AQREVA Medical Billing & Consulting

Client Memo
February 2022

"Normality is a paved road: it's comfortable to walk but no flowers grow." -- Vincent van Gogh

NEWS Update

Public Health Emergency Extended

U.S. Department of Health and Human Services Secretary Xavier Becerra has extended the COVID-19 Public Health Emergency (PHE) for an additional 90 days. This means that the telehealth and other waivers and flexibilities that have been implemented during the PHE will remain in effect until at least April 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 1/16/2022

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

Telehealth Changes for 2022

Outlined below is a summary of the changes to telehealth services for 2022 and through the end of the Public Health Emergency. Information was provided by CMS in its "2022 Guidelines for Telehealth" presentation offered January 4, 2022.

New Place of Service (POS) Codes

- 02 – services provided in an originating site other than the patient's home
- 10 – services provided in the patient's home
- **During the PHE**
  - **Use the POS to reflect what would have been in-person service**
  - **Use Modifier 95**

Technology

- Audio communication system
  - Telephone services using procedure codes 99441 – 99443 through the end of the PHE
  - Diagnosis, evaluation, and treatment of mental health disorders
  - Treatment of substance use disorders or co-occurring mental health disorder
    - Geographic and location restrictions do not apply

Services

- Categories of services
  - Category 1 - Professional services on the telehealth services list
  - Category 2 - Services not like those on the telehealth services list
  - Category 3 - Added on a temporary basis during the PHE for COVID-19
    - Some will end when the PHE ends
    - Some will end December 31, 2023
- List of services - For a complete CMS List of Telehealth Services, go to:

  https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
- CMS updates list on ongoing basis
- New services for 2022 – Category 3
  - Intensive Cardiac Rehabilitation
    - G0422
    - G0423
  - Cardiac Rehabilitation
    - 93797
    - 93798

Modifier

- Modifier G0 - Telehealth service for an acute stroke
- Modifier 95 - Synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system
- Modifier FQ - Opioid Treatment Program therapy and counseling weekly bundles or additional therapy or counseling (G2080)

Virtual Check-in

- Virtual Check-in - G2012
  - Physician or Non-Physician Practitioner (NPP) service
    - Not related to a previous E/M service within 7 days or within 24 hours or the next available appointment following the service
  - **Purpose is to determine need for in-person or telehealth encounter**
- Remote Pre-Record Evaluation - G2010
  - Not related to a previous E/M service within 7 days or within 24 hours or the next available appointment following the service
  - Physician or NPP reviewing picture, video, etc. of what patient submits
  - Physician or NPP making a medical decision
- Virtual Check-in - G2251
  - Provider not able to submit an E/M service
  - If applicable, follow incident to guidelines, 5 to 10 minutes
- Virtual Check-in - G2252
  - 11 to 20 minutes

MIPS Shock - No More Bonus Points or Loopholes

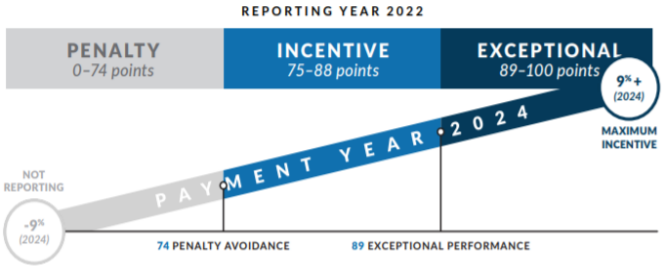
On November 2, 2021, CMS released the 2022 Physician Fee Schedule (PFS) Final Rule which governs MIPS and other quality payment programs. Anticipated changes were made to MIPS, making the program more challenging in 2022 and signaling additional changes to the program in coming years, writes Lauren Patrick in her December 6, 2021, article for *Healthmonix Advisor*.

Key takeaways for the 2022 traditional MIPS program can be seen in their MIPS 2022 face sheet, highlights of which are presented below:

MIPS determines quality and efficiency of care through four performance categories: Quality, Promoting Interoperability (PI), Improvement Activities (IA), and Cost. Performance in these four categories during the 2022 calendar year will aggregate into a final score used to determine a payment adjustment for a MIPS-eligible clinician or group in the 2024 payment year.

2022 Performance Year & 2024 Adjustments

Adjustments occur two years after performance year



What's New for 2022 Reporting?

- The performance threshold is increasing from 60 points to 75 points, making it more difficult to avoid the penalty.
- With this move, CMS predicts that exceptional performers could receive up to more than a 9% increase on 2024 Medicare payments.
- Quality performance category will be 30% of your overall score in 2022, down from 40% in 2021.
- Clinical social workers and certified nurse midwives were added as eligible clinicians.
- Extension of the CMS Web Interface as a quality reporting option within the APM Performance Pathway (APP) for participants in an APM.
- Promoting Interoperability performance category added automatic reweighting for clinical social workers and small practices.
- Cost category increases to 30% of overall score.
- Seven new Improvement Activities added.

MIPS TIPS AND TRICKS

- Get Started at the Beginning of the Year: Complete your 90 days for PI and IA so you can spend more time on Quality and Cost
-Focus on Performance Improvement – Attack Gaps in Care
-Track More Than 6 Quality Measures: Choose 8-10 measures

MIPS Quality Measures for 2022

Substantive changes were made to the following Quality measures reported via Medicare Part B Claims:

ID	Measure Description and Changes
1	**Hemoglobin A1c** Added G9988 denominator exclusion Updated rationale and added numerator note
110	**Preventive Care: Influenza Immunization**
111	**Pneumococcal Vaccination Status** Added G9991 Performance Met Added G9990 Performance Not Met Updated measure description
112	**Breast Cancer Screening** Added G9992 denominator exclusion
113	**Colorectal Cancer Screening** Added G9993 denominator exclusion
117	**Diabetes: Eye Exam** Updated several numerator options Added G9994 denominator exclusion
128	**BMI Screening and Follow Up** Added G9716 denominator exception Removed G8422 and G8938 Added G9996, G9997 denominator exclusion Updated denominator definitions
134	**Screening for Depression/Follow Up Plan** Updated denominator criteria Added G8433 denominator exception Added D32.4 to list of applicable dx codes
226	**Tobacco Use: Screening and Cessation** Updated numerator options for each criteria
236	**Controlling High Blood Pressure** Added G0031 denominator exclusion Updated description and instructions
317	**Screening for HBP/Follow up Documented** Added G8950 performance met Updated denominator criteria Updated measure description
395	**Lung Cancer Reporting – Biopsy/Cytology** Added Telehealth modifiers GQ, GT, 95 POS 2 Added G9418 Performance met
396	**Lung Cancer Reporting – Resection** Added Telehealth modifiers GQ, GT, 95 POS 2 Updated measure description and instructions
397	**Melanoma Reporting**
416	**ER Dept Utilization of CT Head Trauma**
418	**Osteoporosis Mgmt Women Fracture** Added numerator options Added G0048 denominator exclusion Updated measure description

The following claims-based measures have been removed for 2022. Please choose an alternative measure to report.

ID	MIPS Quality Measure Description
014	AMD: Dilated Macular Examination
021	Perioperative Care: Selection Prophylactic Antibiotic – 1st or 2nd Generation Cephalosporin
023	Perioperative Care: VTE Prophylaxis When Indicated
050	Urinary Incontinence: Plan of Care Women 65 +
093	AOE: Systemic Antimicrobial Therapy
154	Falls: Risk Assessment
182	Functional Outcome Assessment
195	Radiology: Stenosis Measurement Carotid Imaging Reports
225	Radiology: Reminder System for Screening Mammograms
254	Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain
326	Atrial Fib & Atrial Flutter: Chronic Anticoagulation Therapy
425	Photo Documentation of Cecal Intubation
429	Pelvic Organ Prolapse: Preop Screening for Uterine Malignancy

Specification sheets containing detailed information on each of the 2022 Quality measures can be found on the Quality Payment Program website: https://qpp.cms.gov
If you have any questions or need assistance, please contact your account representative or call ***1.800.568.4311.***

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 Individual NPI number to find out whether you need to participate in MIPS during the 2022 performance year. Click on 2022 for participation year.

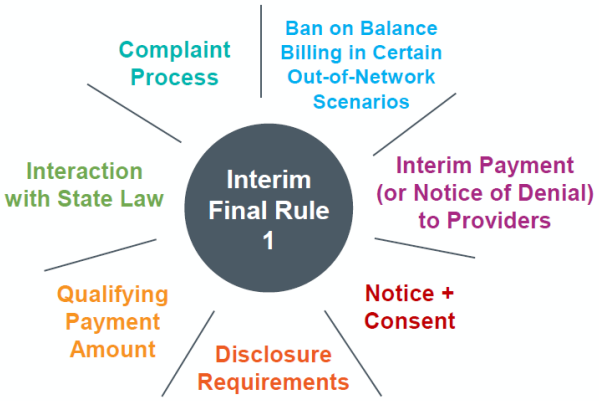
The No Surprises Act: Your Questions Answered -- Heather Kawamoto and Joseph Mercer, WayStar Presentation, January 11, 2022

Background: Intended to protect patients from surprise medical bills in situations where the patient has little or no control over who provides their care, including nonemergency services provided by out-of-network providers (physicians) at in-network facilities.

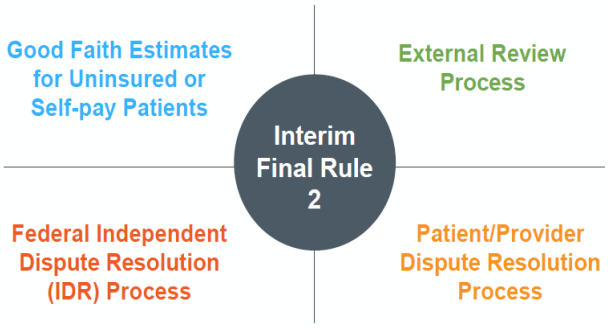
Enforcement: Regulations grant states enforcement authority. Absent of state action, Secretaries of Labor, HHS and Treasury have enforcement authority.

Fines: an amount not to exceed $10,000 per incident

Part 1: Implementing the No Surprises Act 7.13.2020



Part 2: Implementing the No Surprises Act 9.30.2020



Good Faith Estimates – Uninsured + Self-pay Patients 1.1.2022

Providers and facilities that schedule items or services for an uninsured/self-pay individual or receive a request for a Good Faith Estimate. *Emergency services and ground ambulance are excluded.*

Good Faith Estimate Notice

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost

Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

- Inform all self-pay patients of GFE availability when scheduling
- Post notice on the facility/providers website
- Post notice at a physical location

Copy Link to Obtain Forms:
https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791

Out-of-Network Identification

- Currently, providers are responsible to determine in/out of network insurance plan usage.
- Providers should have unique "out-of-network" insurance plans for Patient Access use and identification (Example: Cigna, Select – Out-of-Network).
- Electronic eligibility and benefits are based on EDI payer connections. Electronic information cannot be processed on generic insurance plan (Example: Out of Network Insurance).
- A standard and unique field for the provider's network status with that payer **DOES NOT EXIST** in the current EDI transaction.
- Payers will display a network status for benefit identification (Example: 20% coinsurance in-network and 50% coinsurance for out-of-network).
- Out-of-network consent is necessary for scheduled, non-emergent cases.

Out of Network Consent

Given to out-of-network patients when they seek services.

Must be given to patients within **72 hours** of the scheduled appointment.

If scheduled less than 72 hours must provide **same day** of scheduled appt but **no less than 3 hours** to providing the service.

Out-of-network providers must notify health plans when they provide services, and they must certify that they have met the required notice and consent requirements.

Patient Financial Services

- Weekly/Monthly query of remit data: CARC code 242 or 279, Claim Group code PR with CARC code 45. NOTE: 30-day window to challenge QPA starts with payer payment date -- Remittance Advice Remark Code (RARC): N830, N859, N860
- Validate OON insurance plan was used during registration
- CARC 45 This type of report requires a thorough review. Multiple providers discovered several payer errors in reviewing accounts. The patient was actually in network but the claim processed as OON.

Source:
https://www.federalregister.gov/documents/2021/07/13/2021-14379/requirements-related-to-surprise-billing-part-i

$2B in Provider Relief Fund Payments Heading to Providers

The Provider Relief Fund payments are part of the Phase 4 General Distribution announced in December.

HHS, through the Health Resources and Services Administration (HRSA), is doling out another $2 billion in Provider Relief Fund payments to healthcare providers impacted by the COVID-19 pandemic, reports Jacqueline LaPointe in her January 26, 2022, article for *RevCycle Intelligence.*

More than 7,600 providers across the country will get the payments this week as part of the Phase 4 General Distribution announced in December, HHS said in a January 25th announcement.

Terms and conditions on the payments stipulate that providers who accept the payments can only spend money on efforts to "prevent, prepare for, and respond to coronavirus, and for related expenses or lost revenues attributable to coronavirus." They must also spend the money within a certain timeframe or repay the government.

The $2 billion in Provider Relief Fund payments bring total Phase 4 General Distribution payments to nearly $11 billion. HRSA distributed the funds to more than 74,000 providers in all 50 states, Washington DC, and five territories. The payments were also on top of another $7.5 billion sent specifically to rural providers as part of American Rescue Plan implementation.

MIPS 2021 Update

2021 MIPS Attestation Reminder

MIPS 2021 Data Submission Window Now Open

Data can be submitted and updated from now until 8:00 pm ET on March 31,

The Quality Payment Program (QPP) was developed and tested to support Google Chrome and Microsoft Edge browsers.

(slides courtesy of hsag.com, *Quest Digest*)

2021 Suppressed Quality Measures

CMS has suppressed or truncated the following Quality Measures for the 2021 Reporting Period. Reporting these measures will result in a 10-point deduction for each suppressed measure. Data will be scored from the first 9 months of the performance period if a measure is truncated. If one of the measures affects you, please choose a different measure to submit for 2021.
These are the affected measures and reporting type:

- **Diabetes Hemoglobin A1C Poor Control: Medicare Part B claims**
- **Pneumococcal Vaccination Status for Older Adults: Medicare Part B Claims, eCQM, CQM**
- **Diabetes Eye Exam: Medicare Part B Claims**
- **Preventive Care and Screening BMI & Follow up: eCQM**
- **Preventive Care and Screening for Depression and Follow Up: CMS Web Interface**

2021 MIPS Quality Measure Truncated

CMS will truncate the performance period to the first 9 months of data for the Medicare Part B claims, MIPS clinical quality measure (CQM), and eCQM collection types for measure **Q111: Pneumococcal Vaccination Status for Older** since updated pneumococcal vaccine

recommendations no longer aligned with the current posted measure specifications..

2021 MIPS Quality Measures Suppressed

The following measures are excluded from a MIPS-eligible clinician's total measure achievement points and total available measure achievement points for 2021:

i. each submitted CMS Web Interface-based measure that meets the data completeness requirement, but does not have a benchmark or meet the case minimum requirement, or is redesignated as pay-for-reporting for all Shared Savings Program accountable care organizations by the Shared Savings Program; and

ii. each administrative claims-based measure that does not have a benchmark or meet the case minimum requirement

For more information, please visit the January *Quest* Details webpage to review suppressed measures, collection type, and suppression rationale. Go to: https://www.hsag.com/en/quality-payment-program/qpp-quest-digest/quest-details/january-2022-quest-details/#suppression

QPP SURS Initiative Ending

Over the past five years, CMS has successfully implemented a technical assistance initiative for clinicians in small practices participating in the QPP, known as the Small, Underserved, and Rural Support (SURS) program.

This initiative provides free, customized technical assistance to practices with 15 or fewer MIPS-eligible clinicians. As clinicians are preparing for the start of the 2022 performance year, it is important to note that **the SURS initiative will end on February 15, 2022**. MACRA only provided for five years of direct support.

For those currently receiving MIPS support from the SURS technical assistance organizations, be assured that these organizations have committed to providing exceptional technical assistance through February 15, 2022.

Medicare News

Billing for Patients Vaccinated On or After January 1, 2022

For Medicare Advantage patients vaccinated on or after January 1, 2022, COVID-19 vaccine administration claims must be submitted to the Medicare Advantage Plan. Original Medicare stopped paying these claims on January 1, 2022. Medicare Advantage claims before January 1st needed to be submitted to original Medicare for payment.

How Do I Bill for Hospice Patients?

For hospice patients under Part B only, you must include the GW modifier on COVID-19 vaccine administration claims if either of these apply:

- The vaccine isn't related to your patient's terminal condition
- The attending physician administered the vaccine

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