AQREVA Medical Billing & Consulting

# Client Memo September 2021

**"Although the world is full of suffering, it is also full of the overcoming of it." -- Helen Keller**

***NEWS Update***



## REMINDER: 30 Days Left for Period 1 Provider Relief Fund Reporting

Providers who received payments exceeding $10,000, in the aggregate, between April 10, 2020 to June 30, 2020 are required to report in Reporting Period 1. Providers who are required to report during Reporting Period 1 have until **September 30, 2021**, to enter the Portal and submit their information.

**MANY OF YOU HAVE ALREADY RECEIVED NOTICES VIA EMAIL OR IN THE MAIL**

The PRF Reporting Portal opened on July 1, 2021 for providers who are required to report during the first reporting period. The PRF Reporting Portal is located at: https://prfreporting.hrsa.gov/s/

| | Payment Received Period (Payments Exceeding $10,000 in Aggregate Received) | Deadline to Use Funds | Reporting Time Period |
|---|---|---|---|
| Period 1 | From April 10, 2020 to June 30, 2020 | June 30, 2021 | July 1 to Sept. 30, 2021 |
| Period 2 | From July 1, 2020 to Dec. 31, 2020 | Dec. 31, 2021 | Jan. 1 to March 31, 2022 |
| Period 3 | From Jan. 1, 2021 to June 30, 2021 | June 30, 2022 | July 1 to Sept. 30, 2022 |
| Period 4 | From July 1, 2021 to Dec. 31, 2021 | Dec. 31, 2022 | Jan. 1 to March 31, 2023 |

**Please note: Unfortunately, DRS is unable to help you with the completion of this report due to the personal and confidential information being asked.**

For additional information, please call the Provider Support Line at (866) 569-3522.

**All providers who fail to report may be required to repay funds back to HHS**

## Get Ready for Fall Changes

Though it may not feel like it, fall will soon be here, bringing with it changes to diagnosis codes that occur each October 1st, writes Kent Moore in his August 1, 2021 article "New Diagnosis Codes are Coming" for *FPM Journal*.

The CDC has released this year's changes. Preparing now can ensure your claims will continue to be paid smoothly.

There is a new code related to COVID-19. **U09.9** (Post COVID-19 condition, unspecified) is a special purpose code with its own notes and Code First instructions. It is used to document post-acute sequela of COVID-19 after infection (aka "**long COVID**") rather than active cases, although it can be used for reinfected patients who are still suffering sequela from a previous infection.

You should code first conditions related to COVID-19 such as chronic respiratory failure (J96.1-), loss of smell (R43.8), loss of taste (R43.8), multisystem inflammatory syndrome (M35.81), pulmonary embolism (I26.-), and pulmonary fibrosis (J84.10).

There are also new code choices for low back pain, a condition family physicians commonly see. The current code, M54.5 (Low back pain), will be expanded into three more specific codes:

- M54.50 (Low back pain, unspecified)
- M54.51 (Vertebrogenic low back pain)
- M54.59 (Other low back pain)

Similarly, you will no longer be able to simply report a patient has a cough with R05 (Cough). Instead, you'll have to choose from among six new, more specific codes:

- R05.1 (Acute cough)
- R05.2 (Subacute cough)
- R05.3 (Chronic cough)
- R05.4 (Cough syncope)
- R05.8 (Other specified cough)
- R05.9 (Cough, unspecified)

Finally, beginning in October, you'll have an expanded array of codes for recording various social determinants of health. For instance, code Z59.0 (Homelessness) is now broken out to three codes:

- Z59.00 (Homelessness unspecified)
- Z59.01 (Sheltered homelessness)
- Z59.02 (Unsheltered homelessness)

Code Z59.81- (Housing instability, housed) will also require more specificity, as follows:

- Z59.811 (Housing instability, housed, with risk of homelessness)
- Z59.812 (Housing instability, housed, homelessness in past 12 months)
- Z59.819 (Housing instability, housed unspecified)

A full list of changes can be obtained by going to:
www.cdc.gov/nchs/icd/icd10cm.htm(www.cdc.gov)

## New Codes Cover 3rd Dose of Pfizer and Moderna Vaccines

Medicare stands ready to pay for the administration of a 3rd dose for both the Pfizer BioNTech COVID-19 vaccine and the Moderna COVID-19 vaccine for immune compromised people. CMS will pay the same amount to administer this additional dose as it did for other doses of the COVID-19 vaccine (approximately $40 each).

The AMA released two new administration CPT codes for the additional doses:

**0003A (3rd dose Pfizer vaccine)**
**0013A (3rd dose Moderna vaccine)**

These codes are only to be used for third doses for immunocompromised individuals, which are different than booster shots. While the Biden Administration has announced its intent to offer booster shots to the general population, there is not currently a formal recommendation or FDA approval for them.

| Manufacturer | Administration Codes |
|---|---|
| Pfizer | • 0001A (1st dose)<br>• 0002A (2nd dose)<br>• **0003A (3rd dose)** |
| Moderna | • 0011A (1st dose)<br>• 0012A (2nd dose)<br>• **0013A (3rd dose)** |

## Cost Sharing Waivers for COVID-19 Treatment Winding Down

Many insurers are no longer waiving cost sharing for COVID-19 treatment, writes Samantha Liss, for *Healthcare Dive*, August 20, 2021.

**Dive Brief:**

- Health experts warn patients may soon see big bills related to treatment for COVID-19, according to a new report from researchers at the Kaiser Family Foundation.
- More insurers are expected to end the moratorium on patient cost sharing by the end of October 2021, putting the financial responsibility back on patients, KFF said.

Last year, during the height of the pandemic, many insurers voluntarily waived patient cost sharing for COVID-19 treatment.

Insurers have largely done away with those waivers and more are expected to disappear by the end of October as COVID-19 patients inundate hospitals once again, leaving them more exposed to the costs of the disease.

This could pose a new strain for providers, as some Americans are left to cover their out-of-pocket costs and not the insurer. The average annual deductible was $1,644 in 2020, though much larger figures for families, according to KFF. But many Americans, four in 10, don't have $400 in the bank to cover an unexpected expense, let alone $1,644,

The federal government did mandate insurers to cover testing and vaccines but the requirement does not extend to paying for the patient's share of treatment costs

## CMS expands Medicare payments for at home COVID-19 vaccines

On August 24, 2021, CMS announced that it will give clinicians additional payments for administering in-home COVID-19 vaccines to multiple residents of the same home or communal living setting.

Clinicians will be allowed to receive the increased payment when they give up to 10 Medicare beneficiaries the vaccine on the same day in the same home. The goal is to boost vaccination rates in assisted living facilities, smaller group homes, and other group living situations.

## Quicker, Easier E/M Coding – Staff, *FPM Journal,* August 2, 2021

After several months of using the new E/M coding rules, it has become clear that the most difficult chore of coding office visits now is assessing data to determine the level of medical decision making.

Analyzing each note for data points can be time consuming and sometimes confusing. Fortunately, the majority of visits can be optimally coded without worrying about data at all, if you follow these four steps:

**1. Think time first.** Under the new rules, physicians may code any visit based solely on the total time it took on the date of service (including the time spent preparing for the visit and the time spent documenting it afterwards). If your total time spent on a visit appropriately credits you for level 3, 4, or 5 work, then document that time, code the visit, and be done with it. But if it does not, go to Step 2.

**2. "Problems plus."** The level of MDM is determined by the problems addressed at the visit, the data reviewed, and the patient's risk. But many visits can be coded with MDM just by answering these two questions:

i) What was the highest-level problem you addressed during the office visit; and
ii) Did you order, stop, modify, or decide to continue a prescription medication? Prescription drug management combined with a level 3 or 4 problem equals a level 3 or 4 visit.

If the patient has a level 5 problem, and you consider admission, that's a level 5 visit.

On the rare occasions when you see a patient for level 4 or 5 problems for less than the required time and don't do any prescription drug management, you may have to proceed to Steps 3 and 4.

**3. Level 4 problem with social determinants of health or simple data.** If you see a patient for a level 4 problem, but don't do prescription drug management, you can still code it as a level 4 visit if you do any of the following:

- Personally interpret a study (e.g., an X-ray),
- Discuss management or a test with an external physician,
- Modify the workup or treatment due to social determinants of health.

**4. Level 4 or 5 problem with complex data**. If you saw a patient for a level 4 problem and still haven't been able to code the visit at this point, you have to tally Category 1 data points:

- Review/order of each unique test equals one point each,
- Review of external notes from each unique source equals one point each,
- Use of an independent historian equals one point.

Once you reach three points, code it as level 4.

For a level 5 problem, if you see a really sick patient, order/interpret an X-ray or ECG, and review/order two lab tests, then code level 5.

## 3 Billing Codes Physicians Should Use

Doctors and practice administrators are always looking for ways to maximize profits. Practices that know about the following codes and how to use them may be able to earn additional reimbursement, writes Michael Enos in his July 27, 2021, article for *Physicians Practice.*

### 99441-99443: TELEPHONE SERVICES

CPT offers codes to report telephone services provided by a physician or other qualified health care professional who may report E/M services. ***These codes can only be reported for an established patient and are not billable if the call results in the patient coming in for a face-to-face service within the next 24 hours (or next available urgent visit). These calls are also not billable if they refer to an E/M service performed within the last seven days.*** The codes are selected from code range 99441 to 99443 and are based on the time spent: 5-10 minutes, 11-20 minutes, or 21-30 minutes, respectively.

### 99058: SERVICES PROVIDED ON AN EMERGENCY BASIS

What can you do when your providers already have a packed schedule and a patient walks in demanding to be seen? What if a scheduled nurse visit is more serious than anticipated, and the provider is called to step in and spend a great deal of time with that patient? ***When a patient is seen on an emergency basis in the office, and it disrupts other scheduled office services, you may be able to report add-on code 99058*** for additional reimbursement.

### 96160: HEALTH RISK ASSESSMENT

Providers can bill code **96160** when they perform a health risk assessment with a patient or caregiver/guardian in order to assess the risk of conditions such as mental disorders. Providers should report **96161** for a caregiver-focused health risk assessment, such as a depression inventory, for the benefit of the patient.

(Please note that there is no guarantee that these codes will be reimbursed by the insurance companies.)

## Top Three Takeaways from the 2022 QPP Proposed Rule – Matthew Fusan, *HealthIT Answers*, August 30, 2021

The 2022 Quality Payment Program (QPP) Proposed Rule, which CMS released on July 13, 2021, includes changes to the MIPS program that will make avoiding a penalty difficult, along with updates to the controversial APM Performance Pathway reporting requirements, and more insight into the MVP program.

Following are three key takeaways from the Proposed Rule to consider as you evaluate how changes could impact your organization.

**1. Difficulty Avoiding Penalties Increases --** Avoiding a penalty in MIPS will become a lot harder for three reasons:

1) the Performance Threshold will be increased to 75 points,
2) most bonus points will be removed, and
3) the Cost category will increase to 30 points of the total score.

**2. Extended Web Interface Submission --** In the 2021 Final Rule, CMS announced that the Web Interface submission method would be sunsetted after PY 2021 and MSSP ACOs would be required to submit eCQMs or CQMs for three measures.

**3. MVPs Delayed Until 2023 --** MIPS Value Pathways (MVPs) are being delayed until 2023 and will initially launch with 7 available MVPs.

One thing that was not addressed in the Proposed Rule documentation was clarity around CMS's thinking regarding another COVID-related Hardship Exception for 2022. As the pandemic continues to unfold with the new Delta variant during the second half of this year, it is harder than ever to predict how much of the Proposed Rule will change between now and when the 2022 Final Rule is released in November or December.

## 2022 Final Rules for SNFs and Hospices

Medicare payment policies and rates are set to be adjusted for the 2022 fiscal year. The agency noted that it had finalized changes to Medicare payment policies, rates, and other measures for skilled nursing facilities, hospices, inpatient rehabilitation facilities and inpatient psychiatric facilities, writes Mark Spivey in his July 30, 2021*, ICD 10 Monitor* article "CMS Unveils 2022 Final Rules for Four Provider Types."

What follows is a brief overview of the most notable changes for two of these provider types, as related in an edition of the *CMS MLN Connects Newsletter*.

### SNFs

In addition to rate adjustments, the SNF Final Rule includes several policies that update the SNF Quality Reporting Program and the SNF Value-Based Program (VBP) for the 2022 fiscal year (FY).

CMS has estimated that the aggregate impact of the changes would result in an increase of approximately $410 million in Medicare Part A payments to SNFs in FY 2022, resulting from an update to the payment rates of 1.2 percent, based on a 2.7-percent SNF market basket update, minus a 0.8-percentage point forecast error adjustment and a 0.7-percentage point productivity adjustment.

Officials noted that the Final Rule also features new methodology for recalibrating the Patient-Driven Payment Model (PDPM) parity adjustment; changes to Section 134 of the Consolidated Appropriations Act, 2021 – New Blood Clotting Factor Exclusion from SNF Consolidated Billing; and changes in PDPM ICD-10 code mappings.

To view a comprehensive CMS fact sheet on the SNF Final Rule, go online here: https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2022-skilled-nursing-facility-snf-prospective-payment-system-pps-final-rule-cms-1746

### Hospices

The Final Rule for hospices updates Medicare payments and the aggregate cap amount for FY 2022, done in accordance with existing statutory and regulatory requirements.

This rule finalizes changes to the Hospice Conditions of Participation and Hospice Quality Reporting Program (HQRP)," the *MLN Connects* newsletter post read. It also finalizes a Home Health Quality Reporting Program policy that becomes effective on Oct. 1, 2021, to prepare for public reporting beginning in January 2022.

Under the new rule, hospices would see a 2.0-percent increase ($480 million) in their payments for FY 2022, relative to FY 2021, resulting from a 2.7-percent market basket percentage increase, reduced by a 0.7-percentage point productivity adjustment. Hospices that fail to meet quality reporting requirements receive a 2-percentage point reduction to the annual hospice payment update percentage increase for the year.

The updates also include a change to the statutory aggregate cap amount, which limits the overall payments per patient that are made to a hospice annually. The new amount is just over $31,000, up 2 percentage points from 2021.

The Final Rule also includes additional Medicare hospice payment policies; a request for information (RFI) on the Closing the Health Equity Gap in the HQRP initiative; and a second RFI on the Fast Healthcare Interoperability Resources in Support of the HQRP initiative.

To view a comprehensive CMS fact sheet on the Hospice Final Rule, go online here: https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2022-hospice-payment-rate-update-final-rule-cms-1754-f

## MIPS UPDATE

### Now Available: 2020 MIPS Performance Feedback, Final Score, and 2022 MIPS Payment Adjustment Information

CMS has released MIPS performance feedback and final scores for performance year 2020 and associated MIPS payment adjustment information for payment year 2022.

You can access your 2020 MIPS performance feedback, 2020 final score, and 2022 payment adjustment information by:

- Going to: https://qpp.cms.gov
- Logging in using your HCQIS Access Roles and Profile (HARP) system credentials; these are the same credentials that allowed you to submit your 2020 MIPS data

If you don't have a HARP account, please refer to the "Register for a HARP Account and Connect to an Organization documents" in the QPP Access User Guide on the website.

For Shared Savings Program ACOs, please note that beginning August 5, 2021, you will be able to create a HARP account and manage your account in the ACO Management System (ACO-MS). Contact your ACO to find out how you can obtain a HARP account via ACO-MS. If you have any questions, please contact the ACO Information Center at: SharedSavingsProgram@cms.hh s.gov

To learn more about the information in your performance feedback, review 2020 MIPS Performance Feedback Resources in the QPP website.

### Now Available: 2020 MIPS Targeted Review

You can now review your performance feedback, including your MIPS final score and payment adjustment factor(s), on the Quality Payment Program website.

For MIPS eligible clinicians, your 2020 final score determines the payment adjustment you'll receive in 2022, with a positive, negative, or neutral payment adjustment being applied to the Medicare paid amount for covered professional services furnished in 2022.

**When to Request a Targeted Review**

If you believe an error has been made in the calculation of your MIPS payment adjustment factor(s), you can request a targeted review **until October 1, 2021**.

**How to Request a Targeted Review**

You can access your MIPS final score and performance feedback and request a targeted review by:

- Going to the Quality Payment Program website.
- Logging in using your HCQIS Access Roles and Profile System (HARP) credentials; these are the same credentials that allowed you to submit your MIPS data. Please refer to the QPP Access Guide for additional details.

CMS generally requires documentation to support a targeted review request, which varies by circumstance. You'll be contacted by a representative with information about any specific documentation required.

If the targeted review request is approved and results in a scoring change, we'll update your final score and/or associated payment adjustment (if applicable), as soon as technically feasible. Please note that targeted review decisions are final and not eligible for further review.

### 2021 APM Incentive Payments

Eligible clinicians who were Qualifying APM Participants should have begun receiving their 2021 5% APM Incentive Payments earlier this summer.

You can now log in to the QPP website to see the amount and the organization paid by using the 10-digit NPI number and the organization name.

You will not need to do anything to receive your payment, unless CMS is unable to verify your Medicare billing information.

If you have not yet received your payment, you should check for your name on this public notice to see if you will need to verify your Medicare billing information**. If you do not verify your Medicare billing information by November 1, 2021, then CMS will not be able to issue your APM Incentive Payment**.

For questions, please contact the Quality Payment Program at QPP@cms.hhs.gov or call 1-866-288-8292.

## MEDICARE NEWS

### Provider Enrollment Activities Resume in October

Beginning October 2021, CMS will resume some provider enrollment activities that were paused during the COVID-19 public health emergency, including:

- Application Fees – 42 C.F.R. 424.514
- Criminal background checks associated with fingerprint-based criminal background checks– 42 C.F.R. 424.518
- Revalidation – 42 C.F.R 424.515

For more information, see the COVID-19 Medicare Provider Enrollment Relief FAQs (PDF) pp 19, 20, 26, and 27: https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf

### OIG audit revealed millions in Medicare overpayments for chronic care management services.

The auditors examined over 7.8 million claims from physicians and 240,00 claims from hospitals for CCM services provided in 2017 and 2018. OIG found $1.9 million in overpayments due to noncompliance with federal requirements across over 50,000 claims. Medicare beneficiaries' cost sharing for these over-payments totaled $540,680.

### Impact of the PHE on Telehealth

In late August, CMS issued a Special Edition Comparative Billing Report (CBR) on the impact of the Public Health Emergency (PHE) on Part B claims for telehealth.

Providers can use the data-driven report to compare their billing practices during the PHE with those of their peers in their state and across the nation.

CBRs aren't publicly available. Providers can look for an email from cbrpepper.noreply@religroupinc.com to access their report. Email addresses can be updated in PECOS to ensure delivery.

More Information can be found by:

- Viewing a webinar recording at https://cbr.cbrpepper.org/About-CBR/CBR-202108
- Visiting the CBR website at https://cbr.cbrpepper.org/Home

### Affordable Care Act's Shared Savings Program Continues to Improve Quality of Care While Saving Medicare Money During the COVID-19 Pandemic

CMS announced August 24, 2021, that ACOs participating in the Medicare Shared Savings Program in 2020 earned performance payments (shared savings) totaling nearly $2.3 billion while saving Medicare approximately $1.9 billion, marking the fourth consecutive year of net savings for Medicare.

The Shared Savings Program, established by the Affordable Care Act, promotes accountability for patient populations and fosters coordination of items and services under Medicare Parts A and B

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