"Our greatest glory is not in never falling but in rising every time we fall." -- Confucius

Client Memo
July 2020

NEWS Update

- UnitedHealthcare COVID-19 Update (Page 2)
- Updated End Dates for Relaxed Telehealth Rules (Page 3)
- COVID-19 and Malpractice: New Risks (Page 3)
- Virtual Visits Without Video (Page 3)
- Collecting Patient Vitals for Telehealth Visits, AWVs (Page 4)
- OIG Audit & Updated ABN Form (Page 4)
- MIPS Information (Page 5)
- Medicare News (Page 5)

Extending Telehealth Coverage

In his article "House to Debate Extending CARES Act Telehealth Coverage Indefinitely," (*mHealth Intelligence,* June 29, 2020), Erick Wicklund writes that the stage is being set for discussions on extending the telehealth freedoms enacted over the past few months by the Health and Human Services Department to address the COVID-19 pandemic.

Introduced on June 25, 2020, the **Advancing Telehealth Beyond COVID-19 Act** aims to make those freedoms permanent. It would continue the telehealth policies implemented by the Trump Administration through the CARES Act, while advancing access to emerging technology for seniors especially in rural areas.

This bill will allow seniors to utilize telehealth services even after the emergency declaration has ended.

COVID-19 presented unprecedented challenges, one being the facilitation of a safe environment for our seniors to receive high quality health care," Rep. Liz Cheney (R-WY), who introduced the bill with Reps. Greg Gianforte (R-MT), David Kustoff (R-TN) and Jason Smith (R-MO), said in a press release.

According to its sponsors, the bill would direct the HHS Secretary to eliminate originating site and geographical limitations to Medicare coverage for telehealth, which had been waived for the duration of the national emergency in the CARES Act. It would also make permanent telehealth coverage at federally qualified health centers (FQHCs) and rural health centers (RHCs), and remove restrictions that limit health care providers' ability to provide access to smart devices and innovative digital technology to their patients.

The bill joins no fewer than half a dozen other bills aiming to expand telehealth and mHealth opportunities in the wake of the COVID-19 pandemic, as well as a task force of healthcare providers, organizations, vendors and advocates formed to lobby for permanent telehealth freedoms.

CMS Evaluating Telehealth Waivers

Medicare members using telehealth grew 120 times in early weeks of COVID-19 as regulations eased.

- The number of Medicare beneficiaries using telehealth skyrocketed in the early weeks of the pandemic as the Trump administration relaxed regulations to virtual care.
- Almost 1.3 million members received telehealth services in the week ending April 18, compared to just 11,000 in the week ending March 7, according to current Medicare claims data — an increase of more than 11,718% in just a month and a half.
- The looser regulations are only in place for the extent of the national public health emergency, but a myriad of groups have called on HHS to permanently relax the barriers. Top administration health officials have said they're exploring the possibility.

Federal agencies, public payers and large commercial insurers alike have scrambled to expand access to telehealth amid the pandemic, slashing cost-sharing, removing regulatory and administrative roadblocks and distributing funding to build out communities' health IT infrastructure, writes Rebecca Pifer in her May 27, 2020, article "Medicare members using telehealth grew 120 times in early weeks of COVID-19 as regulations eased," for *Healthcare Dive.*

CMS Administrator Seema Verma told reporters on May 26, 2020, that her department is evaluating the telehealth waivers to determine if they should be extended past the scope of the national emergency, and is in the process of additional rulemaking around the issue.

"You'll see that some of the provisions that we have extended on a temporary basis will be made permanent," Verma said.

Previously, telehealth use in Medicare was severely restricted to specific locations and circumstances, like for beneficiaries in rural areas or patients already in a hospital. According to CMS, only 90,000 fee-for-service Medicare beneficiaries used virtual care through the entire 2016 calendar year — seven times fewer than the amount that used telehealth the week ending April 4th alone.

CMS has sharply expanded the number of services available via virtual care, upped payments for audio-only visits and granted a blanket waiver enabling providers licensed in one state to provide services to patients in another.

Analysts say virtual care is likely to remain popular for low-acuity care, like chronic disease management, behavioral healthcare and evaluation visits that can easily be conducted through a telehealth modality, especially if CMS retains telehealth payment parity for Medicare's 44 million beneficiaries.

-- linkedin.com

UnitedHealthcare COVID-19 Update

Extending Temporary Telehealth Expansion and Reimbursement

UnitedHealthcare will continue to waive the CMS originating site requirements for members through September 30, 2020. UnitedHealthcare will also temporarily reimburse providers for telehealth visits at parity with the rate they would receive for an in-person visit.

Individual and Fully Insured Group Plans

In Network

UnitedHealthcare will extend the expansion of telehealth services for in-network providers through Sept. 30, 2020. During this expansion timeframe, UHC will temporarily reimburse providers for telehealth services at their contracted rate for in-person services.

Out of Network

UnitedHealthcare will extend the expansion of telehealth services for out-of-network providers through July 24, 2020. As of July 25, 2020, out-of-network telehealth services will be covered according to the member's benefit plan and UnitedHealthcare's standard telehealth reimbursement policy.

Medicare Advantage Plans

In Network

UnitedHealthcare will extend the expansion of telehealth services for in-network providers through Sept. 30, 2020. During this expansion timeframe, we will temporarily reimburse providers for telehealth services at their contracted rate for in-person services.

Out of Network

UnitedHealthcare will extend the expansion of telehealth services for out-of-network providers through July 24, 2020. As of July 25, 2020, out-of-network telehealth services will be covered according to the member's benefit plan and UnitedHealthcare's standard telehealth reimbursement policy

Extending Telehealth Cost Share Waivers

UnitedHealthcare is also continuing its expansion of telehealth including temporarily waiving member cost share for telehealth visits for medical, outpatient behavioral, physical, occupational and speech therapy, chiropractic therapy, home health, hospice and remote patient monitoring services, with opt-in available for self-funded employers.

- For COVID-19 in-network and out-of-network telehealth services, UnitedHealthcare is waiving cost share through the national public health emergency period.
- For COVID-19 in-network only telehealth services, UnitedHealthcare will extend the cost share waiver from July 25, 2020 through Sept. 30, 2020.*
- For non-COVID-19 in-network only telehealth services, UnitedHealthcare will extend the cost share waiver through Sept. 30, 2020.*

* This date is subject to change based on directions from CMS.

Additional Details

UnitedHealthcare is waiving the CMS originating site restriction through Sept. 30, 2020.

The temporary policy changes apply to members whose benefit plans cover telehealth services and allow those patients to connect with their doctor through live, interactive audio-video or audio-only visits.

Depending on whether a claim is for a Medicare Advantage, Medicaid, Individual and fully insured Group Market health plan members, those policies may require slightly different modifiers, date of service limitations or place of service indicators for a telehealth claim to be reimbursed. For more details, please visit: UHCprovider.com/covid19

Updated End Dates for Relaxed COVID-19 Telehealth Rules

Below are updated end dates for other insurance plans' relaxed telehealth visit rules.

As always, this is a fluid situation and the dates below are subject to change. Information is as current as reasonably possible, as of July 1, 2020. Telehealth visits billed after the end dates will be denied.

End Dates by Payers for Relaxed Telehealth Visit Rules

Insurance Plan	Proposed End Date
Aetna	8/4/2020
AHCCCS plans	until end of COVID-19 emergency
BCBS AZ	7/31/2020
BCBS AZ Medicare Adv	12/31/2020
BCBS Federal Plan	until end of COVID-19 emergency
Cigna	7/31/2020
GEHA	6/30/2020
Humana	until end of COVID-19 emergency
Medicare	until end of COVID-19 emergency
Tricare	until end of COVID-19 emergency
UnitedHealthcare	9/30/2020

The federal government emergency period is slated to end 7/24/20 but that may change going forward.

COVID-19 and Malpractice: New Risks

The coronavirus pandemic has affected many aspects of healthcare, including medical malpractice. Chris Mazzolini of *Medical Economics Pulse* discusses this topic with Sean P. Byrne, JD, a malpractice defense lawyer.

The video discusses how COVID-19 has scrambled a physician's malpractice risks, and what doctors need to do to prepare. To watch the video, please go to: https://www.youtube.com/watch?v=_MaC8T7Eluk&feature=youtu.be

A transcript of the video, edited for length and clarity, can also be read in the June 2020 issue of *Medical Economics:* https://www.medicaleconomics.com/view/covid-19-and-malpractice-new-risks-to-watch-for

Virtual Visit Options for Patients Who Can't Do Video – staff, *FPM bulletin*, May 30, 2020

Patients may be leery about coming into your office during the COVID-19 pandemic, no matter how many safety measures you take. Here are four ways to treat them remotely even if they don't have the equipment or technological know-how to do video visits:

1) Online digital evaluation and management (E/M) services, or "e-visits" (**CPT 99421-99423**): Back-and-forth, not real-time (asynchronous) communication, usually done through a secure email or patient portal.

2) Virtual check-ins (**HCPCS G2012**): Synchronous brief communication by phone or other device to determine if in-person care is needed.

3) Remote evaluation (**HCPCS G2010**): Evaluation of recorded video or images (store and forward).

4) Telephone E/M services (**CPT 99441-99443**): Diagnosis and management of a patient's problem over the phone. Medicare has agreed to temporarily reimburse these services at the same rates as if they were performed in-person and increased the number of services that can be performed over the phone.

The following rules apply to all four types of services:

- They are not limited to rural settings, no location restrictions.
- Medicare covers them (check with commercial payers before billing).
- Time-based codes must have time documented in the note.
- They can be provided to new or established patients during the public health emergency.
- They must be patient-initiated. The patient calls the practice or sends a message requesting a new appointment, or the patient agrees to change a previously scheduled face-to-face visit to a virtual encounter.
- They may result in co-pay or cost-sharing; patient consent must be documented.
- Information that can be stored and shared (for example, text messages, recorded video, or images) must be stored in the patient's electronic health record. Best practice is to include it in the encounter note.

How to Collect Patient Vitals for Telehealth Visits, Including AWVs – staff, *FPM Journal,* May 29, 2020

CMS stated that during the COVID-19 public health emergency, patients may self-report vital signs and other biometric data for Medicare annual wellness visits (AWV) done via telehealth.

Medicare AWVs have always been on the CMS list of covered telehealth services. But there was some confusion about how to collect certain required biometric data (e.g., height, weight, blood pressure, and other measurements deemed appropriate based on medical and family history) after CMS waived the originating site requirement and allowed telehealth to be delivered to patients in their homes during the COVID-19 emergency.

CMS staff reaffirmed on May 12, 2020, that an AWV can be provided via telehealth and physicians may record vital signs that patients have measured themselves. CMS has said it will soon release further guidance, including what to do when patients are unable to collect their own measurements.

Additionally, it may be useful for practices to ask patients to submit self-reported vitals for other telehealth visits as well during the pandemic. Jesse Bracamonte, MD, and Augustine Chavez, DO, write in an *FPM Practice Pearl* that they started having their staff instruct patients to submit vitals via the portal in advance of telehealth visits, and it has helped with chronic disease management in particular.

Patients with conditions such as hypertension, obesity, and diabetes may be experienced at measuring glucose and blood pressure but may require a gentle reminder to have those measurements ready for the appointment.

OIG to Audit $50B in Coronavirus Relief Funds Given to Providers

The OIG (Office of the Inspector General) at HHS recently announced that it will audit the distribution of $50 billion in coronavirus relief funds to hospitals and other eligible healthcare providers, states Jacqueline LaPointe in the June 1, 2020, issue of *RevCycle Intelligence.*

In the announcement released at the end of May, the OIG said the audit will determine the effectiveness of HHS controls over the awarding and disbursement of the coronavirus relief funds given to healthcare providers through the Provider Relief Fund.

The audit will also, among other things, decide whether HHS control over the funds ensured that the payments were correctly calculated and disbursed to eligible providers. The federal watchdog will collect data and interview program officials to complete the audit, which is expected to conclude in 2020.

ABN, Form CMS-R-131, Renewed

The Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, and instructions have been approved for renewal by the Office of Management and Budget (OMB). The use of the renewed form with the **expiration date of 06/30/2023 will be mandatory on 8/31/2020.**

An ABN form is issued by providers (including independent laboratories, home health agencies, and hospices), physicians, practitioners, and suppliers to Original Medicare FFS beneficiaries in situations where Medicare payment is expected to be denied.

The ABN is issued in order to transfer potential financial liability to the Medicare beneficiary in certain instances, such as:

- Prior to providing an item or service that is usually paid for by Medicare under Part B (or under Part A for hospice, HHA, and RNHCI providers only) but **may not be paid for in this particular case because it is not considered medically reasonable and necessary**;
- Prior to providing custodial care;
- For hospice providers, prior to caring for a patient who is not terminally ill;
- For DME supplies;
- For HHA providers, prior to providing care when the individual is not confined to the home or does not need intermittent skilled nursing care.

Enough time should be given for the beneficiary to make an informed decision on whether or not to receive the service or item in question and accept potential financial liability.

An ABN Quick Guide is available by going to:
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf

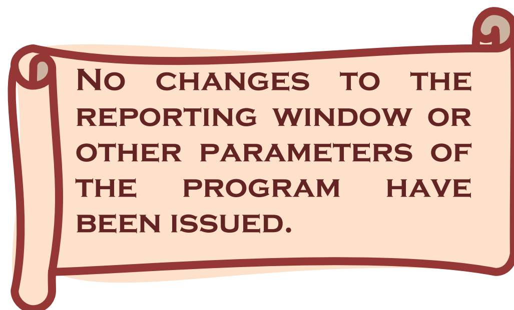
Note: SNFs issue the ABN to transfer potential financial liability for items/services expected to be denied **under Medicare Part B only.**

The ABN form and instructions may be found at:
https://www.cms.gov/Medicare/Medicare-General-Information/BNI/Downloads/ABN-Form-Instructions.pdf

How Will the QPP MIPS Program Be Affected by the COVID-19 Pandemic?

To date, CMS has issued many changes. The 2019 MIPS reporting requirement had an extended deadline and options for hardship exemptions. The 2020 MSSP program reporting period had many changes in both of the interim final rules with comment periods issued by CMS, at the end of March and the end of April 2020, reports Lauren Patrick for *Healthmonix Advisor*, May 18, 2020.

CMS has also added a COVID-19 improvement activity to the 2020 program, that provides full credit for the Improvement Activity category for MIPS, if an individual or 50% of a group (TIN) participates in clinical trial reporting.



With the exponential adoption of telehealth through this period, we know that the MIPS quality measures to be reported will be affected.

Organizations have two options for quality reporting when a large portion of their visits move to telehealth:

1. Stick with the measures that the practice already is familiar with. In some cases, the number of patients that are eligible for reporting will significantly decrease, as patient visits that are telehealth are not eligible to be included in the measure. That's okay -- Just because the number of eligible visits is reduced does not in any way lessen the scoring of the measure.

2. Choose measures based on their applicability to telehealth visits. If a practice wants to decrease their reporting population, they can select measures that DO NOT apply to telehealth. If they want to capture all patient visits in their reporting, they may choose different measures.

For the MIPS 2020 performance period, more measures are being introduced into the Cost category of MIPS. While the impact of the Cost category is not increasing this year from a percentage standpoint, the number of Medicare providers impacted by this category is growing due to this factor.

More MIPS News

CMS Announces Relief for Clinicians Participating in the Quality Payment Program in 2020

In response to the COVID-19 public health emergency, CMS is announcing flexibilities for clinicians participating in the MIPS Quality Payment Program in 2020.

- Clinicians significantly impacted by the public health emergency may submit an Extreme & Uncontrollable Circumstances Application to reweight any or all of the MIPS performance categories. Those requesting relief via the application will need to provide a justification of how their practice has been significantly impacted by the public health emergency.

- Reminder: In April 2020, CMS added a new COVID-19 clinical trials improvement activity. There are two ways MIPS-eligible clinicians or groups can receive credit for this new improvement activity:

  - A clinician may participate in a COVID-19 clinical trial and have the data entered into a data platform for that study; or

  - A clinician participating in the care of COVID-19 patients may submit clinical COVID-19 patient data to a clinical data registry for purposes of future study.

For More Information please go to the QPP website: https://qpp.cms.gov

Medicare News

CMS Finalizes Telehealth Reimbursement for Medicare Advantage Plans, ESRD Patients

CMS has issued a final rule on expanded telehealth coverage for members in Medicare Advantage plans and those living with end-stage renal disease.

Building on a proposed rule issued this past February, CMS is encouraging MA plans to increase access to telehealth services for members living in rural areas and including specialties, such as dermatology, psychiatry, cardiology, otolaryngology, ophthalmology, allergy and immunology, nephrology, primary care, gynecology and OB/GYN, endocrinology and infectious diseases, in meeting CMS network adequacy standards.

The final rule also expands the opportunities for patients with end-stage renal disease (ESRD) to get coverage for telehealth services.

Following through on provisions in the 21st Century Cures Act and an executive order issued by President Trump in July 2019, CMS will now allow beneficiaries with ESRD to enroll in the MA plan that best fits their needs, beginning in 2021.

This opens the door to, among other things, home-based dialysis programs that use remote patient monitoring technology for care management and transplant programs that use telehealth to improve organ procurement and post-operative recovery.

The agency said it is issuing a subset of its proposed changes now to enable MA plans to add those services to their 2021 plans.

Further changes will be announced later.

Physician Compare Preview Period is Now Open

The Physician Compare 60-day Preview Period is officially open as of June 22, 2020 at 10 a.m. ET (7 a.m. PT). You can now preview your 2018 Quality Payment Program performance information before it will appear on Physician Compare profile pages and in the Downloadable Database.

You can access the secured Preview through the Quality Payment Program website. https://qpp.cms.gov

Access the "Physician Compare Preview Period User Guide" to preview your data:
https://www.cms.gov/files/document/2018-preview-period-guide.pdf

Please note the 2018 performance information is targeted for public reporting in 2020 and will be added to Physician Compare and/or the Downloadable Database after all Targeted Reviews are completed. If you have an open Targeted Review request, you will still be able to preview your 2018 Quality Payment Program performance information through the Physician Compare Preview Period.

For additional assistance with accessing the Quality Payment Program website, or obtaining your EIDM user role, contact the Quality Payment Program service center at QPP@cms.hhs.gov.

CMS Publishes 2019 Open Payments Data

On June 30, 2020, CMS published Open Payments Program Year 2019 data, along with newly submitted and updated payment records for previous program years. The data is accessible at https://openpaymentsdata.cms.gov/.

Open Payments is a national disclosure program that promotes transparency and accountability by making information about the financial relationships between applicable manufacturers and group purchasing organizations and physicians and teaching hospitals available to the public.

Payments are reported in three payment categories: general payments, research payments, and ownership or investment interests.

CMS is scheduled to refresh the Open Payments data in early 2021 to reflect updates to the data made since this publication.

We are working hard to keep you on the edge of healthcare. Help us fulfill our strong commitment to maintain our level of service excellence by providing us with your feedback. Please feel free to contact Sue or Julie at 1.877.845.2969.

For more information about any of these articles, we invite you to contact:

Susan Magalnick or Julie Serbin @ DRS 1.877.845.2969

www.doctorsresourcespecialists.com