AQREVA Medical Billing & Consulting

Client Memo
January 2022

"Hope smiles from the threshold of the year to come, whispering "it will be happier."
– Alfred, Lord Tennyson

NEWS Update

Medicare FFS Claims: 2% Payment Adjustment (Sequestration) Changes

The Protecting Medicare and American Farmers from Sequester Cuts Act impacts payments for all Medicare Fee-for-Service (FFS) claims:

- No payment adjustment through March 31, 2022
- 1% payment adjustment April 1–June 30, 2022
- 2% payment adjustment beginning July 1, 2022

Medicare Payment Cuts Delayed

Bipartisan Legislation to Address Medicare Cuts Enacted

Congress passed and President Joe Biden signed into law the "Protecting Medicare & American Farmers from Sequester Cuts Act" on December 10, 2021, reports David Rich & Jon Cooper for *GNYHA News*, December 13, 2021.

The new law addresses several Medicare provider payment cuts slated to go into effect on January 1, 2022. Among its provisions, the law relieves the 2% Medicare "sequestration" cuts, delays the 4% Statutory Pay-As-You-Go (PAYGO) Act cuts, and mitigates Medicare physician fee schedule (PFS) cuts.

The moratorium on sequestration is extended through March 31, 2022, and the sequestration cut is reduced to 1% from April 1 to June 30, 2022. In effect, providers won't see any Medicare payment reductions until April 1, 2022, with the full 2% sequestration cut in effect beginning July 1, 2022.

The law delays the Statutory 4% PAYGO Act reductions by eliminating the cuts in 2022 and shifting the 2023 PAYGO scorecard balances. While this provision prevents the PAYGO sequester from taking effect in 2022, it does not remove the scorecard's balances entirely, which means the PAYGO cuts will need to be addressed again at the end of 2022.

The law also increases the Medicare PFS conversion factor for 2022 by 3%. Absent such Congressional action, the 2022 conversion factor would have been calculated without consideration of the 3.75% increase provided via the Consolidated Appropriations Act of 2021, resulting in a significant PFS cut for 2022.

Finally, the law delays Medicare payment cuts for clinical diagnostic laboratory tests resulting from implementation of the private payer rate policy until January 1, 2023, with the phase-in extended through 2025. The law also delays the reporting of private payer rates until January 1, 2023.

Top challenges of 2022

Below is a summary of the 5 top challenges facing physicians for 2022. The articles were written by the staff at *Medical Economics* over a 5-day period, beginning December 27th and ending December 31, 2021.

CHALLENGE No. 1: Hiring and retaining staff

A medical practice relies on more than the physicians who see patients, with nonclinical administrative staff being vital to overall success. Hiring and retaining staff can often be difficult. The recent fears of COVID-19 caused many to stay far away from the health care field, although even before the pandemic, the industry was experiencing a shortage of qualified applicants.

Tips for Hiring and Retaining Staff -- Although a record number of people resigned from positions in the United States in September, many experts are optimistic that 2022 will be different.

Here are some tips on hiring new staff:

1. **Increase compensation and incentives:** Money talks, but so do benefits and perks. Offer sweeteners that workers will not find anywhere else.
2. **Add flexibility:** The days of the 8 a.m. to 6 p.m. workplace are quickly fading. Although it is unreasonable for a practice to allow employees to work whenever they want, be open to having them work at different times on certain days so they can attend to family and other life issues.
3. **Go digital:** When looking for new employees, utilize job sites like Monster.com on both a local and regional level. Use your internal social media channels for networking and finding worker talent.
4. **Have open dialogue:** For current staff, ask employees what they want and what issues they are having. Solve problems before they get too big and fix concerns that are reasonable. Employees will appreciate that you listened.
5. **Go beyond health care:** Practices often prefer those with experience in health care, but many qualified people have never worked in a practice. Be open to bringing in bright people from outside the health care arena.

CHALLENGE No. 2: Electronic Health Records

Since their introduction, EHRs have been a perennial issue for physicians across all specialties. From user experience to interoperability, nearly every facet of the computer-based system has drawn the ire of those using them.

Tips to improve EHRs -- David Lareau, CEO of Medicomp Systems, says medical practices can combat the burnout associated with EHR use by focusing on these four core areas for improving their systems.

- **Improving patient care:** Incorporate technological tools that work behind the scenes to capture and interpret billing and coding detail.
- **Increasing physician productivity:** Workflows supporting the automatic identification and interpretation of medical information from previous sessions, inpatient records, laboratory reports and other sources allow physicians to focus on the patient instead of their computers. EHRs should not disrupt the way physicians think and work.
- **Ensure accurate reimbursements:** Practices should incorporate technologies that prompt the physician at the point of care when patients have potential hierarchical condition category conditions, allowing the doctor to immediately address treatment, documentation or coding gaps while the patient is in the room rather than during a follow-up appointment.
- **Reducing operational expenses:** EHR systems can reduce operational expenses by enhancing clinician productivity and streamlining documentation, coding and billing processes.

CHALLENGE No. 3: Prior Authorizations

Doctors want to treat patients using the care they were trained to give but often find themselves arguing with someone from an insurance company about what the best course of treatment is. This is the main reason physicians consistently rank third-party interference as one of their biggest challenges.

There are some strategies practices can use to streamline the process.

- **Assign a staff member to each payer**. This person can become an expert on the payers for which they are responsible and create a basic guidebook for each payer that others can follow if needed.
- **Maximize the use of technology**. Most payers offer online forms for the prior authorization process and some EHRs integrate directly with payer formularies.
- **Document all treatment decisions and back them up with evidence-based practices**. Payer justification for prior authorizations is that physicians are not always following the latest evidence-based practices, so ensure all treatment decisions are based on the latest guidelines.
- **Prepopulate forms for each payer**. In some cases, you may be able to create a prepopulated form that has common information from the practice already filled in. This just leaves the specific patient information to be added.
- **Create a spreadsheet** outlining what treatments and medications for frequent diagnoses require a prior authorization by payer and what the permitted alternatives are.
- **Inquire about gold card programs**. Some payers offer physicians with a good track record of following clinical best practices a gold card that allows them to skip the prior authorization process for some treatments. Find out whether you are eligible and what it takes to earn eligibility.

CHALLENGE NO 4: Increased Competition

Physicians are not the only option when it comes to primary care services. How can physicians in traditional practices compete? Here are some strategies:

You know telehealth — use it

Patients want convenient services. Telehealth is one way to meet patients when, how and where they want to see their physician. It is something most physicians have had lots of practice with since the pandemic began. If your virtual care program has gone dormant as your practice opened to in-person appointments, dust off the cobwebs and get going again.

Be available

Patients do not get sick only during business hours; offering a few Saturday appointments no longer caters to their busy lifestyles. With urgent care centers and retail clinics offering extended hours daily, if a practice does not adapt its schedule to its patients, they will seek care from a place that does.

Make it easy — and do not make them wait

Patients do not want to spend 15 minutes on hold with your front desk to make an appointment. When they arrive, patients expect the doctor to see them within about 15 minutes of their appointment time. Consider implementing a system that texts updates on wait times to patients, allowing them to adjust their arrival to reflect the doctor's current schedule.

Streamlined paperwork

The more forms that can be filled out electronically and in advance, the better. No one wants to sit in a waiting room filling out forms on a clipboard that could easily have been done the night before. Checkout should be just as easy, with little or no time spent standing in line.

Quick responses to questions

Patients expect a response to questions posed via email or an EHR portal in 24 hours or less. This timeframe is basic business protocol established by the retail and service industry. Medical practices must embrace it as well.

CHALLENGE No. 5: Loss of Trust in Physicians

Doctors often complain that, like the late comedian Rodney Dangerfield, they "don't get no respect." But when it comes to respect and trust, medicine and its practitioners fare better than many other aspects of American society.

Still, trust in physicians has been declining. The trend is especially pronounced among younger Americans.

There are reasons specific to medicine:

- Probably the biggest of these is the limited time primary care doctors working for large hospital systems — now the majority — can spend with patients. Compounding the problem, patients often do not stay with the same doctor long enough to establish trust; doctors leave (or are dropped from) insurance networks, or employers change insurance carriers in search of lower costs.
- Another contributor to eroding trust is the ready availability of medical and wellness information, as well as information and ratings for health care providers, on the internet and via social media. This means patients are less likely to un-questioningly trust a physician's diagnosis or follow a treatment plan than were patients in the era before the internet.
- Patients' confidence in their care providers is further weakened by skyrocketing care costs. Although doctors are not primarily responsible for the problem, they often bear the brunt of patient anger.

Establishing — or rebuilding — trust with patients is not easy, especially given the time and financial constraints most doctors face. The process starts with maximizing the time available to spend with patients by, for example, delegating to staff members tasks that reduce time for doctor-patient interactions. Then use the time to listen.

2022 Medicare PFS Final Rule

CMS issued the 2022 Medicare Physician Fee Schedule (PFS) final rule on November 2, 2021, that includes updates to payment policies, payment rates, and other provisions for services, effective on or after January 1, 2022:

- Revises telehealth services under the Consolidated Appropriations Act, 2021; allows use of audio-only communications technology when furnishing mental health services in certain circumstances.
- Finalizes recent changes to Evaluation and Management (E/M) visit codes, such as policies for split (or shared) E/M visits, critical care services, and services furnished by teaching physicians.
- Modifies payment for therapy services furnished in whole or in part by a Physical Therapist Assistant or Occupational Therapy Assistant.

- Updates a payment regulation for Medical Nutrition Therapy services.
- Finalizes considerations for vaccine administration services.

2022 PFS Impact on Telehealth and Care Management: Initial impressions

What the new physician fee schedule may mean for your practice.

Daniel Tashnek, JD, summarizes the big take-aways on how the 2022 PFS final rule impacts telehealth and care management in his December 6, 2021, article for *Physicians Practice.*

Chronic care management is a big winner

Chronic Care Management (CCM), and with it, Complex Chronic Care Management (CCCM) and Principal Care Management (PCM), further cemented itself as one of the most lucrative of Medicare programs, one all practices should look into offering for patients in 2022 and beyond. CMS finalized a significant increase in reimbursement for some of the CCM and CCCM CPT codes, writes Mr. Tashnek.

CPT	Description	Avg. Base Reimbursement	
		2021	2022
99490	Base clinical staff CCM first 20 minutes	$41.17	$62.16
99439	Base clinical staff CCM each additional 20 minutes	$37.69	$47.04
99487	Complex CCM first 60 minutes	$91.77	$130.37
99489	Complex CCM each additional 30 minutes	$43.97	$68.54

CMS also finalized the addition of five new CCM and PCM CPT codes:

- **99437** — CCM services, each additional 30 minutes by a physician or other qualified healthcare professional, per calendar month (list separately in addition to code for primary procedure)
- **99424** — PCM services for a single high-risk disease, first 30 minutes provided personally by a physician or other qualified healthcare professional, per calendar month
- **99425** — PCM services for a single high-risk disease, each additional 30 minutes provided personally by a physician or other qualified healthcare professional, per calendar month (list separately in addition to code for primary procedure)
- **99426** — PCM for a single high-risk disease, first 30 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month
- **99427** — PCM services for a single high-risk disease, each additional 30 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month (list separately in addition to code for primary procedure)

"Direct supervision" via telehealth

CMS declined to act on remote direct supervision of clinical staff providing "incident to" services. For now, the agency is not making permanent the temporary exception that permits the virtual presence of the supervising physician or practitioner using telehealth. This form of direct supervision is permitted through the end of the calendar year in which the COVID-19 public health emergency (PHE) ends.

Considering the current state of the PHE, direct supervision via telehealth is likely to remain approved through at least 2022.

Many services that can be furnished by clinical staff, including the Medicare annual wellness visit (AWV) and other preventive services, can continue to be performed by agents of a provider while those agents are not physically present in the provider's office.

In the final rule, Medicare stated that it may review the topic in future rulemaking. Although it is unlikely that any more changes will occur in 2022, it is worth keeping a long-term eye on the remote direct supervision requirement and on the list of services that only require general supervision.

Category 3 services are extended

In the 2021 Medicare PFS final rule, CMS created a third category (i.e., Category 3) of criteria for adding services to the Medicare telehealth service list on a temporary basis following the end of COVID-19 pandemic.

With the 2022 final rule, CMS has extended the timeframe for reimbursement of this temporary category of telehealth services until the *end of 2023* with the stated goal of collecting data to see if these services should be allowable via telehealth after the PHE concludes.

Remote therapeutic monitoring

In the 2022 proposed rule, CMS devoted attention to remote therapeutic monitoring (RTM), which is different from remote patient/physiologic monitoring (RPM). The final rule further defines RTM but still leaves questions unanswered.

Most significantly, CMS finalized five RTM CPT general medicine codes. As such, they can be billed by physicians and other qualified healthcare professionals who cannot independently order and bill for E/M services (e.g., physiatrists, nurse practitioners, physical therapists. The codes are as follows:

- **98975** — Remote therapeutic monitoring initial set-up and patient education on use of equipment;
- **98976** — Remote therapeutic monitoring respiratory system, each 30 days;
- **98977** — Remote therapeutic monitoring musculoskeletal system, each 30 days;
- **98980** — Remote therapeutic monitoring treatment requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes;
- **98981** — Remote therapeutic monitoring treatment requiring at least one interactive communication with the patient/caregiver during the calendar month; each additional 20 minutes.

The device supply codes are currently limited to just respiratory or musculoskeletal system monitoring. RTM management time must be furnished by the actual billing practitioner, not clinical staff under supervision.

Longer virtual check-ins

Finally, the 2022 final rule permanently adopted coding and payment for the longer virtual check-in service described by HCPCS **G2252:** Brief communication technology-based service, e.g., virtual check-in service, by a physician or other qualified healthcare professional who can report E/M services provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11–20 minutes of medical discussion. This gives practices another option to HCPCS **G2012,** which only covered "5-10 minutes of medical discussion."

CMS Expands Telehealth Coverage and Access for Mental Health Services

On November 2, 2021, CMS issued the final rule on the Medicare Physician Fee Schedule detailing how health care services offered by psychologists and other providers will be delivered and reimbursed in 2022, as reported in the American Psychological Association's December 2021 announcement.

Below are some of the key issues of interest to psychologists.

Telehealth services

Following changes made through new federal legislation, CMS will allow *audio-only services* to be provided for the diagnosis, evaluation, and treatment of mental health conditions and substance use disorders after the public health emergency (PHE) ends. The originating site requirement will not apply when patients receive these services through audio-only devices in their homes, with the definition of home being viewed broadly to include temporary lodging, such as a hotel.

Absent new federal legislation, health behavioral services, feedback sessions for psychological and neuropsychological testing evaluations, and other services will not be allowed via audio-only technology after the PHE ends.

Additional requirements for audio-only services

Under the final rule, once the PHE ends, audio-only telehealth services for mental health and substance use disorder (SUD) services will require an in-person visit within six months of the initial telehealth visit and within 12 months of any subsequent telehealth visit.

Providers will be able to request exemptions if they believe it would benefit the patient not to meet in-person. CMS will not require additional documentation but providers furnishing audio-only services will need to use a billing modifier on claims to indicate that the patient did not have access to two-way audio-visual communication technology or did not consent to its use.

Psychological and neuropsychological testing remain temporary telehealth services through December 2023.

Multiple family group psychotherapy

APA asked CMS to add multiple family group psychotherapy (90849) to Medicare's permanent telehealth list but the agency declined, noting that generally the code is not separately payable in Medicare as an in-person service.

MIPS 2022 Final Rule

The MIPS 2022 Final Rule has been released. Joy Rios provides a breakdown of what you need to know about the program in her December 14, 2021, article for *Health IT Answers*.

Overall:

- For the 2022 performance year, eligible clinicians must earn a score of at least 75 points to avoid a penalty.
- To earn exceptional performance points, eligible clinicians must earn a score of 89 points.

Cost:

- Category weight will now be 30%.
- CMS is adding 5 newly developed episode-based cost measures into the MIPS cost performance category beginning with the 2022 performance period.
    - 2 Procedural Measures:
        - Melanoma Resection
        - Colon and Rectal Resection
    - 1 Acute Inpatient Measure:
        - Sepsis
    - 2 Chronic Condition Measures:
        - Diabetes
        - COPD

Improvement Activities:

- Category weight remains at 15%.
- Improvement Activity Inventory is expanding. CMS is:
    - Adding 7 new improvement activities, 3 of which are related to Promoting Health Equity.
    - Removing 6 previously adopted improvement activities.

Quality:

- Category weight will be worth 30% of the overall MIPS score.
- The data completeness threshold will remain at 70%. This means you must report performance data for at least 70% of the denominator-eligible encounters.
- There are substantive changes to 87 existing MIPS quality measures.
- Changes to specialty sets.
- Removal of measures from specific specialty sets.
- Removal of 13 quality measures.
- Addition of 4 quality measures, including 1 new administrative claims measure.

CMS will create historical benchmarks for the 2022 performance period, using data submitted for the 2020 performance period.

Promoting Interoperability:

- Category weight remains at 25%.
- In addition to the existing special statuses/clinician types, ***automatic reweighting will apply for small practices and clinical social workers***. If you qualify, this means the quality category will be worth at least 40% of your overall score.
- CMS is modifying the reporting requirements and requiring MIPS eligible clinicians to report the following two measures (unless an exclusion can be claimed):
    - Immunization Registry Reporting
    - Electronic Case Reporting

Beginning with the 2022 performance period, the following measures are optional; clinicians, groups and virtual groups that report a "yes" response for any of these measures will earn 5 bonus points:

- Public Health Registry Reporting measure
- Clinical Data Registry Reporting measure
- Syndromic Surveillance Reporting measure

Reporting more than one of these optional measures will not result in more than 5 bonus points.

New required measure: MIPS eligible clinicians must attest to conducting an annual assessment of the High Priority Guide of the Safety Assurance Factors for EHR Resilience Guides (SAFER Guides), details to follow next month.

Complex patient bonus: Because of the concerns of the direct and indirect effects of the COVID-19 PHE, CMS will continue to double the complex patient bonus available for the 2021 MIPS performance year/2023 MIPS payment year. These bonus points (capped at 10-points) would be added to the final score.

The revised complex patient bonus beginning with the 2022 MIPS performance will:

- Limit the bonus to clinicians who have a median or higher value for at least 1 of the 2 risk indicators (Hierarchical Condition Category score and pro-

portion of patients dually eligible for Medicare and Medicaid benefits).
- Updating the formula to standardize the distribution of two risk indicators so that the policy can target clinicians who have a higher share of socially and/or medically complex patients.
- Increasing the bonus to a maximum of 10 points.

This bonus will be available to clinicians, groups, subgroups, virtual groups or APM entities that meet the criteria above and submit data for at least one performance category, beginning with the 2023 performance year.

(Please note: More detailed information on the changes to each performance category can be found on the Quality Payment Program website: https://qpp.cms.gov)

HSAG's 'Changes to MIPS Highlights' Video

HSAG, which is 1 of 11 organizations awarded by CMS as a QPP Technical Assistance Support Contractor for Medicare providers in Arizona, California, Hawaii, New Mexico, and the U.S. Virgin Islands, has created a 3-minute video to provide an overview of the **2022 QPP Final Rule** changes. The video can be viewed on HSAG's YouTube channel: https://www.youtube.com/watch?v=_ilzoJ1pULQ

Check Your 2022 MIPS Eligibility

You can now use the Quality Payment Program Participation Status Tool to check your 2022 MIPS eligibility status. The tool can be found on the QPP website: https://qpp.cms.gov

Just enter your NPI number to find out whether you need to participate in MIPS during the 2022 performance year.

The reporting window for MIPS 2021 is now open on the QPP website.

Please report your data early. The reporting deadline is the end of March 2022. You may need to update your login information first.

Ten Coding Tips for Capturing Patient Risk and Ensuring Proper Payment

Important for the new year is knowing how to correctly code in order to capture patient risk, a key requirement for succeeding in value-based payment programs.

The staff of *FPM Journal* reprinted the following article on December 15, 2021. Value-based payment programs frequently quantify risk through hierarchical condition categories (HCCs). Remembering these 10 tips can help ensure you're getting proper credit for managing high-risk patients and keeping them as healthy as possible:

1. **Report diagnosis codes for active diagnoses each year** -- HCC codes reset annually, which means that each patient's active diagnoses must be reported every year, regardless of how long the patient has had the condition, to be counted toward the patient's overall risk. Annual wellness visits are a good time to do this.

2. **Be specific** -- Most unspecified diagnosis codes don't risk adjust (e.g., ICD-10 code E11 for type 2 diabetes), so use the most specific code possible for each diagnosis (e.g., E11.22 for type 2 diabetes with diabetic chronic kidney disease).
3. **Address chronic conditions at least annually** -- Many chronic conditions are also HCCs, so try to address each chronic condition at least once a year and report that diagnosis code.

4. **Avoid symptom codes when possible** -- Symptom codes do not result in risk adjustments. If a specific diagnosis code can be used instead, use that.

5. **Report secondary diagnoses** -- Physicians often address conditions that risk adjust, even if they're not the primary reason for the visit. Don't forget to code for the risk-adjusted secondary diagnosis if you addressed it or if it played a role in managing the other condition that prompted the visit.

6. **Code the complications as well as the condition** -- Complications of conditions such as diabetes usually increase patient risk scores, so be sure to code for the complications as well as the underlying condition.

7. **Address problems during Medicare wellness visits** -- A diagnosis code that risk adjusts can be used for a Medicare wellness visit if the condition is addressed during the visit (but it should not be the primary diagnosis for the visit).

8. **Avoid undocumented codes** -- Provide documentation for diagnoses. If a patient has a diagnosis that you are not documenting, it not only affects reimbursement in value-based care but also can affect patient outcomes.

9. **Use diagnosis code specificity tools** -- If your EHR has a diagnosis code calculator, make sure you use it to help you code to the highest level of specificity supported by documentation.

10. **Don't use "history of" codes for active conditions** -- If a patient's condition is currently being treated, do not use "history of" codes for that condition. This includes chronic conditions such as diabetes and heart failure, along with cancers.

RAPs Discontinued for Home Health Periods of Care in 2022 – *Palmetto GBA Bulletin*

Requests for Anticipated Payment (RAPs) are not to be submitted for periods of care (30-day billing periods) that begin on or after 1/1/2022. Periods of care that begin on or after 1/1/2022, either for new admissions or patients continuing care in 2022, require the HHA to submit a one-time NOA. For more information, please go to: https://www.cms.gov/files/document/mm12256.pdf

Once the January 2022 Quarterly Release is installed, RAPs for periods of care that begin on or after 1/1/2022, will be returned to the provider. If an HHA has submitted a RAP and it processed for a period of care that begins on or after 1/1/2022, the HHA must cancel it as soon as possible. HHAs may also need to contact their billing/software vendors to address this concern.

Please refer to the Billing the Home Health Notice of Admission (NOA) job aid for how to submit NOAs for patients continuing care in 2022. Please note NOAs cannot be submitted early, i.e., before the "From" date reported on the NOA.

https://www.palmettogba.com/palmetto/providers.nsf/files/Billing_the_Home_Health_Notice_of_Admission.pdf/$FILE/Billing_the_Home_Health_Notice_of_Admission.pdf

Medicare News

No Surprise Billing Allowed

Reminder: Effective January 1, 2022, the new No Surprises Act restricts out-of-network billing and protects patients from excessive costs should they receive care from providers that are not on their insurance plans.

A standard notice and consent form for nonparticipating providers can be obtained by going to: https://www.cms.gov/files/document/standard-notice-consent-forms-nonparticipating-providers-emergency-facilities-regarding-consumer.pdf

Please refer to the D December 2021 newsletter for more detailed information. Additional details regarding the rule and how it will be applied are still forthcoming as the new rule goes into effect for 2022.

Current news related to this interim rule can also be found at: https://www.cms.gov/nosurprises

Medicare deductible for 2022 = $233.00

Medicare Premiums Increase by 15%

Monthly premiums covering physician and outpatient care for Medicare beneficiaries will increase by 15% next year. The $21.60 monthly jump in Part B premiums equals an extra $259.20 in costs over 2022.

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