. Go to the Quality Payment Program website: https:/qpp.cms.gov
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 In to the Quality Payment Program Data Submission System

To sign in and submit data, clinicians will need to register in the HCQIS Authorization Roles and Profile (HARP) system. For clinicians who need help enrolling with HARP, please refer to the QPP Access User Guide.

CMS Applying MIPS Extreme and Uncontrollable Circumstances Policy to all MIPS Eligible Clinicians

CMS is applying the MIPS automatic extreme and uncontrollable circumstances (EUC) policy to all MIPS eligible clinicians for the 2020 performance period. CMS is also reopening the MIPS EUC application for individual MIPS eligible clinicians, groups, virtual groups, and Alternative Payment Model (APM) Entities through March 31, 2021 at 8 p.m. ET.

Please note that applications received between now and March 31, 2021 won't override previously submitted data for individuals, groups and virtual groups.

Individual clinicians, groups, and virtual groups that haven't submitted data.

- Individual MIPS eligible clinicians don't need to take any additional action to qualify for the automatic EUC policy. They will be automatically identified and will receive a neutral payment adjustment for the 2022 MIPS payment year unless:
  a) they submit data as an individual in 2 or more performance categories, or
  b) the practice reports as a group, by submitting data for one or more performance category.
- Groups don't need to take any further action if they're not able to submit data for the 2020 performance period. Group participation is optional, and your individual MIPS eligible clinicians qualify for the automatic EUC policy. They will have all 4 performance categories reweighted to 0% and receive a neutral payment adjustment for the 2022 MIPS payment year unless:
  a) they submit data in 2 or more performance categories as individuals, or
  b) the practice reports as a group, by submitting data for one or more performance category.
- Virtual Groups: If unable to submit data for the 2020 performance period, they must submit an EUC application for all 4 performance categories by the deadline.

Individual clinicians, groups, and virtual groups that have submitted data.

- Individual MIPS eligible clinicians that have submitted data for a single performance category (such as Medicare Part B Claims measures submitted throughout the 2020 performance period):
  a) don't need to take any additional action to be eligible for the automatic EUC policy.
     i. will be automatically identified and have all 4 performance categories reweighted to 0% and will receive a neutral payment adjustment for the 2022 MIPS payment year unless data

is submitted for another performance category (i.e. Improvement Activity) or

ii. the group submits data for one or more performance category.

- Individual MIPS eligible clinicians that have submitted data as an individual for 2 or 3 performance categories:
  a) will receive a MIPS final score and MIPS payment adjustment for the 2022 MIPS payment year based on the data submitted;
  b) will only be scored in the performance categories for which data is submitted;
  c) can't submit an application to override previously submitted data.

For more information on other designations, please go to the Quality Payment Program COVID-19 Response webpage on the QPP website. (https://qpp.cms.gov).

For the 2021 performance year, CMS will continue to use the Extreme and Uncontrollable Circumstances policy to allow clinicians, groups, and virtual groups to submit an application requesting reweighting of one or MIPS performance categories due to the COVID-19 public health emergency. The application should be available in Spring 2021 along with additional resources.

Complex Patient Bonus

For the 2020 performance period only: CMS will double the complex patient bonus so that clinicians, groups and APM entities can earn up to 10 bonus points (instead of 5 bonus points) to account for the additional complexity of treating their patient population due to COVID-19.

For 2021 reporting period, the Complex Patient Bonus will revert back to 5 bonus points.

Conducting a Security Risk Analysis

To comply with HIPAA, and to successfully attest to the government's requirements for meaningful use of EHRs, please don't forget that medical practices must conduct a security risk analysis and attest that they have done so when submitting MIPS data.

This means that practices must conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of their electronic protected health information (ePHI), according to the HIPAA Security Rule

2021 MIPS Keys to Success

Telligen offers the following tips for MIPS 2021 reporting:

Start Now!
With the performance threshold increase to 60 points, you have to plan now to avoid the negative 9% payment adjustment in 2023.

Quality
Maximize your quality score by performing 6 or more measures for the full year.

Promoting Interoperability
Know the measures. For 2021there is a new optional HIE Bi-Directional Exchange Measure. If you are not able to perform the measures or do not have an EHR, you can apply for a PI Hardship Exception in the summer of 2021.

Improvement Activities
Make sure at least 50% of your group completes the activities you plan to report.

Cost
Familiarize yourself with the measures to see if they apply to your practice. Review cost scores from past years to see if there is room for improvement.

Payment Adjustments (for 2023 Payments)
Earn 60 points to avoid a negative payment adjustment of up to 9%. Earn 85 points to receive an exceptional Performer bonus.

Bonuses
The small practice bonus is calculated as part of the quality score. You must submit at least one quality measure to receive the 6-point bonus.

Telligen provides free services to solo and small physician offices in Iowa, Nebraska, North Dakota, and South Dakota to help them understand and succeed in the CMS Quality Payment Program (QPP), established by MACRA. Telligen will help providers stay informed about the Quality Payment Program. Please visit their website for assistance: https://telligenqpp.com.

2021 Physician Fee Schedule: 3 Things to Do Now

The new CMS 2021 Physician Fee Schedule (PFS) went into effect on January 1, 2021. Most of the final rule consists of expected policy refinements, but the regulations do include some significant changes that will impact medical practice productivity, strategy and revenue.

In the February 23, 2021, issue of *Health IT Answers*, Lucy Zielinski writes that medical practice leaders should focus on three immediate priorities to take full advantage of the new fee schedule.

Evaluate How the New Conversion Factor Will Impact Revenue

The new PFS has cut the payment conversion factor from $36.09 to $34.89, a decrease of more than 3%. However, CMS has also increased relative value units (RVUs) for several E/M codes. For example, the most utilized code for established patients is 99213. Under the new fee schedule, work RVUs for this code have increased by 34% and payment has increased by approximately 23%.

Here is a snapshot of some important E/M code changes and what they mean for physician payments.

CPT	2020 RVUs	2021 RVUs	2020 Pymt	2021 Pymt	Difference
99202	.93	.93	77.23	74.32	-4%
99203	1.42	1.60	109.35	114.44	5%
99204	2.43	2.60	167.09	172.01	3%
99205	3.17	3.50	211.12	227.13	8%
99211	.18	.18	23.46	23.73	1%
99212	.48	.70	46.19	58.27	26%
99213	.97	1.30	76.15	93.51	23%
99214	1.50	1.92	110.43	132.93	20%
99215	2.11	2.80	148.33	185.96	25%

How will these changes affect practice revenue? It all depends on your practice's service mix, service utilization and payer contracts. To assess the revenue impact for your practice:

- Identify your practice's 2020 unit volume by CPT code;
- Use the 2020 PFS to establish your baseline revenue;
- Run the same calculation using 2021 work RVUs and the updated conversion factor.

Once you have determined how the new PFS will affect gross practice revenue, calculate the impact on your operating margin.

Take Advantage of Relaxed Requirements for E/M Visits

In addition to increasing payment for many E/M codes, CMS has also relaxed documentation requirements for these visits.

Starting in 2021, history and physical documentation has been eliminated for code selection purposes. Physicians can now document E/M codes based on either MDM or time. The goal of all these changes is to reduce administrative burden by simplifying code selection so it is more clinically relevant and intuitive.

Build Your Practice's Telehealth Capabilities

As everyone knows, telehealth utilization exploded during COVID-19. Before the pandemic, only about 15,000 Medicare fee-for-service beneficiaries received a telemedicine service in any given week. During the height of the pandemic, that weekly average increased to more than 800,000 beneficiaries.

The 2021 PFS reflects this new reality. The list of covered telehealth services now includes nearly 250 codes, including codes for home visits and psychological and neuropsychological testing. Note that about 35% of these covered codes allow for audio-only services.

Right now, physicians and practice leaders should examine ways to expand their telehealth program:

- New telehealth services: annual wellness visits, depression screening, counseling/coordination of care, review test results with patients and manage their prescriptions.
- Chronic care check-ins: Telehealth provides the opportunity to meet more frequently with chronic care patients.
- Remote monitoring services: consider partnering with a home health agency to provide remote monitoring for homebound patients. This is a strong opportunity to improve your care of older patients while building practice revenue.

More Practical Strategies

The 2021 Physician Fee Schedule contains important opportunities to increase practice revenue, simplify provider documentation and improve patient care.

New ICD-10 Codes for COVID-19 – Staff, *AAP News*, January 13, 2021

ICD-10-CM broke from the usual release schedule and implemented the following six new codes related to COVID-19 on January 1, 2021, and issued accompanying guidelines.

Z20.822 Contact with and (suspected) exposure to COVID-19

- For asymptomatic individuals with actual or suspected exposure to COVID-19, assign code Z20.822. For symptomatic individuals with actual or suspected exposure to COVID-19 and the infection has been ruled out, or test results are inconclusive or unknown, assign code Z20.822.
- If a patient with signs/symptoms associated with COVID-19 also has an actual or suspected contact with or exposure to COVID-19, assign Z20.822 as an additional code.

Z20.822 replaces code Z20.828 for 2021.

Z11.52 Encounter for screening for COVID-19
During the COVID-19 pandemic, a screening code generally is not appropriate. Do not assign code Z11.52. For encounters for COVID-19 testing, including pre-operative testing, code as exposure to COVID-19. Coding guidance will be updated as new information concerning changes in the pandemic status becomes available.

Z86.16 Personal history of COVID-19
For patients with a history of COVID-19, assign code Z86.16.

M35.81 Multisystem inflammatory syndrome (MIS)

- For individuals with MIS and COVID-19, assign code U07.1 for COVID-19, as the principal/first-listed diagnosis, and assign code M35.81 as an additional diagnosis.
- If MIS develops as a result of a previous COVID-19 infection, assign codes M35.81 and B94.8, sequelae of other specified infectious and parasitic diseases.
- If an individual with a history of COVID-19 develops MIS and the provider does not indicate that MIS is due to the previous COVID-19 infection, assign codes M35.81 and Z86.16.
- If an individual with a known or suspected exposure to COVID-19 and no current COVID-19 infection or history of COVID-19 develops MIS, assign codes M35.81 and Z20.822.
- Assign additional codes for any associated complications of MIS.

M35.89 Other specified systemic involvement of connective tissue
No guidance was created as this code had to be developed to stay within the coding conventions of an "other" code under M35.8-.

J12.82 Pneumonia due to coronavirus disease 2019
For a patient with pneumonia confirmed as due to COVID-19, assign codes U07.1 and J12.82.

Coding COVID-19 Vaccines – Erica Remer, MD, CCDS, *ICD 10 Monitor*, March 1, 2021

Vaccines are being federally purchased at this time, so there is no charge or reimbursement for them. Medicare patients are not billed for any charges, such as co-payments, coinsurance, or deductibles. It is also stipulated that people without health insurance or whose insurance does not provide coverage for vaccination administration can get a COVID-19 vaccine at no cost. Reimbursement can be requested through the Provider Relief Fund at https://www.hrsa.gov/CovidUninsuredClaim

The Medicare payment rates for COVID-19 vaccine administration are $28.39 for single-dose vaccines and $16.94 for the first shot and $28.39 for the second or final dose for multiple-dose regimens. Other insurers are either reimbursing at contracted or Medicare rates.

There is only one ICD-10-CM code being utilized: Z23.

The ICD-10-CM code indicates that a vaccination was given; the CPT code(s) indicate which vaccine it was.

The two-dose COVID-19 vaccines that we currently have available to use under EUA (Emergency Use Authorization) are made by Pfizer and Moderna. Billing for vaccine administration requires two CPT codes – one to identify the manufacturer, and one to signify which dose it was.

- Pfizer: 91300. First dose: 0001A; second dose: 0002A.
- Moderna: 91301. First dose: 0011A; second dose: 0012A

There are codes queued up for AstaZeneca and Johnson & Johnson vaccines as well (See: List of COVID-19 vaccines and monoclonal antibody codes and payment allowances:

https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonal-antibodies

Prolonged Services in 2021

The AMA developed CPT® code **99417** for 15 minutes of prolonged care, done on the same day as office/outpatient codes 99205 and 99215.

Medicare developed HCPCS code **G2212** to use instead of 99417.

If using either code, only report it with codes 99205 and 99215, use only clinician time, and use it only when time is used to select the code, states coding expert, Betsy Nicoletti in her January 21, 2021, article for *Coding Intel.*

There are changes to the rules for use of existing codes 99354, 99355 (face-to-face prolonged care) and codes 99358, 99359 (non-face-to-face prolonged care).

In the 2021 Physician Fee Schedule Final Rule, CMS indicated its agreement with the new E/M definitions for codes 99202—99215 that were developed by the AMA and are in the 2021 CPT® book.

CMS and the AMA, however, are not in agreement about the use of prolonged care code 99417, resulting in a new HCPCS code G2212.

New prolonged care code 99417

CPT® developed a prolonged care code, which is in the 2021 CPT®, for each additional 15 minutes of time spent on the calendar day of service. This prolonged services code is used to report total time, both with and without direct patient contact, after the time threshold for 99205 or 99215 is met.

If time is spent performing other services identified by a CPT® code, do not include that time in the office visit or prolonged care service. The total time of 15 minutes must be met to report 99417, not the midpoint time.

This new add-on prolonged services code may only be used with 99205 and 99215.

CMS developed its own code G2212

G2212 Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified health-care professional, with or without direct patient contact (List separately in addition to CPT® codes 99205, 99215 for office or other outpatient evaluation and management services)

Non-face-to-face prolonged care codes 99358, 99359

The non-face-to-face prolonged care codes are still active, billable codes. But, they may not be reported on the same date of service as 99202—99215. If non-face-to-face prolonged care is performed by the billing practitioner on the day of an office/outpatient visit, include that in the total time for the day

Face-to-face prolonged care codes 99354, 99355

These are still active, billable codes, but they may not be reported with codes 99202–99215. They may be reported for prolonged care services with psychotherapy codes 90837, 90847, with office consultation codes 99241—99245, with domiciliary care codes 99324—99337, with home visit codes 99341—99350, and with cognitive assessment code 99483.

Employment Law Developments That Will Impact the Health Care Industry

The impact of COVID-19 on the health care industry can hardly be overstated. Numerous important employment law developments occurred in 2020 related to COVID-19 that impacted the industry. Excerpts from the February 15, 2021, *National Law Review, K&L Gates HUB* article by Gregory Lewis, Erinn Rigney, Meghan Meade et al. provide an overview of some of these key legal issues and sets forth several recommendations for health care industry employers on proactive steps to reduce employment law-related legal risks.

EEOC GUIDANCE ON MANDATORY COVID-19 VACCINATION

On December 16, 2020, the Equal Employment Opportunity Commission (EEOC) updated its guidance on COVID-19 vaccination requirements and employee rights under the Americans with Disabilities Act (ADA), Title VII of the Civil Rights Act of 1964 (Title VII), and the Genetic Information Nondiscrimination Act.

The ADA permits employers to implement a qualification standard, such as a vaccination requirement, that includes "a requirement that an individual shall not pose a direct threat to the health or safety of individuals in the workplace."

To determine whether a direct threat exists, employers should conduct an individualized assessment of the following four factors:

i. the duration of the risk,
ii. the nature and severity of the potential harm,

iii. the likelihood that the potential harm will occur, and
iv. the imminence of the potential harm.

If the employer determines that an unvaccinated employee poses a direct threat, he or she must evaluate whether a reasonable accommodation can be provided, absent undue hardship, that would eliminate or reduce this risk. If such accommodation cannot be made, the employee can be excluded, but before any adverse action, such as termination, is taken, the employer should evaluate whether the employee has any other rights under federal, state, or local laws and should consult with counsel.

As under the ADA, if an employee is unable to receive a vaccination for COVID-19 because of sincerely held religious belief, practice, or observance, and there is no feasible reasonable accommodation available, then an employer may lawfully exclude the employee from the physical workplace. Employers should not take any other adverse actions until they have assessed whether an employee has rights under other applicable federal, state, or local laws.

POST-VACCINATION CONSIDERATIONS

The CDC details the difference in post-vaccine symptoms and symptoms of COVID-19, so that health care facilities can distinguish between the two, and has designed strategies to limit unnecessary work restrictions on health care personnel who present symptoms after receiving a COVID-19 vaccine.

Employees demonstrating symptoms that may result either from a COVID-19 vaccination or from a COVID-19 infection—such as fatigue, headache, and chills—should be medically evaluated. They may return to work without testing if they feel well, do not have a fever, and do not have any other symptoms of COVID-19 not associated with post-vaccination symptoms, including cough, shortness of breath, sore throat, or change in smell or taste.

FAMILY MEMBER ALLEGATIONS OF TRANSMISSION BY EMPLOYEES

Family members of workers who have contracted COVID-19 have begun to pursue legal actions to hold employers liable based on the theory that their exposure to COVID-19 was a result of failure to provide a safe workplace to an employee family member.

Given the ease with which COVID-19 can be transmitted, proving causation will be a significant hurdle for individuals attempting to pursue such claims. Nevertheless, health care employers, having faced a substantial number of COVID-19-related claims to date, can expect to see a disproportionate number of family member claims as well.

MEDICARE NEWS

Doctors and Clinicians: Don't forget to preview your performance information

CMS opened the Doctors and Clinicians Preview Period on January 25, 2021. The Preview Period provides an opportunity for doctors and clinicians to review their 2019 Quality Payment Program (QPP) performance information before it is publicly reported on clinician and group profile pages on Medicare Care Compare and in the Provider Data Catalog (PDC).

You can access the secured review through the QPP website. https://qpp.cms.gov

Accountable Care Organizations (ACOs) can preview their performance information via their 2019 MIPS Performance Feedback Reports. A list of ACO performance information targeted for public reporting is available on the Care Compare: Doctors and Clinicians Initiative page.

THE PREVIEW PERIOD WILL CLOSE ON MARCH 25, 2021.

If you have any questions about public reporting for doctors and clinicians or the Preview Period, please send an email to QPP@cms.hhs.gov.

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