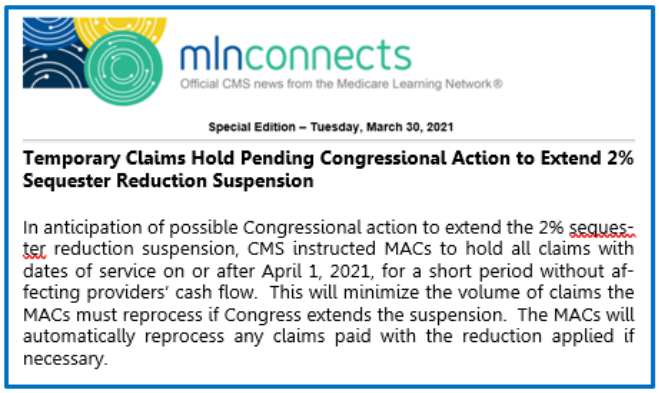
DOCTORS' RESOURCE SPECIALISTS

"Yesterday is not ours to recover, but tomorrow is ours to win or lose." -- Lyndon B Johnson

Client Memo
April 2021

NEWS Update



mlnconnects
Official CMS news from the Medicare Learning Network®

Special Edition – Tuesday, March 30, 2021

Temporary Claims Hold Pending Congressional Action to Extend 2% Sequester Reduction Suspension

In anticipation of possible Congressional action to extend the 2% sequester reduction suspension, CMS instructed MACs to hold all claims with dates of service on or after April 1, 2021, for a short period without affecting providers' cash flow. This will minimize the volume of claims the MACs must reprocess if Congress extends the suspension. The MACs will automatically reprocess any claims paid with the reduction applied if necessary.

Hailey Mensik provides the following update in the March 31, 2021, edition of *Healthcare Dive*.

- CMS instructed Medicare administrative contractors to hold all claims for services provided on or after April 1, when Medicare sequester cuts are currently scheduled to go back into effect.
- CMS will automatically reprocess claims paid with the reduction applied if necessary, as the House is expected to take up the bill passed in the Senate when it returns from break April 13.

The Senate passed a bill March 25, 2021, extending the pause on Medicare sequester cuts through the duration of the COVID-19 public health emergency.

The House also passed different legislation that would extend the moratorium through the end of 2021, and includes a provision to eschew budget rules that would have imposed additional cuts on Medicare payments to providers.

The cuts are slated to go back into effect April 1st, and the House isn't expected to take up the Senate bill until it returns from Easter recess the week of April 13th.

CMS will likely hold the Medicare claims until the bill is signed into law as it has done previously, according to the American Hospital Association.

MIPS 2021

Here is a quick recap of this year's requirements now that 2020 MIPS performance period is done.

A MIPS 2021 Quick Start Guide is located at: file:///U:/MACRA%20&%20MIPS/2021%20MIPS%20Overview%20Quick%20Start%20Guide%20(2).pdf

If you are participating in an APM, please refer to the above referenced guide for additional information.

Things to know for 2021:

1. Check Current Eligibility on the QPP website site https://qpp.cms.gov
2. Use the 2021 Quality Measures list on the QPP website to identify the measures you will report.
    - Specialty measure guides are available on the QPP website.
    - The data completeness requirement remains at 70%, which means that you need to report performance, exclusion or exception data for at least 70% of patients or encounters that are eligible for the measure's denominator.
3. Promoting Interoperability
    - Querying the PDMP remains an optional measure worth 10 bonus point.
    - Optional Health Information Exchange bi-directional exchange measure was added.
4. Improvement Activities
    - No significant changes
5. Cost category measures remain the same
    - For further information on how Cost is calculated, please go to the QPP website and review the 2021 Cost Guide.
6. The Exceptional performance threshold remains at 85%.

End Dates Same for Relaxed Telehealth

End Dates by Payers for Relaxed Telehealth Visit Rules

Insurance Plan	Proposed End Date
Aetna	until further notice
AHCCCS plans	until end of COVID-19 emergency
BCBS AZ	until end of COVID-19 emergency
BCBS AZ Medicare Adv	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 Commercial	New 2021 Telehealth Reimbursement Policy

- updated 3/31/2021

The COVID-19 Public Health Emergency set to end April 20, 2021

** Cigna's Virtual Care policy went into effect January 1, 2021. Details are available at: https://static.cigna.com/assets/chcp/secure/pdf/resourceLibrary/clinReimPolsModifiers/Notifications/R31_Virtual_Care.pdf

*** United Healthcare's Telehealth Reimbursement policy went into effect January 1, 2021. Details are located at: https://www.uhcprovider.com/content/dam/provider/docs/public/policies/comm-reimbursement/COMM-Telehealth-and-Telemedicine-Policy.pdf

No word has yet been received on whether the COVID-19 Public Health Emergency will be extended.

What is the Cures Act?

Implementation of the Cures Act -- April 5, 2021.

The patient is at the center of the 21st Century Cures Act. Putting patients in charge of their health records is at the center of the U.S. Department of Health and Human Services' (HHS's) work toward a value-based healthcare system. It is also the first step in transparency in healthcare information, explains Terry Fletcher in his March 29th article "The Cures Act: Enpowering Patients," for *ICD 10 Monitor.*

As outlined in the Act, patients need more power in their healthcare choices – and access to information is key to making that happen, he adds.

November 2, 2020, was the original deadline for the implementation of the Act. This applicability date was changed to April 5, 2021, in light of the challenges associated with the COVID-19 pandemic.

In a nutshell, this legislation directs providers to:

- cease all efforts of information blocking with respect to their electronic records, and
- encourage and promote interoperability and allow for communication and cooperation with third-party application program interfaces.

With respect to portions of the clinical notes, there appears to be certain exceptions, wherein physicians can block access to some items, including psychotherapy notes, HIV testing results, and any notes that, in a physician's judgement, could cause harm to an individual.

For the American public as a whole, the Act promotes innovation in the healthcare technology system to deliver better information and more conveniently to patients and clinicians.

Following are a few of the FAQs available on the ONC's Cures Act site to further clarify some of the confusion on what may be considered failure to fulfill the requirements of the Act.

Q: When would a delay in fulfilling a request for access, exchange or use of electronic health information (EHI) be considered an interference under the information blocking regulation?

A: A determination as to whether a delay would be an interference would require a fact-based, case-by-case assessment of the circumstances. Please see 45 CFR 171.103 regarding the elements of information blocking.

- If the delay is necessary to enable the access, exchange, or use of EHI, it is unlikely to be considered an interference under the definition of information blocking (85 FR 25813).
- The delay would likely be considered an interference for purposes of information blocking if a healthcare provider established an organizational policy that, for example, imposed delays on the release of lab results for any period of time in order to allow an ordering clinician to review the results or in order to personally inform the patient of the results before a patient can electronically access such results (see also 85 FR 25842 specifying that such a practice does not qualify for the "Preventing Harm" Exception).

Q: Do information blocking regulations require healthcare providers to be proactive and make electronic health information available through patient portals or other health information technology?

A: No, there is no requirement under the information blocking regulations to proactively make available any EHI to patients or others who have not requested the EHI.

- We note, however, that a delay in the release or availability of EHI in response to a request for legally permissible access, exchange, or use of EHI may be an interference under the information blocking regulations (85 FR 25813, 25878).
- If the delay was to constitute an interference under the information blocking regulations, a health provider's practice or actions may still satisfy the conditions of an exception under the information blocking regulations.

Q: Are providers expected to release test results proactively, through a patient portal, or application programming interface (API or healthcare app), as soon as results are available by the ordering clinician?

A: While the information blocking regulations do not require providers to proactively make electronic health information available, once a request to access, exchange, or use EHI is made by a patient, providers must timely respond to the request (for example, from a patient for their test results). Delays or other unnecessary impediments could implicate the information blocking provisions.

- In practice, this could mean a patient would be able to access EHI such as test results in parallel to the availability of the test results to the ordering clinician.
- It appears that the information blocking criteria is based on whether the patient requested this information, versus whether it was readily available when there was no request in play.

More detailed information can be found on the website: https://www.healthit.gov/curesrule

Minimizing Litigation Risk in the Post-COVID Era

There were countless learning moments in 2020 as physicians scrambled to modify their check-in procedures, waiting rooms and examination rooms so they could safely see and care for patients. Some practices had minimal telehealth services in place and moved quickly to create the infrastructure, technology and training needed to see patients on secure video-conference or telephone platforms.

While now necessary, telehealth creates a challenge in that it precludes providers the opportunity to lay hands on their patients and provide proper examination. This has forced medical providers to adapt in their practice of medicine as the global pandemic has demanded major changes to be made almost on a daily basis.

Despite the PREP Act's immunity protections for health care providers, countless COVID-19 lawsuits have already been filed, and new ones are emerging daily. Plaintiff attorneys are getting creative in their attempts to allege liability for things such as misdiagnosis, wrongful diagnosis, or negligent care. These tactics underscore the necessity for health care providers to be incredibly diligent in how their practice is run:

- Demonstrating that policies, procedures, and protocols are based on guidance and recommendations from the CDC, state and county departments of health, and other regulatory or public health authorities is critical.
- Physicians must also be able to show that their policies are regularly updated and reviewed by the proper personnel and that any citations or lapses are taken seriously and corrected to mitigate the risk of infectious spread.
- The value of capturing additional information that wasn't standard practice before the pandemic has also become vital in defending against various liability claims against providers.

To reduce the risk of litigation in the first place, every practice should conduct an immediate internal audit to reveal potential weaknesses in current policies, staff training, and documentation protocols. Should a practice be sued, it's important to be able to show that the entire staff was acting in accordance with (or above) the standard of care.

In the field of medical negligence, it is inevitable that the PREP Act is going to be challenged and tested extensively in the coming months, and it is paramount that providers can demonstrate that there was no willful misconduct. Sound policies, procedures, training, documentation and communication will help ensure that practices can continue providing the very best patient care for many years to come.

The Public Readiness and Preparedness Act (PREP)

The PREP Act was enacted in 2005 by Congress. The PREP Act authorizes the Secretary of the U.S. Department of Health and Human Services to issue a PREP Act declaration in response to a public health emergency. A PREP Act declaration provides immunity from tort liability claims (except willful misconduct) to individuals or organizations involved in the manufacture, distribution, or dispensing of medical countermeasures.

CDC Adds New Medical Conditions to COVID-19 High-Risk List – Miriam Tucker, *Medscape Medical News*, March 31, 2021

The US Centers for Disease Control and Prevention has added several new medical conditions to its list of those that predispose adults to more severe COVID-19 illness.

Conditions that had previously been categorized as "might be" placing individuals at increased risk — but now are listed as high risk — include:

- type 1 diabetes (in addition to type 2),
- moderate-to-severe asthma,
- liver disease,
- dementia or other neurological conditions,
- stroke/cerebrovascular disease,
- HIV infection,
- cystic fibrosis,
- overweight (in addition to obesity).
- substance use disorders (which hadn't been previously listed, are now also considered high-risk)

The new list groups together certain categories, such as chronic lung diseases (chronic obstructive pulmonary disease, asthma, cystic fibrosis, etc) and heart conditions (heart failure, coronary artery disease, hypertension, etc). Both diabetes types are now grouped under "diabetes."

The added medical conditions were posted on the CDC website's COVID-19 page on March 29, 2021 and can be reviewed at:
https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html

No conditions have been removed from the list.

OIG Defends Recent Telehealth Audits

Telehealth has become so popular during the coronavirus pandemic that it is drawing increased scrutiny from federal regulators.

Federal authorities are cracking down on telehealth fraud and misuse during the coronavirus pandemic, and that has the attention of advocates who worry that connected health may be getting a bad rap in some circles, writes Eric Wicklund in his *mHealth Intelligence* March 2, 2021 article.

Last week, the Health and Human Services Department's Office of the Inspector General (OIG) issued a letter recognizing the value of telehealth during the COVID-19 public health emergency, and pointing out that with increased use and value comes increased scrutiny.

"It is important that new policies and technologies with potential to improve care and enhance convenience achieve these goals and are not compromised by fraud, abuse, or misuse," HHS-OIG Principal Deputy Inspector General Christi Grimm said in the letter. "OIG is conducting significant oversight work assessing telehealth services during the public health emergency."

Telehealth has become so valuable during the COVID-19 public health emergency that it's finding its way into more schemes.

According to Nathaniel Lacktman, a partner with Foley & Lardner and chair of the firm's Telemedicine & Digital Health Industry Team, and Rachel Goodman, senior counsel with the firm, the OIG is conducting at least seven different audits, evaluations and inspections of telehealth programs that receive Medicare and Medicaid support.

These recent audits are separate from the department's past high-profile efforts to combat schemes that might mention telehealth but aren't really about it.

The American Telehealth Association (ATA) CEO, Ann Mond Johnson, stated the OIG also rightly points out the need to differentiate between 'telefraud' and telemarketing schemes and legitimate telehealth services. This is a critical message from the OIG, to address confusion and allay concerns around the safety and effectiveness of telehealth.

The ATA stands ready to work with the OIG and other government agencies to ensure that telehealth services continue to delivery safe, quality and convenient care, Ms Johnson added.

Adding Care Management in 4 Steps -- Staff, *FPM Journal,* March 22, 2021

Care management has the potential to improve the health of a practice's most at-risk patients while reducing costs.

Here are 4 steps to help you get started:

i. **Identify what care management services you will provide** -- consider the needs of your patient population as well as the tasks that are burdening you and your staff. These tasks could include coordinating and managing transitions of care (e.g., acute to post-acute care settings or acute to home), assessing and closing care gaps (preventive or

related to social determinants of health), addressing complex patient needs, coordinating care among the patient's health care team, and navigating the patient through the complexities of the health care system.

ii. **Identify who can perform these functions** --many care management tasks require a staff member with a professional license, such as a licensed nurse or a licensed clinical social worker. Consider whether current staff members have the capacity to take on some of these tasks as you grow the program.

iii. **Identify high-risk patients who could benefit from the program** -- the names of several patients might immediately come to mind as good candidates for care management because their care is complex or they are high risk.

iv. **Understand how you will pay for it --** some care management services can generate revenue right away, such as diabetes education, self-monitored blood pressure management, transitional care management, or chronic care management.
    - Make sure your staff knows how to document and code for all billable care management services.
    - If your practice participates in value-based care arrangements, make sure your staff is documenting and reporting the appropriate measures to assure shared savings.

Care Management Billing – listed below are a few care management services that can be billed along with Medicare allowable amounts. Please note that reimbursement varies by insurance plan and location.

Service	Code	Description	Pymt **
Diabetes Education (provide information/skills to manage diabetes & related conditions)	G0108 G0109	individual in a group	$55 $16
Transitional Care (addresses the hand-off period between inpatient and other setting)	99495 99496	Within 14 days Within 7 days	$202 $275
Chronic Care Mgmt (comprehensive care plan for all health issues)	99490 99491 99487 G0506	20 min clinical staff 30 min provider 60 min clinical staff Add to Initiating visit	$40 $80 $90 $60

For more information on any of the above Care Management services, please contact Sachi at DRS 1.877.845.2969.

The Fully Vaccinated Employee: What the New CDC Guidelines Mean for Employers --

Matthew Feery, Laura Elkayam, *The National Law Review,* March 17, 2021

On March 9, 2021, the CDC issued its first set of recommendations for fully vaccinated people, providing guidance for everyone who has been patiently wondering what types of pre-COVID activities they can safely resume now that vaccines are here.

For employers navigating the constantly changing landscape of COVID-19 policies, the guidelines offer new options and potential new challenges, whether due to easing workplace restrictions or continuing them.

For example, the CDC guidelines explicitly state that fully vaccinated people still need to follow guidance issued by their employers, as well as the travel requirements and recommendations of the CDC and local health departments.

This means that employers that wish to continue maintaining robust safety protocols may do so, and employers may require all employees to abide by those protocols, regardless of vaccination status. This is especially true for employers that do not mandate vaccinations, or that have vaccinated and unvaccinated employees interacting in the workplace.

Most workplaces are not the "small gatherings" contemplated by the new guidelines, so the COVID-19 precautions we are all used to, such as mask-wearing, social distancing, and disinfection of high-touch surfaces, should continue.

The most helpful aspect of the CDC's guidelines may be the ability of vaccinated employees to avoid quarantining and testing even after a known exposure to COVID-19 so long as they remain asymptomatic. As many employers have learned over the past year, the main operational challenges posed by COVID-19 were not just the absence from the workplace of employees seeking testing or testing positive, but also the quarantine imposed on employees who may have been exposed to the virus.

A single case of COVID-19 could completely shut down operations for over two weeks. Now, employers can consider whether to have fully vaccinated employees continue to work even after a known exposure, keeping operations going and easing, somewhat, the difficulties of an ongoing pandemic.

The pace at which employers can ease workplace restrictions will depend on the percentage of employees vaccinated. Employers should also consider the potential

impact of creating different sets of rules for vaccinated and unvaccinated employees.

State and local rules, in addition to standards adopted by OSHA, should be considered before modifying policies or easing enforcement for fully vaccinated employees. And we anticipate that the CDC, as well as state and local health authorities, will continue to issue updated guidance as more and more individuals are vaccinated, and as new information comes to light regarding variants of the virus, how well COVID-19 vaccines keep people from transmitting the disease to others, and how long the vaccines' protective effects will last.

MEDICARE NEWS

Repayment of COVID-19 Accelerated and Advance Payments Began on March 30, 2021

CMS has begun recovering these payments as of March 30, 2021, depending upon the 1st year anniversary of when the first payment was received. Repayment will be recouped from any payments due to providers from their Medicare claims

Repayment terms:

- Repayment begins 1 year starting from the date CMS issued the first COVID-19 Accelerated and Advance Payment (CAAP).
- Beginning 1 year from the date the CAAP was issued and continuing for 11 months, CMS will recover the CAAP from 25% of the providers or suppliers Medicare payments.
- After the end of this 11 month period, CMS will continue to recover the remaining CAAP at a rate of 50% for 6 months.
- After the end of the 6 month period, the provider's Medicare Administrative Contractor (MAC) will issue a demand letter for full repayment of any remaining balance of the CAAP.
- If payment is not received within 30 days, interest will accrue at the rate of 4% from the date the MAC issued the demand letter.
- After that, CMS will assess interest for each full 30-day period that a provider fails to repay the balance

For more information, please go to the COVID-19 Accelerated and Advance Payments webpage at: https://www.cms.gov/medicare/covid-19-accelerated-and-advance-payments

CMS Raises Payment for COVID-19 Vaccine Administration

CMS has announced it will increase the payment rate for the administration of COVID-19 vaccines. As of March 15, 2021, the national average payment will be $40 for each dose of a COVID-19 vaccine. That means the average payment will go from approximately $28 to $40 for administration of a single-dose vaccine, and $45 to $80 total for administration of both doses of a two-dose vaccine.

Actual payment rates will vary geographically. Check with the local Medicare Administrative Contractor for the rate in your region.

The increase, which the American Academy of Family Physicians (AAFP) and other groups advocated for, reflects the additional resources and work required to safely store and administer the vaccines.

Practices should update the allowable charges for the COVID-19 vaccine administration codes in their billing systems to ensure they receive the increased payment rate.

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

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