"Behind the cloud the sun is still shining."

-- Abraham Lincoln

AQREVA Medical Billing & Consulting

Client Memo March 2022

Last Month to Attest for MIPS 2021

The data submission window for MIPS 2021 closes on March 31, 2022.

As announced on November 10, 2021, CMS is applying the MIPS automatic extreme and uncontrollable circumstances (EUC) policy to all *individual* MIPS eligible clinicians for 2021.

Under the automatic EUC policy, individually eligible clinicians qualify for automatic reweighting of all performance categories; data submitted by or on behalf of the individual clinician will override reweighting on a category-by-category basis.

CMS has just reopened the MIPS EUC application for groups, virtual groups, and Alternative Payment Model (APM) Entities through March 31, 2022. The application deadline was originally the end of 2021.

To apply, please go to:
https://qpp.cms.gov/mips/exception-applica tions?py=2021

Please note that applications received between now and March 31, 2022, won't override previously submitted data for groups and virtual groups.

What happens if I am a MIPS eligible clinician covered by the automatic EUC policy but still submit data?

It depends on how many performance categories you submit data for as an individual.

- If you submit data for one performance category (or no data at all), you will receive a final score equal to the performance threshold and receive a neutral payment adjustment.
- If you submit data for 2 or 3 performance categories, you will be scored on the performance categories for which you submitted data. Your payment adjustment will be determined by your final score.
- You won't be scored in any performance category for which data isn't submitted.
- You won't be scored on the cost performance category under the automatic EUC policy even if data is submitted in other performance categories.

Data Submitted	Quality Category Weight	Promoting Interoperability Category Weight	Improvement Activities Category Weight	Cost Category Weight	Payment Adjustment
No data	0%	0%	0%	0%	Neutral
Submit Data for One Performance Category					
Quality Only	100%	0%	0%	0%	Neutral
Promoting Interoperability Only	0%	100%	0%	0%	Neutral
Improvement Activities Only	0%	0%	100%	0%	Neutral
Submit Data for 2 Performance Categories					
Quality **and** Promoting Interoperability	70%	30%	0%	0%	Positive, Negative, or Neutral
Quality **and** Improvement Activities	85%	0%	15%	0%	Positive, Negative, or Neutral
Improvement Activities **and** Promoting Interoperability	0%	85%	15%	0%	Positive, Negative, or Neutral

How do I sign in to the QPP website to submit my data or check my status?

You will need to create an account and connect to an organization, such as your practice, for individual or group reporting. You create an account on the HARP website and then log in and connect to your organization through the QPP website. For more information, please refer to *the Quality Payment Program Access User Guid*e, available in the Resource Library, on the Quality Payment Program website: https://qpp.cms.gov

NOTE: Quality measures reported through Part B claims are always reported at the individual level. CMS will automatically aggregate this quality data to the group or virtual group level in addition to scoring the individual clinicians.

No Surprises Act: Expert Insights to Help Doctors Follow the Law – Andis Robeznieks, *AMA New Bulletin*, February 1, 2022

Implementation of the No Surprises Act, intended to protect patients from unexpected out-of-network medical expenses, will take a while. But there are things that doctors must know and do now to comply and be prepared as regulations are developed and put in place.

A recently published AMA toolkit to help prepare doctors for implementation of the No Surprises Act contains information that can help ensure that the doctors themselves won't be taken by surprise by elements embedded deep within the regulations. Please review it at:
https://www.ama-assn.org/system/files/ama-nsa-toolkit.pdf

Experts from Manatt Health recently detailed enforcement challenges and the interaction between state and federal surprise billing regulations in an "AMA Advocacy Insights" webinar which can be viewed by copying and pasting or clicking on the link below:
https://www.ama-assn.org/delivering-care/patient-support-advocacy/ama-advocacy-insights-webinar-series-implementing-no

Manatt partner Michael Kolber outlined four key areas that physicians need to know about and prepare for:

- How is patient cost-sharing and physician payment determined for these out-of-network situations?
- What obligations exist to provide good faith estimates to patients?
- When a patient chooses to be treated by an out-of-network physician at an in-network facility, when can the physician get consent to balance bill for those nonemergency services?
- When can the physician get consent to balance bill for post-stabilization services in connection with an emergency visit to a hospital or a free-standing emergency department?

Please watch the webinar for answers to these questions.

Patient Cost-sharing, Doctor Payment

The core issues of the law concern patients receiving emergency care at an out-of-network hospital emergency department or freestanding ED; or patients receiving care from an out-of-network physician or other health professional for an ancillary service such as anesthesiology, pathology or radiology at an in-network facility.

"In either of those two situations, one of the core protections is that the patient can only be required to pay the in-network cost-sharing amount under the patient's health plan," Kolber said. "In all of these, the context is this is an insured patient that either has employer-sponsored coverage or has individual market commercial coverage."

The process involves two calculations: Patient cost-sharing, which happens at the front of the process; and physician payment, which is at the back end.

"The patient's obligation should be resolved relatively soon in this process—even if there continues to be a dispute between the provider and the plan about what the out-of-network reimbursement should be," Kolber said.

He added that, if a disputed payment between a health plan and a physician or other health professional goes to arbitration, it doesn't affect the amount the patient will pay. "It's just between the plan" and the doctor, Kolber explained.

The independent-dispute resolution process created by the regulations differs from what was written in the law, and Kolber noted that this is the subject of some lawsuits—including one jointly filed by the AMA and the American Hospital Association.

Kolber said the courts may issue rulings in the spring, or about the time the first arbitration proceedings begin—which would be 90 days after services were rendered. There is also the likelihood that the decisions would be appealed.

Good Faith Estimates for Uninsured

The good faith estimate has been an area of enormous agitation among physicians and others, Kolber said, adding that it only applies to services provided to uninsured or self-pay patients—included those who are covered by commercial insurance but are choosing not to use it.

If the actual charges for the episode of care exceed the good faith estimate by more than $400, the patient can dispute that bill through a new patient-physician dispute-resolution process.

Patients can also choose to be treated by an out-of-network physician at an in-network facility. But to do so, the physician must gain the patient's formal consent.

Getting What You're Owed Through Proper Coding

Proper documentation and taking advantage of new coding designations can ensure practices are getting the most for the care they provide.

A physician's goal is to care for their patients, but a key part of being able to provide that care is the eternal quest for payment, writes Keith A. Reynolds in his February 23, 2022, article for *Physicians Practice*.

One way to ensure that a practice maximizes its coding regimen is to make sure that each encounter can be efficiently billed. Adhering to the following expert coding tips can help practices supercharge their revenue.

Don't Tinker Around the Margins

Bill Dacey, MHA/MBA, president and CEO of The Dacey Group, says that when some people think of supercharging their coding practices, they think of billing for smaller things that they're not already doing. He warns this approach may not be as effective as expected.

"My approach to this has always been to stop working the corners and the little $3 codes and counting all that little stuff," he says. "Why don't you just make sure you're doing the stuff that you do 99% of the time? That will probably get your revenue where it's supposed to be."

Dacey says that mastering the new outpatient coding guidelines, released last year, can help shore up revenues by enabling the practice to bill for what the new guidance allows. He gives the example of code 99213.

It's the most commonly reported code in the country, and it's been a 99213 for 30 odd years, but with the changes that came in 2021, it makes it a whole lot easier to call that a 99214, he explains.

Dacey says this feels off to long-time physicians because it's been an evaluation and management level three for so long, but now it is a four.

"If (a practice) wanted to supercharge their coding, I would do it with the codes that had the real money," Dacey says. "You're doing the exact same thing you did two years ago, but now it's worth 50% more."

Documentation Is Key

Nancy Enos, FACMPE, CPC-I, coding consultant with Enos Medical Coding, says that the key to getting the most revenue through coding is proper documentation of time spent.

A focus on extensive documentation allows practices to keep track of all the time spent on a patient encounter, enabling the practice to efficiently bill. This documentation becomes very important when billing for non-patient facing activities.

Non-patient Facing Activities

Ms. Enos also recommends that practices understand which non-patient facing activities still count for time.

"There are several different things that count as reportable time as long as they're performed by a billing provider on the same date as the billable visit," she says. "It can't be the day before, it can't be the medical assistant, it has to be a billing provider and it has to be the same date."

These non-patient facing activities include:

- Preparing to see the patient
- Obtaining and reviewing separately obtained history
- Ordering medications, tests, or procedures
- Referring and communicating with other physicians
- Documenting clinical information in the electronic or other health record
- Independently interpreting results and communicating them to the patient, family, or caregiver
- Care coordination

There are so many things that billing providers can just confirm, like the patient history and labs that were collected by their support staff. When they review it on the day of the service before they see the patient, that could be another 20 minutes that is billable time toward the level of service.

After the patient leaves, any calls to physicians to put in place any coordination of care or documenting and updating the medical record itself is now billable time that never was counted before 2021

Ms. Enos also recommends making sure that a practice keeps track of time when it comes to telehealth appointments.

In instances where a telemedicine visit results in advice to come into the office because the patient does need to be seen, you can only bill one visit per patient per day, so it's just the office visit that's billed. You can bill for total time spent on the day of the encounter. If you're using time, then you could add the time together for the telemedicine visit and the in-office visit.

This is also a good reason to get your practice's documentation in order, as properly documented activities are more likely to stand up to scrutiny from insurance companies, Ms. Enos adds.

Principal Care Management

Effective January 1, 2022, Medicare began accepting four new CPT codes for principal care management (PCM) and discontinued two Healthcare Common Procedure Coding System G codes, reports Lisa Eramo in her February 2022 article for *Medical Economics*.

Experts say the new codes, which are paid at a higher rate than the G codes, afford physicians the opportunity to improve outcomes while simultaneously generating additional revenue.

What is PCM? PCM is similar to Chronic Care Management (CCM) in that both services are for patients who require ongoing clinical monitoring and care coordination. However, unlike its CCM counterpart, **PCM only requires patients to have one complex chronic condition**; CCM requires three or more.

For example, PCM could be appropriate for a patient with uncontrolled diabetes or uncontrolled hypertension or a high-risk patient with severe asthma who has frequent hospital readmissions, says Terry Fletcher, B.S., CPC, a health care coding and reimbursement consultant.

Many practices are already doing this work to take care of these patients. They just need to capture the right information so they can bill for it compliantly.

That information includes details such as:

- disease-specific care plans,
- adjustments in medication regimens,
- ongoing communication with specialists and more.

Internists who treat a high volume of Medicare patients should definitely consider providing and billing for all care management services, including transitional care management (TCM), CCM and PCM because this population tends to struggle with at least one chronic condition and frequent hospitalizations, says Don McDaniel, CEO of Canton & Company, a health care growth and strategic services firm.

Consider a patient who is admitted to the hospital with uncontrolled hypertension. The patient may require TCM for 30 days after discharge, followed by PCM for an additional 30 days or more. If the patient develops an additional complex chronic condition that requires ongoing monitoring, they may even be eligible for CCM instead of PCM.

Note that CCM is also a 30-day service for a patient with two or more chronic conditions expected to last at least 12 months and that place the patient at significant risk of death, acute exacerbation/decompensation or functional decline.

How can internists provide PCM effectively? Experts provide these five considerations for internists who plan to offer PCM in the months ahead:

1. Choose the right patients - Not every patient with a complex chronic condition requires PCM. Make sure you're documenting that the condition is severe enough that the patient is at risk for hospitalization or was recently hospitalized several times due to that condition
2. Bill the right codes:
   99424 and 99425 -- when a physician or nonphysician provider performs the PCM, and
   99426 and 99427 -- when clinical staff under the direct supervision of a physician or other qualified health care professional provides the service.
3. Document patient consent
4. Document who did what and for how long
5. Determine whether you'll outsource PCM -- ask these questions:
   - What type of PCM services are you currently providing but not billing?
   - Are you able to bill for those services and potentially cover the cost of hiring an additional staff member?

Preventive Counseling – 99401

This code has been used as a behavioral counseling code to report services for the purpose of promoting health and preventing illness.

Reimbursement for 99401 is typically on the order of $30-40. While not a princely sum, this is typically a service done in addition to pharmacotherapy management. Apply a 25 modifier, denoting a separate service on the same visit, and this will earn an extra $35 on your standard 99214 reimbursement.

Please note that this applies only to commercial membership. CPT 99401 is not covered for Medicare Advantage members. Medicare has its own separate code, **G0447**, which pays about 25% less and comes with more specific coding rules.

This notice is a clarification of the appropriate coding for provider reimbursement for COVID-19 vaccine counseling for vaccine-hesitant commercial members

Key Details

- CPT 99401: Preventative medicine counseling and/or risk factor reduction intervention(s) provided to an individual, up to 15 minutes -- may be used to counsel commercial members regarding the benefits of receiving the COVID-19 vaccine.
- CPT 99401 can be billed at only one visit for each member per day.
- Providers may bill CPT 99401 with ICD-10 code Z71.89 for no member cost-share.
- This service can be provided by MD/DO, NP, PA, and/or CNM.

For more information, view the special bulletin from the North Carolina Department of Health and Human Services:
https://www.bluecrossnc.com/provider-news/provider-reimbursement-covid-19-vaccine-counseling

MENTAL STATUS EXAM FOR TELEHEALTH VISITS

– Marc Berger, MD, *Practice Pearls, Family Practice Management*, Jan-Feb 2021 issue

Many of us are doing more telehealth visits during the COVID-19 pandemic. But when those visits call for a mental status exam, things can get tricky.

The Mini-Mental State Examination, Montreal Cognitive Assessment, and St. Louis University Mental Status Exam all require reading and writing, which are difficult to do via telehealth.

Instead, I use an old but validated 10-question screen: the Short Portable Mental Status Questionnaire (SPMSQ). It includes 10 standard questions with no need for the patient to write or read, which makes it a very useful test in hospitals, in nursing homes, and via telephone or telehealth visits.

Documenting the patient's correct or incorrect answers can help indicate the complexity of the medical decision making or the extended time required for the visit and support higher level coding.

For patients who do poorly on the SPMSQ, I usually estimate the Glasgow Coma Scale to get a quantitative estimate of their verbal and command-following abilities. If mood is a consideration, the Patient Health Questionnaire-2 is a quick screen that also produces a numerical score.

MIPS 2022 Updates

MIPS Explore Measures Tool Updated for 2022

CMS has updated the MIPS Explore Measures and Activities tool for the 2022 performance year. This handy tool is located at:
https://qpp.cms.gov/mips/explore-measures?tab=quality Measures&py=2022

CMS created the tool to help MIPS eligible clinicians get familiar with the available measures and activities for each performance category under traditional MIPS. *It's for planning purposes only and will not submit anything to CMS.*

The tool supports traditional MIPS participation.

Visit the MIPS Value Pathways (MVPs) and APM Performance Pathway (APP) webpages for more details about the measures and activities in those participation frameworks. The links are listed below:
https://qpp.cms.gov/mips/mips-value-pathways
https://qpp.cms.gov/mips/apm-performance-pathway

You can also download the specifications and other supporting materials related to the Promoting Interoperability, improvement activities, quality, and cost performance categories on the QPP website as well to assist with 2022 participation.
https://qpp.cms.gov

MEDICARE NEWS

What's the latest on Medicare coverage for tele-health?

For the duration of the COVID-19 public health emer-gency, CMS will pay for professional Medicare telehealth services furnished to beneficiaries in all areas of the country in all settings.

These visits will be considered the same as in-person visits and paid at the same rate as regular in-person visits. Services covered include the Medicare annual wellness visit and Medicare preventive services. CMS continues to update a blanket list of waivers for the duration of the emergency. See: https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

The 2022 Medicare Physician Fee Schedule final rule extended coverage for in-home telemental health services, including audio-only services, beyond the COVID-19 public health emergency. It also allows federally qualified health centers and rural health clinics to continue with telehealth after the public health emergency. But it did not provide the same extension to other types of telehealth.

Care Compare Quarterly Refresh – February 2022

The February 2022 quarterly refresh for the Hospice Quality Reporting Program is now available on Care Compare. https://www.medicare.gov/care-compare/

Public reporting of quality measure data has resumed following the temporary exemption to HQRP data sub-mission requirements, and the subsequent data freeze after the November 2020 refresh. Consumer Assessment of Healthcare Providers and Systems (CAHPS) Hospice Survey measure scores continue to exclude Quarter 1 and Quarter 2 of calendar year 2020. For additional information, please see the FY2022 Hospice Wage Index Final Rule at: https://www.cms.gov/Center/Provider-Type/Hospice-Center

CMS Makes Nursing Home COVID-19 Booster Vaccination Data Available Online,

CMS) is now posting data on COVID-19 vaccine booster shots administered to nursing home residents and staff on the Medicare.gov Care Compare website. The data will show resident and staff booster rates at the facility level and will include national and state averages.

CMS is also urging facilities to communicate with their fully vaccinated staff members and residents about the importance of staying up to date with COVID-19 shots to protect the vulnerable nursing home population. The new booster data will be displayed along with the other COVID-19 vaccination data already included on the Medicare.gov Care Compare website.

The CMS Omnibus Health Care Staff Vaccination rule requires that, by the Phase 2 implementation dates, staff be fully vaccinated, meaning individuals have completed their primary vaccination series, which is two weeks after a person has received their dose of a single dose vaccine, or two weeks after the second dose of a two-dose vaccine.

CMS requires that nursing homes educate their residents and staff and offer the COVID-19 vaccine, which includes the booster, but does not currently require booster doses.

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