AQREVA Medical Billing & Consulting

Client Memo May 2021

"However long the night, the dawn will break."
-- African Proverb

NEWS Update

Medicare Sequestration Cuts Delayed

The Medicare 2% sequester cuts have been suspended until December 31, 2021. CMS will release all claims held since the start of April.

The April 16, 2021, announcement via the *MLN Connects* newsletter, stated that the 2% Medicare sequestration cuts would not be applied to Medicare fee-for-service payments for the rest of 2021 because of the ongoing public health emergency.

The law, signed by President Biden on April 15th, extended the suspension of the 2% cut from April 1, 2021, to December 31, 2021.

CMS is now releasing claims held since the beginning of April while Congress debated and then passed the legislation. Medicare contractors have been instructed to release claims held from the beginning of April and to reprocess any that were already paid with the 2% reduction.

PHE Extended Another 90 Days

The current COVID-19 public health emergency was extended for another 90 day period on April 15, 2021. The PHE will now be set to expire on July 20, 2021.

Terry Fletcher, writing for *RAC Monitor*, states in his April 19, 2021, article that the Biden Administration has indicated that the PHE will likely remain in place throughout 2021 States will receive 60 days' notice before the end of the PHE to prepare for the end of the emergency authorities and the resumption of pre-PHE rules.

To continue to monitor the PHE status, providers can go online to this link and review the U.S. Department of Health and Human Services (HHS) current policy:

https://www.phe.gov/emergency/news/healthactions/phe/Pages/COVID-15April2021.aspx

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 4/19/2021

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

What Lies Ahead for Telehealth Payments?

When President Trump declared COVID-19 a public health emergency, Congress and CMS responded by making it easier for doctors to use telehealth (telephone, video, and online communications) to treat Medicare patients, and paying them more to do so, explains Jeffrey Bendix in his April 2021 article for *Medical Economics*.

The immediate goal of these changes was to reduce the need for face-to-face visits during the pandemic. But many primary care advocates believe the resulting spike in telehealth use has provided a glimpse into the technology's potential to expand and transform primary care delivery in the U.S. But for that to happen, they say, the changes put in place at the start of the PHE must become permanent.

While it's still too early to know if that will happen, MedPAC, the commission that advises Congress on Medicare payment issues, believes the idea is at least worth

exploring. In its most recent report, issued in mid-March, MedPAC recommends continuing several of the policies instituted under the PHE for a year or two so as to obtain more evidence regarding telehealth's impact on care access, quality, and cost.

The commission's specific recommendations for this time period include:

- allowing Medicare to pay for certain telehealth services regardless of the patient's location at the time of the visit;
- adding some telehealth services to the list of those Medicare covered before the PHE, provided they have potential for clinical benefit; and
- allowing Medicare to cover certain services provided via audio-only (as opposed to audio-visual) E/M visits with established patients if there is potential for clinical benefit.

To reduce the possibility of unnecessary spending and protect against fraud, the report also recommends:

- closely studying the claims of doctors who bill many more telehealth services per patient than similar clinicians;
- requiring clinicians to hold an in-person visit before ordering high-cost durable medical equipment or expensive laboratory tests for a patient; and
- prohibiting "incident to" billing for telehealth services from any clinician who can bill Medicare directly.

The full report is available at http://www.medpac.gov.

AMA Lobbies CMS to Extend Medicare Coverage for Audio-Only Telehealth

The AMA has sent a letter urging CMS to permanently extend Medicare coverage for audio-only telehealth services, writes Eric Wicklund in his April 7, 2021, article for *mHealth Intelligence.com.*

Separately, CMS is being urged to include virtual care in the Medicare Diabetes Prevention Program.

AMA Executive Vice President and CEO James Madara, MD, urged the agency to continue coverage for phone calls beyond the public health emergency caused by the coronavirus pandemic.

CMS and many states have allowed that coverage during the PHE to boost access to care at a time when providers are looking to replace in-person visits with virtual visits.

For the duration of the PHE, Medicare coverage is based on CPT codes **99441-99443** and HCPCS code **G2252**.

Connected health advocates say the audio-only telehealth platform, such as a phone or laptop connection, may be the only means of access to healthcare for people in remote areas where broadband connectivity is limited and those with limited resources who can't afford audio-visual telemedicine tools.

Federal officials are also being pressed to include coverage for telehealth services in the Medicare Diabetes Prevention Program.

More than 20 organizations, including the American Telemedicine Association, Blue Cross Blue Shield Association, eHealth Initiative, National Kidney Foundation and Diabetes Leadership Council, have signed a letter asking Health and Human Services Secretary Xavier Becerra to extend Medicare coverage for virtual visits during the PHE and "work on longer-term reforms" that would make connected health a permanent part of the program.

Arriving Soon: Post-COVID Code U09.9

ICD-10 officials announced that providers could get a new diagnosis code this Fall to report their post COVID-19 cases **when the patient continues to have lingering symptoms after the infection is gone**, writes Laura Evans for the March 11, 2021, issue of *Decision Health*.

The World Health Organization added a new ICD-10 diagnosis code category, U09 (Post COVID-19 condition) and, within it, a new code, U09.9 (Post COVID-19 condition, unspecified). The new code is expected to be implemented for use in the U.S. on October 1, 2021, stated officials with the ICD-10-CM Coordination and Maintenance Committee during a March 10 meeting.

While details for the proposed code still must be ironed out before it is finalized, code U09.9 could be reported secondary to specific condition codes, such as chronic respiratory failure (J96.1-), loss of smell (R43.8) or loss of taste (R43.8), according to the proposal.

The expected implementation date for U09.9 is October 1, 2021.

Patients Can Read Your Notes

April 5, 2021 was the official start of a US law requiring healthcare organizations to provide patients with free, full, and immediate electronic access to their doctor's clinical notes as well as test results and reports from pathology and imaging.

The mandate, called "open notes" by many, is part of the 21st Century Cures Act, a wide-ranging piece of federal healthcare legislation.

Organizations must provide access via patient portals to the following types of notes: consultations, discharge summaries, histories, physical examination findings, imaging narratives, laboratory and pathology report narratives, and procedure and progress notes. Non-compliant organizations will eventually be subject to fines from the US Department of Health and Human Services for "information blocking."

Excerpts from Nick Mulcahy's April 1, 2021 article for *Medscape Medical News* offer a few key points for clinicians to consider:

- **Clinicians Don't Have to Change Writing Style**. The new law mandates timely patient access to notes and test results, but doesn't require that clinicians alter their writing. Everyday experience should guide clinicians when writing notes, says one expert.

- **Some Clinical Notes Can Be Withheld.** The new rules from the federal government permit information blocking if there is clear evidence that doing so "...will substantially reduce the risk of harm" to patients or to other third parties, wrote Tom Delbanco, MD, and Charlotte Blease, PhD, of OpenNotes, a Boston-based advocacy and research organization, in a *Medscape* commentary in February.

  The OpenNotes organization also points out that, with regard to sensitive psychotherapy notes that are separated from the rest of a medical record, those notes can be kept from patients without their permission, and such rules vary state by state.

- **Some Patients Are More Likely Readers**. Some patients are more likely to peer into their files than other, says Liz Salmi, senior strategist at OpenNotes, who is also a brain cancer patient. "Those patients who have more serious or chronic conditions...are more likely to read their notes," she commented to *Medscape Medical News*.

- **The Start Day Will Come and You Won't Notice**. Dr. Scott MacDonald, an internist and EHR medical director at UC Davis Health in Sacramento, California, suggested that open notes are both new and not new. Last fall, he predicted that the launch day would come and few clinicians would notice, in part because many patients already access truncated information via patient portals.

Do Not Charge, Balance Bill Patients for COVID-19 Vaccines – Jacqueline LaPointe, *RevCycle Intelligence*, April 19, 2021

HHS OIG released a message to healthcare providers after receiving complaints from patients that they are being charged by providers for COVID-19 vaccines.

Healthcare providers should not charge or balance bill patients for getting the COVID-19 vaccine, the Office of Inspector General (OIG) at HHS recently warned.

In an April 15th message, the federal watchdog reminded vaccine providers that vaccines being provided by the federal government to providers must be administered at no cost to patients per the CDC's COVID-19 Vaccination Program.

Currently, all COVID vaccines in the US have been purchased by the US government for administration exclusively by providers enrolled in the COVID-19 Vaccination Program, the CDC states on its website at the time of this article's publication.

The program stipulates that all participating organizations and providers must administer the vaccines with no out-of-pocket cost to recipients. This includes fees for office visits or other charges if the COVID-19 vaccination is the sole medical service provided.

Additionally, providers may not seek any reimbursement from patients for the vaccination through balance billing.

Provider compliance with the program also includes not denying anyone vaccination based on insurance or network status and not requiring additional medical services at the time of vaccination.

However, OIG stated in its latest message on the program and provider compliance that it is aware of complaints filed by patients about charges by providers when getting their COVID-19 vaccines.

"Providers that charge impermissible fees must refund them and ensure that individuals are not charged fees for

the COVID-19 vaccine or vaccine administration in the future," the watchdog wrote in the message.

While vaccine providers cannot charge or seek reimbursement from patients for the vaccines, they can bill third-party payers for an administration fee, depending on the payer's applicable medical billing rules. That includes Medicare, Medicaid, the Health Resources and Services Administration's (HRSA's) COVID-19 Uninsured Program, and private payers, OIG stated.

CMS has released guidance about vaccine-related fees and provider charges.

The guidance states that Medicare does cover the COVID-19 vaccine and that providers cannot charge beneficiaries for an office visit or any other fee for the vaccination. It also advises beneficiaries who have been charged for vaccination to report the activity as suspicious and ask providers for a refund.

Several states are also reimbursing at similar rates for Medicaid beneficiaries who receive a vaccine.

Private payers that must comply with the Affordable Care Act are also required to cover the COVID-19 vaccine regardless of whether the vaccine provider is within the patient's network, according to the Coronavirus Aid Relief, and Economic Security (CARES) Act.

Reimbursement rates for administering a COVID-19 vaccine will vary from payer to payer.

Finally, vaccine providers administering doses to uninsured patients can submit claims to the HRSA's COVID-19 Uninsured Program, which will reimburse generally at the Medicare rate.

2021 Remote Patient Monitoring

Remote patient monitoring involves the collection and analysis of patient physiologic data used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition, explains Nathaniel Lacktman, Thomas Ferrante, and Rachel Goodman in their article for the December 7, 2020, issue of *Health Care Law Today*.

On December 1, 2020, CMS finalized new policies related to remote patient monitoring services reimbursed under the Medicare program. The changes, part of the 2021 Physician Fee Schedule Final Rule are intended to clarify CMS's position on how it interprets requirements for RPM services.

The five primary Medicare RPM codes are:
99091: collection and interpretation of physiologic data digitally stored and transmitted from the patient or caregiver to the physician or other qualified healthcare provider.
99453: initial set up and training provided to patients. The device used in the training and set up must be an FDA defined medical device
99454: the supply, provisioning, and monitoring of devices
99457: direct, monthly expense for a minimum 20 minutes time spent by clinical staff, a physician, or other qualified healthcare professional in communication with the patient or their caregiver.
99458: An add-on code, that can only be billed in conjunction with CPT code 99457. This allows for reimbursement for an additional 20 minutes of clinical staff time spent in communication with the patient or their caregiver.

Listed below are some of the most significant takeaways from the final rule:

- For CPT codes 99457 and 99458, an "interactive communication" is defined as a conversation occurring in real time that includes synchronous, two-way interactions that can be enhanced with video or other kinds of data.
- The 20 minutes of time associated with 99457 and 99458 "should include care management services and synchronous, real-time interactions."
- As part of 99454, devices must meet the definition of a medical device per the Food, Drug, and Cosmetic Act and electronically (i.e., automatically) collect and transmit a patient's physiologic data rather than permit patients to self-report or self-collect data.
- An established patient-physician relationship must exist for the furnishing of RPM services following the end of the COVID-19 public health emergency.
- CMS established a permanent policy that allows auxiliary personnel to furnish 99453 and 99454 services under a physician's supervision.
- With the final rule, CMS clarified that practitioners may furnish RPM services to patients with acute conditions as well as chronic conditions.

- 16 days of data for each 30- day period must be collected and transmitted to bill 99453 and 99454.

- CMS is now permitting providers to bill for "complex" RPM services when the provider must spend significant time managing the patient and their RPM care plan.

-- statnews.com

Going forward, we can expect new rules and revisions to existing rules on the federal and possibly state levels. Providers will benefit most from well-tailored RPM programs designed within the current requirements that also have the means to be flexible as requirements inevitably shift.

ABIM Broadens, Lengthens MOC Extension

Citing the ongoing COVID-19 pandemic, the ABIM says that all diplomates whose certificate expired in 2020 or 2021 will now have until the end of 2022 to fulfil the requirements for maintenance of certification.

Alicia Ault's article in the March 8, 2021 edition of *Medscape Medical News* points out that the ABIM last April extended MOC deadlines by a year for those with certificates expiring in 2020.

The decision to extend certification requirements was formed by the actual experience of a group of clinicians facing COVID in their day job and thinking empathetically and realistically about what's it like out there, ABIM Present and CEO Richard Baron MD told *Medscape Medical News.*

He noted that specialists in internal medicine , which encompasses infectious disease, critical care, and hospitalists among others, have been particularly stressed by the COVID-19 pandemic.

In 2020, 32,000 physicians had expiring certificates; about half took advantage of the extension, according to ABIM. Some 12,000 of the 20,000 diplomates whose certificates were expiring in 2021 had no other option except to take the 10-year exam in person.

Now those physicians can wait until 2022 and either take the one-time in-person exam or begin the new alternative longitudinal knowledge assessment program. Under that program, diplomates receive several questions a week that can be answered at any time on any device, as long as they meet a quarterly quota of responses.

The ABIM/ACC Collaborative Maintenance Pathway — offered to certain cardiology disciplines — will also be an option for 2020 and 2021 diplomates.

Clinicians who already registered for the 10-year exam in 2021 but want to cancel can do so, and the fee they paid will be banked and applied to the cost of any future exam or program.

The organization offered the main new certification exam in August, despite having earlier considered canceling because of COVID-related restrictions on capacity. About 8000 physicians took the test that month, and some 2500 more took advantage of bonus exam dates offered in December.

The initial certification exam will be offered again this August as usual, Dr Baron stated.

MEDICARE NEWS

Renee Dustman summarizes some of the latest Medicare developments in the April 13, 2021, issue of *AAPC.com.*

Do I have to repay the money I received from Medicare during the COVID-19 public health emergency?

Providers and suppliers who received COVID-19 Accelerated and Advance Payments (CAAPs) from the government must repay those funds. Repayment begins 1 year from the date you received your first CAAP. CMS will adjust your claims by 25 percent for the first 11 months and by 50 percent for the following six months. If you aren't paid up by then, your Medicare contractor will send you a demand letter for payment in full. You then have 30 days from the date the letter was issued (not received) to pay, or you will be charged 4 percent interest on the balance due. This interest rate is reassessed every month thereafter.

Recoupments will show on the remittance advice for Medicare Part A/B claims as an adjustment in the Provider-Level Balance section. For institutional providers, CMS will recoup payments from periodic interim payments. (MLN SE21004)

What is the limitation for subsequent nursing facility care services via telehealth?

The limitation for the patient's admitting physician or non-physician practitioner (NPP) has changed from one telehealth visit every 30 days to one every 14 days. This limitation does not apply to consulting physicians or practitioners. This edit applies to CPT® codes 99307, 99308, 99309, 99310 when billed with the applicable GT or GQ modifier or place of service code 02 on Medicare claims with dates of service on or after Jan. 1, 2021, that are processed on or after July 6, 2021. (MM12068 Revised)

The Hospice Care Index – Introducing a New Measure of Quality for Hospice Care

CMS is proud to introduce the Hospice Care Index (HCI) as a new proposed measure for the Hospice Quality Reporting Program. The HCI is intended to strengthen our quality reporting program, while also providing families and patients the information they need to decide which hospice care facility is right for them.

The HCI takes ten claims-based indicators into consideration. Collectively, the indicators represent different aspects of hospice care and aim to convey a comprehensive characterization of the quality of care furnished by a hospice care facility. To learn more about the background of the HCI, please watch this video:
https://youtu.be/by68E9E2cZc

This information can also be found on the Quality Measure Development webpage at:
https://www.cms.gov/medicare/hospice-quality-reporting-program/quality-measure-development

Other Medicare Screening Services

Alcohol Misuse: Medicare Covers Screening & Counseling

Medicare covers alcohol misuse screening and counseling (G0443) once per year for adults who use alcohol but don't meet dependency criteria. If you detect misuse, Medicare covers up to 4 brief face-to-face counseling sessions per year if the patient is alert and competent during counseling. Patients pay nothing if the provider accepts assignment. More Information is available at:

https://www.medicare.gov/coverage/alcohol-misuse-screenings-counseling

Screening, Brief Intervention, and Referral to Treatment Services - SBIRT

Screening, Brief Intervention, & Referral to Treatment (SBIRT) is an evidence-based approach to deliver early intervention and treatment services for persons with Substance Use Disorders (SUDs), and those at risk of developing a SUD. This approach differs from specialized treatment of individuals with more severe substance misuse or those who meet criteria for a substance use disorder.

There are 3 major components for SBIRT:

1. Screening
2. Brief Intervention
3. Referral to Treatment

SBIRT Codes & Descriptors

HCPCS Code G2011	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention, 5–14 minutes
HCPCS Code G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes
HCPCS Code G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and intervention, greater than 30 minutes

An informational booklet is available at:
https://www.cms.gov/Outreach-and-ducation/Medicare-Learning-Network-LN/MLNProducts/downloads/SBIRT_Factsheet_ICN904084.pdf

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