AQREVA Medical Billing & Consulting

Client Memo November 2021

"The hardest arithmetic to master is that which enables us to count our blessings." – Eric Hoffer

NEWS Update

National Public Health Emergency Extended Due to COVID-19

The U.S. Department of Health and Human Services has extended the COVID-19 national public health emergency by another 90 days. It was scheduled to end October 17, 2021, and now is scheduled to end on January 16, 2022.

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 10/18/21

The COVID-19 Public Health Emergency is now set to end January 16, 2022

All applicable waivers remain in place, writes Chuck Buck in his October 18, 2021, article for *ICD 10 Monitor.*

As expected, Xavier Becerra, the Secretary of the U.S. Department of Health and Human Services renewed the COVID-19 public health emergency, extending the many waivers that are in place until January 16, 2022.

This renewal was anticipated as the COVID-19 pandemic continues without an end in sight, with continued stress on healthcare workers, hospitals, nursing facilities, and other healthcare facilities around the country.

Payment Changes Coming Soon

Physicians are bracing for upcoming changes in reimbursement that may start within a few months. As doctors gear up for another wave of COVID, payment trends may not be the top priority, but some "uh oh" announcements this fall could have far-reaching implications that could affect your future, states Elizabeth Woodcock, MBA, CPC, in her article for *Medscape Medical News,* September 15, 2021.

Here's what could be in store:

1. The **Medicare Physician Fee Schedule** ruling confirmed a sweeping payment cut. The drive to maintain budget neutrality forced the federal agency to reduce Medicare payments, on average, by nearly 4%.
2. **Sequestration** will be back. Sequestration is the mandatory, pesky, negative 2% adjustment on all Medicare payments. It had been put on hold during the pandemic and is set to return at the beginning of 2022.
3. Down to a nail-biter: The final ruling is expected in early November. The situation smacks of earlier days when physicians clung to a precipice, waiting in anticipation for a legislative body to save them from the dreaded income plunge. Indeed, we are slipping back to the decade-long period when Congress kept coming to the rescue simply to maintain the status quo

Many anticipate a last-minute Congressional intervention to save the day, particularly in the midst of another COVID spike. The promises of a stable reimbursement system made possible by MACRA have been far from realized, and there are signs that the payment landscape is in the midst of a fundamental transformation.

Other changes proposed in the 1747-page ruling include:

- More telehealth services will be covered by Medicare, including home visits.

- Telemental health services got a big boost; many restrictions were removed so that now the patient's home is considered a permissible originating site. It also allows for audio-only (no visual required) encounters; the audio-only allowance will extend to opioid use disorder treatment services. Phone treatment is covered.
- Permanent adoption of **G2252**: The 11 to 20-minute virtual check-in code wasn't just a one-time payment but will be reimbursed in perpetuity.
- Boosts in reimbursement for chronic care and principal care management codes
- Physician assistants will be able to bill Medicare directly.
- A new approach to patient cost-sharing for colorectal cancer screenings will be phased in. This area has caused problems in the past when the physician identified a need for additional services (eg, polyp removal by a gastroenterologist during a routine colonoscopy).
- The proposed conversion factor for 2022 is $33.58, a 3.75% drop from the 2021 conversion factor of $34.89.

Almost half (47%) of medical groups and integrated health systems recently polled by AMGA said they would redesign physician compensation if the cuts totaling nearly 10% of Medicare payments to physicians are enacted on January 1st. Another 43% said they would put a freeze on hiring, reports Jacqueline LaPointe in her article "Physician Compensation, Staffing to Take Big Hit from 10% Medicare Cut," for *RevCycle Intelligence*, October 13, 2021.

Generally, the healthcare workforce would take the biggest hit from the cuts, which include:

- 4% statutory pay-as-you-go (PAYGO) cut,
- 2% cut for Medicare sequestration, and a
- 3.75% cut due to E&M policy changes

AMGA, along with other healthcare stakeholders and lawmakers, have been calling on the federal government to prevent the cuts from happening next year. Just recently, Representatives Ami Bera (D-CA) and Larry Bucshon (R-IN), who are both physicians, called on their colleagues to stop the scheduled Medicare Physician Fee Schedule cut, which was temporarily paused to support providers during the COVID-19 pandemic.

"As Congress considers a framework to ensure appropriate reimbursements and improve the Medicare payment system broadly, we must act before the end of the year to avert the imminent cuts and provide continued stability for physicians and other healthcare professionals," Bera and Bucshon wrote in a draft letter.

Long Haul' COVID-19 May Qualify as a Disability – Judith Retana, *WNCT9*, October 4, 2021

While thousands of people have recovered from COVID-19, some are testing negative but are not feeling any better.

It's a condition referred to as long COVID — those patients are considered "long haulers."

The Office for Civil Rights of the Department of Health and Human Services and the Civil Rights Division of the Department of Justice say these long haulers may be protected from discrimination under federal laws. HHS said long COVID is covered under the American Disability Act, Section 504, and Section 1557 "if it substantially limits one or more major life activities."

In their guidance, HHS said "A person with long COVID has a disability if the person's condition or any of its symptoms is a 'physical or mental' impairment that 'substantially limits' one or more major life activities."

HHS listed the following as potential impairments:

- Lung damage
- Heart damage, including inflammation of the heart muscle
- Kidney damage
- Neurological damage
- Damage to the circulatory system resulting in poor blood flow
- Lingering emotional illness and other mental health conditions

HHS also listed the following as potential major life activities:

- Caring for oneself, performing manual tasks
- Seeing
- Hearing
- Eating
- Sleeping
- Walking, standing, sitting
- Reaching, lifting, bending,
- Speaking, breathing
- Learning, reading, concentrating, thinking, writing, communicating
- Interacting with others
- Working

HHS warned that long COVID patients do not always have a disability and that a patient must be assessed by a professional to determine whether they qualify. Researchers are still working to learn more about long COVID. The condition may impact one or more organs for four weeks or longer.

CPT Update for Pediatric COVID-19 Vaccine Candidate – Staff, *Health IT Answers*, October 15, 2021

The AMA announced that the CPT code set has been updated to include vaccine and administration codes for pediatric doses of the COVID-19 vaccine developed by Pfizer.

The provisional CPT codes will be effective for use on the condition that Pfizer's two-dose regimen for the prevention of COVID-19 in children ages 5 to 11 receives approval or emergency use authorization from the U.S. Food and Drug Administration.

The AMA is publishing the CPT code update now to ensure electronic systems across the U.S. health care system are prepared in advance for the potential FDA approval or authorization.

The development of vaccine-specific CPT codes has clinically distinguished each coronavirus vaccine and dosing schedule for better tracking, reporting and analysis that supports data-driven planning and allocation. COVID-19 vaccines from AstraZeneca, Janssen (Johnson & Johnson), Moderna, Novavax and Pfizer have previously been issued unique CPT codes.

For quick reference, the new vaccine and administration codes assigned to the pediatric doses of Pfizer's COVID-19 vaccine are:

Vaccine product code
91307 – Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use

Vaccine Administration Codes
0071A – Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; first dose

0072A – Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; second dose

Rule Against Surprise Billing Angers AMA, Hospital Groups

A new rule on surprise medical bills drew sharp criticism from physician and hospital groups for its tilt in favor of using previously established payment rates as a benchmark, but organizations representing insurers, consumers, and large employers praised this approach.

The Department of Health and Human Service (HHS) joined other federal agencies on September 30, 2021, in releasing the third in a series of rules about surprise medical bills. They had already proposed a rule that would facilitate the collecting of data on the air ambulance industry and a rule on consumer protections against surprise billing. These rules, which would ensure that consumers are protected from most surprise bills, would take effect on January 1, 2022, HHS said.

The battles will be concentrated in fights between insurers and medical practitioners.

The new rule focuses on perhaps the most contentious issue in surprise billing, the question of how much health plans should pay for services provided by clinicians and hospitals outside of their networks.

The AMA in a statement called the rule "an undeserved gift to the insurance industry that will reduce health care options for patients." In contrast, America's Health Insurance Plans (AHIP) described the rule as signaling "a strong commitment to consumer affordability and lower health care spending."

The new rule stems from a mandate to address surprise medical billing that Congress added to a December 2020 spending package.

Federal lawmakers want to protect consumers who have paid for health insurance from large, unexpected expenses for out-of-network medical care. Often such care is provided during emergencies.

The new rule that was unveiled gives great clout to agreements that insurers already have in place with hospitals and clinicians.

A key benchmark for payment disputes is the qualifying payment amount (QPA), which is pegged to median contracted rates. In the dispute-resolution process outlined in the rule, there is a presumption that the QPA is the appropriate out-of-network rate.

The AMA urged the Biden administration to delay implementation of the rule.

The American Hospital Association described the rule as a "windfall for insurers." Chip Kahn, the chief executive officer of the Federation of American Hospitals, said in a statement that the new rule was "a total miscue.

Families USA, which describes itself as a nonpartisan consumer advocacy group, praised the approach outlined in the rule. Jane Sheehan, director of federal relations for Families USA, said in a statement that on the occasions when arbitration must occur, the amount an insurer typically charges for similar in-network services in the same area should be the primary factor in deciding cases and needs to be defined clearly by regulators from the outset.

"If a provider demands greater out-of-network rates than what other providers in that market have agreed to, the burden is on them to justify it," stated James Gelfand, executive vice president for public affairs at ERIC, an association that represents the views of large employers on issues of worker benefits.

-- Kerry Dooley Young, *Medscape Medical News*, October 1, 2021

HIPAA Rules Surrounding Vaccination Status

The U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) issued guidance emphasizing that the HIPAA Privacy Rule does not prohibit anyone from asking an individual about their vaccination status, writes Jill McKeon in her October 4, 2021, article for *Health IT Security.*

The COVID-19 pandemic and vaccine rollout have brought HIPAA into the spotlight, but many Americans continue to misunderstand how HIPAA relates and does not relate to vaccination status.

HIPAA applies strictly to covered entities, defined as health plans, healthcare clearinghouses, and healthcare providers. The OCR emphasized that despite common misconceptions, the HIPAA Privacy Rule does not prohibit any individual, business, or HIPAA covered entity from asking whether an individual has received a vaccine.

The rule also does not regulate a covered entity's ability to request such information from patients and visitors. The rule simply regulates how and when covered entities and business associates are allowed to use and share the protected health information (PHI) that those covered entities create, maintain, receive, or transmit.

The HIPAA Privacy Rule does not apply when an employer, school, store, restaurant, or entertainment venue asks about one's vaccination status. Individuals are allowed to ask other people, including their own healthcare providers, whether they are vaccinated.

Additionally, the rule does not apply to employment records, including records held by covered entities. Regulating what information can be requested as terms and conditions of employment is not in the scope of HIPAA.

"However, other federal or state laws do address terms and conditions of employment," the OCR clarified. "For example, federal anti-discrimination laws do not prevent an employer from choosing to require that all employees physically entering the workplace be vaccinated against COVID-19 and provide documentation or other confirmation that they have met this requirement, subject to reasonable accommodation provisions and other equal employment opportunity considerations."

Since the rule only applies to the covered entities themselves, an individual who discloses their vaccination status to anyone does not fall under HIPAA protection.

HIPAA does not prohibit a covered entity from requiring its employees to wear a mask, disclose whether they have received a COVID-19 vaccine, or provide vaccination documentation to their employer.

The rule generally does prohibit covered entities from disclosing a patient's PHI unless the individual gives consent. The rule does allow covered entities to disclose PHI for certain purposes. For example, a covered pharmacy can tell a public health agency whether an individual has received a COVID-19 vaccine.

"We are issuing this guidance to help consumers, businesses, and health care entities understand when HIPAA applies to disclosures about COVID-19 vaccination status and to ensure that they have the information they need to make informed decisions about protecting themselves and others from COVID-19," Lisa Pino, the OCR's recently appointed director, explained in a press release.

-- mjcpa.com

CMS Increases Payments for Cognitive Assessments and Care Plan Services –

According to the Alzheimer's Association, "Alzheimer's disease is the most common cause of dementia" due to brain changes, states Rachel V. Rose, JD, MBA, in her article for the October 2021 issue of *Physicians Practice.*

Given that an estimated 12.7 million people over 65 years of age are projected to have Alzheimer's by 2050, it is not surprising that CMS evaluated its reimbursement for cognitive assessments and care plan services.

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

Use CPT code 99483 to bill for both in-person and telehealth services.

Why is this important for physicians and patients and what types of providers can conduct a cognitive assessment?

1) Cognitive impairment detection is a requirement of Medicare's Annual Wellness Visit.
2) Medical providers such as physicians, nurse practitioners, physician assistants, and clinical nurse specialists may offer a cognitive assessment in a variety of locations (e.g., office/outpatient setting, private residence, care facility, rest home, and/or telehealth).

The subsequent visits and care plans should utilize the following codes:

SERVICE	CODE	THINGS TO KNOW
Initial AWV	G0438	Checking for cognitive impairment is a requirement of the AWV
Subsequent AWVs	G0439	Checking for cognitive impairment is a requirement of the AWV
Assessment/Care Planning for patients with cognitive impairment	99483	Detailed cognitive impairment assessment and care plan

Additional Information on 99483:

- Part B coinsurance and deductible apply.
- This code may be billed separately from the AWV.
- Includes Level 5 E/M service CPT code 99215 elements like:
  - comprehensive history
  - comprehensive exam,
  - high complexity medical decision-making

- Providers can't bill CPT code 99483 on the same day as these services:
  - 90785 (Psytx complex interactive),
  - 90791 (Psych diagnostic evaluation)
  - 90792 (Psych diag eval w/med srvcs)
  - 96103 (Psych testing admin by comp)
  - 96120 (Neuropsych test admin w/comp)
  - 96127 (Brief emotional/behav assmt)
  - 99201– 99215 (Office/outpatient visits)
  - 99324–99337 (Domicil/r-home visits new patient)
  - 99341–99350 (Home visits)
  - 99366–99368 (Team conf w/pat by health care professional)
  - 99497 (Advanced care plan 30 min)
  - 99498 (Advanced care plan addlt 30 min)

MIPS UPDATES

Now Open: Virtual Group election Period for the MIPS 2022 Performance Year

If you are interested in forming a virtual group for the 2022 MIPS performance year, the election period has begun.

To form a virtual group, an election must be emailed to CMS between **October 1, 2021** and **December 31, 2021 (11:59 p.m. ET)**: MIPS_VirtualGroups@cms.hhs.gov

NOTE: A virtual group must submit an election to CMS for each performance year that it intends to participate in MIPS as a virtual group (as required by statute). If your virtual group was approved for the 2021 MIPS performance year and intends to participate in MIPS as a virtual group for the 2022 MIPS performance year, your virtual group is still required to submit an election to CMS for the 2022 MIPS performance year between **October 1, 2021 and December 31, 2021 (11:59 p.m. ET)**.

What Is a Virtual Group?

A virtual group is a combination of 2 or more Taxpayer Identification Numbers (TINs) consisting of the following:

- Solo practitioners who are MIPS eligible (a solo practitioner is defined as the only clinician in a practice); and/or
- Groups that have 10 or fewer clinicians (at least one clinician within the group must be MIPS eligible). A group is considered to be an entire single TIN.

A virtual group has the flexibility to determine its own makeup. A solo practitioner or group can only participate in one virtual group during the performance year.

For more information, please contact the Quality Payment Program at 1-866-288-8292 or by e-mail at: QPP@cms.hhs.gov

Upcoming MIPS Important Dates and Deadlines

CMS would like to remind clinicians of important upcoming MIPS dates and deadlines:

- December 31st: Promoting Interoperability Hardship Exception and Extreme and Uncontrollable Circumstances Applications close for 2021
- December 31st: virtual group election period closes for 2022
- January 3, 2022: the 2021 MIPS performance year data submission period begins
- March 31, 2022: last day for 2021 MIPS performance year data submissions

MEDICARE NEWS

Pneumococcal Conjugate Vaccine, 20 Valent

Medicare announced it would start covering the Pneumococcal conjugate vaccine, 20 valent after October 1, 2021.

CMS suggests submitting separate claims for this vaccine (**HCPCS code 90677**).

Part A Medicare Administrative Contractors (MACs) will hold these claims until the April 2022 system update.

Part B MACs began processing these claims on October 4, 2021. CMS will deny claims for vaccines provided July 1–September 30, 2021, (before it was covered by Medicare).

The staff at AQREVA wishes you all a safe and happy Thanksgiving Holiday!

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