



“Although the world is full of suffering, it is also full of the overcoming of it.” -- Helen Keller

NEWS Update

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**Client Memo
September 2021**

**REMINDER: 30 Days Left for Period 1
Provider Relief Fund Reporting**

Providers who received payments exceeding \$10,000, in the aggregate, between April 10, 2020 to June 30, 2020 are required to report in Reporting Period 1. Providers who are required to report during Reporting Period 1 have until **September 30, 2021**, to enter the Portal and submit their information.

**MANY OF YOU HAVE ALREADY RECEIVED NOTICES
VIA EMAIL OR IN THE MAIL**

The PRF Reporting Portal opened on July 1, 2021 for providers who are required to report during the first reporting period. The PRF Reporting Portal is located at: <https://prfreporting.hrsa.gov/s/>

	Payment Received Period (Payments Exceeding \$10,000 in Aggregate Received)	Deadline to Use Funds	Reporting Time Period
Period 1	From April 10, 2020 to June 30, 2020	June 30, 2021	July 1 to Sept. 30, 2021
Period 2	From July 1, 2020 to Dec. 31, 2020	Dec. 31, 2021	Jan. 1 to March 31, 2022
Period 3	From Jan. 1, 2021 to June 30, 2021	June 30, 2022	July 1 to Sept. 30, 2022
Period 4	From July 1, 2021 to Dec. 31, 2021	Dec. 31, 2022	Jan. 1 to March 31, 2023

Please note: Unfortunately, DRS is unable to help you with the completion of this report due to the personal and confidential information being asked.

For additional information, please call the Provider Support Line at (866) 569-3522.

**All providers who fail to report may
be required to repay funds back to
HHS**

Get Ready for Fall Changes

Though it may not feel like it, fall will soon be here, bringing with it changes to diagnosis codes that occur each October 1st, writes Kent Moore in his August 1, 2021 article "New Diagnosis Codes are Coming" for *FPM Journal*.

The CDC has released this year's changes. Preparing now can ensure your claims will continue to be paid smoothly.

There is a new code related to COVID-19. **U09.9** (Post COVID-19 condition, unspecified) is a special purpose code with its own notes and Code First instructions. It is used to document post-acute sequela of COVID-19 after infection (aka "**long COVID**") rather than active cases, although it can be used for reinfected patients who are still suffering sequela from a previous infection.

You should code first conditions related to COVID-19 such as chronic respiratory failure (J96.1-), loss of smell (R43.8), loss of taste (R43.8), multisystem inflammatory syndrome (M35.81), pulmonary embolism (I26.-), and pulmonary fibrosis (J84.10).

There are also new code choices for low back pain, a condition family physicians commonly see. The current code, M54.5 (Low back pain), will be expanded into three more specific codes:

- M54.50 (Low back pain, unspecified)
- M54.51 (Vertebrogenic low back pain)
- M54.59 (Other low back pain)

Similarly, you will no longer be able to simply report a patient has a cough with R05 (Cough). Instead, you'll have to choose from among six new, more specific codes:

- R05.1 (Acute cough)
- R05.2 (Subacute cough)
- R05.3 (Chronic cough)
- R05.4 (Cough syncope)
- R05.8 (Other specified cough)
- R05.9 (Cough, unspecified)

Finally, beginning in October, you'll have an expanded array of codes for recording various social determinants of health. For instance, code Z59.0 (Homelessness) is now broken out to three codes:

- Z59.00 (Homelessness unspecified)
- Z59.01 (Sheltered homelessness)
- Z59.02 (Unsheltered homelessness)

Code Z59.81- (Housing instability, housed) will also require more specificity, as follows:

- Z59.811 (Housing instability, housed, with risk of homelessness)
- Z59.812 (Housing instability, housed, homelessness in past 12 months)
- Z59.819 (Housing instability, housed unspecified)

A full list of changes can be obtained by going to: www.cdc.gov/nchs/icd/icd10cm.htm(www.cdc.gov)

New Codes Cover 3rd Dose of Pfizer and Moderna Vaccines

Medicare stands ready to pay for the administration of a 3rd dose for both the Pfizer BioNTech COVID-19 vaccine and the Moderna COVID-19 vaccine for immune compromised people. CMS will pay the same amount to administer this additional dose as it did for other doses of the COVID-19 vaccine (approximately \$40 each).

The AMA released two new administration CPT codes for the additional doses:

- 0003A (3rd dose Pfizer vaccine)**
- 0013A (3rd dose Moderna vaccine)**

These codes are only to be used for third doses for immunocompromised individuals, which are different than booster shots. While the Biden Administration has announced its intent to offer booster shots to the general population, there is not currently a formal recommendation or FDA approval for them.

Manufacturer	Administration Codes
Pfizer	<ul style="list-style-type: none"> • 0001A (1st dose) • 0002A (2nd dose) • 0003A (3rd dose)
Moderna	<ul style="list-style-type: none"> • 0011A (1st dose) • 0012A (2nd dose) • 0013A (3rd dose)

Cost Sharing Waivers for COVID-19 Treatment Winding Down

Many insurers are no longer waiving cost sharing for COVID-19 treatment, writes Samantha Liss, for *Healthcare Dive*, August 20, 2021.

Dive Brief:

- Health experts warn patients may soon see big bills related to treatment for COVID-19, according to a new report from researchers at the Kaiser Family Foundation.
- More insurers are expected to end the moratorium on patient cost sharing by the end of October 2021, putting the financial responsibility back on patients, KFF said.

Last year, during the height of the pandemic, many insurers voluntarily waived patient cost sharing for COVID-19 treatment.

Insurers have largely done away with those waivers and more are expected to disappear by the end of October as COVID-19 patients inundate hospitals once again, leaving them more exposed to the costs of the disease.

This could pose a new strain for providers, as some Americans are left to cover their out-of-pocket costs and not the insurer. The average annual deductible was \$1,644 in 2020, though much larger figures for families, according to KFF. But many Americans, four in 10, don't have \$400 in the bank to cover an unexpected expense, let alone \$1,644,

The federal government did mandate insurers to cover testing and vaccines but the requirement does not extend to paying for the patient's share of treatment costs

CMS expands Medicare payments for at home COVID-19 vaccines

On August 24, 2021, CMS announced that it will give clinicians additional payments for administering in-home COVID-19 vaccines to multiple residents of the same home or communal living setting.

Clinicians will be allowed to receive the increased payment when they give up to 10 Medicare beneficiaries the vaccine on the same day in the same home. The goal is to boost vaccination rates in assisted living facilities, smaller group homes, and other group living situations.

Quicker, Easier E/M Coding – Staff, *FPM Journal*, August 2, 2021

After several months of using the new E/M coding rules, it has become clear that the most difficult chore of coding office visits now is assessing data to determine the level of medical decision making.

Analyzing each note for data points can be time consuming and sometimes confusing. Fortunately, the majority of visits can be optimally coded without worrying about data at all, if you follow these four steps:

1. Think time first. Under the new rules, physicians may code any visit based solely on the total time it took on the date of service (including the time spent preparing for the visit and the time spent documenting it afterwards). If your total time spent on a visit appropriately credits you for level 3, 4, or 5 work, then document that time, code the visit, and be done with it. But if it does not, go to Step 2.

2. “Problems plus.” The level of MDM is determined by the problems addressed at the visit, the data reviewed, and the patient’s risk. But many visits can be coded with MDM just by answering these two questions:

- i) What was the highest-level problem you addressed during the office visit; and
- ii) Did you order, stop, modify, or decide to continue a prescription medication? Prescription drug management combined with a level 3 or 4 problem equals a level 3 or 4 visit.

If the patient has a level 5 problem, and you consider admission, that’s a level 5 visit.

On the rare occasions when you see a patient for level 4 or 5 problems for less than the required time and don't do any prescription drug management, you may have to proceed to Steps 3 and 4.

3. Level 4 problem with social determinants of health or simple data. If you see a patient for a level 4 problem, but don’t do prescription drug management, you can still code it as a level 4 visit if you do any of the following:

- Personally interpret a study (e.g., an X-ray),
- Discuss management or a test with an external physician,
- Modify the workup or treatment due to social determinants of health.

4. Level 4 or 5 problem with complex data. If you saw a patient for a level 4 problem and still haven't been able to code the visit at this point, you have to tally Category 1 data points:

- Review/order of each unique test equals one point each,
- Review of external notes from each unique source equals one point each,
- Use of an independent historian equals one point.

Once you reach three points, code it as level 4.

For a level 5 problem, if you see a really sick patient, order/interpret an X-ray or ECG, and review/order two lab tests, then code level 5.

3 Billing Codes Physicians Should Use

Doctors and practice administrators are always looking for ways to maximize profits. Practices that know about the following codes and how to use them may be able to earn additional reimbursement, writes Michael Enos in his July 27, 2021, article for *Physicians Practice*.

99441-99443: TELEPHONE SERVICES

CPT offers codes to report telephone services provided by a physician or other qualified health care professional who may report E/M services. *These codes can only be reported for an established patient and are not billable if the call results in the patient coming in for a face-to-face service within the next 24 hours (or next available urgent visit).* *These calls are also not billable if they refer to an E/M service performed within the last seven days.* The codes are selected from code range 99441 to 99443 and are based on the time spent: 5-10 minutes, 11-20 minutes, or 21-30 minutes, respectively.

99058: SERVICES PROVIDED ON AN EMERGENCY BASIS

What can you do when your providers already have a packed schedule and a patient walks in demanding to be seen? What if a scheduled nurse visit is more serious than anticipated, and the provider is called to step in and spend a great deal of time with that patient? *When a patient is seen on an emergency basis in the office, and it disrupts other scheduled office services, you may be able to report add-on code 99058* for additional reimbursement.

96160: HEALTH RISK ASSESSMENT

Providers can bill code **96160** when they perform a health risk assessment with a patient or caregiver/guardian in order to assess the risk of conditions such as mental disorders. Providers should report **96161** for a caregiver-focused health risk assessment, such as a depression inventory, for the benefit of the patient.

(Please note that there is no guarantee that these codes will be reimbursed by the insurance companies.)

Top Three Takeaways from the 2022 QPP Proposed Rule

– Matthew Fusan, *HealthIT Answers*, August 30, 2021

The 2022 Quality Payment Program (QPP) Proposed Rule, which CMS released on July 13, 2021, includes changes to the MIPS program that will make avoiding a penalty difficult, along with updates to the controversial APM Performance Pathway reporting requirements, and more insight into the MVP program.

Following are three key takeaways from the Proposed Rule to consider as you evaluate how changes could impact your organization.

1. Difficulty Avoiding Penalties Increases -- Avoiding a penalty in MIPS will become a lot harder for three reasons:

- 1) the Performance Threshold will be increased to 75 points,
- 2) most bonus points will be removed, and
- 3) the Cost category will increase to 30 points of the total score.

2. Extended Web Interface Submission -- In the 2021 Final Rule, CMS announced that the Web Interface submission method would be sunsetted after PY 2021 and MSSP ACOs would be required to submit eQMs or CQMs for three measures.

3. MVPs Delayed Until 2023 -- MIPS Value Pathways (MVPs) are being delayed until 2023 and will initially launch with 7 available MVPs.

One thing that was not addressed in the Proposed Rule documentation was clarity around CMS's thinking regarding another COVID-related Hardship Exception for 2022. As the pandemic continues to unfold with the new Delta variant during the second half of this year, it is harder than ever to predict how much of the Proposed Rule will change between now and when the 2022 Final Rule is released in November or December.

Completing FMLA Paperwork Quickly

The following tips can help you complete FMLA paperwork quickly and accurately, states Anne Kantner, MD, *Family Practice Management*, 2021 Jul-Aug;28(4):12-16.

KEY POINTS

- ✚ The Family and Medical Leave Act (FMLA) allows eligible employees to take unpaid leave for family and medical reasons.

- ✚ To qualify for leave, patients are required to provide their employer with a certification form from their physician or other health care provider.

- ✚ To help you complete FMLA forms quickly and accurately, familiarize yourself with the questions, keep answers concise, involve your staff, and obtain patient input.



The FMLA allows eligible employees to take unpaid leave for family and medical reasons. During leave, their job is protected and health insurance coverage is continued.

Employees must notify their employer that they plan to take FMLA leave according to established procedures within their place of work. The employer is required to notify employees whether they are eligible for leave within five business days of the request for leave. Not all employed persons are eligible for FMLA, depending on the size of the company and length of employment.

The employer may require medical certification for pregnancy or serious health conditions. That medical certification is the FMLA form.

QUALIFYING REASONS FOR LEAVE

Twelve weeks of leave in a 12-month period for:

- The birth of a child and care of the child within one year of birth;
- Adoption or foster care placement and care of the child within one year of adoption or placement;
- Care for a spouse, child, or parent who has a serious health condition;
- The employee's own serious health condition that makes the employee unable to perform the essential functions of his or her job;
- A qualifying urgent situation while the employee's spouse, child, or parent is on covered active duty for the military.

Twenty-six weeks of leave during a 12-month period for:

- Care for a spouse, child, parent, or next of kin who is a covered service member with a serious injury or illness.

OVERVIEW OF THE FMLA FORMS

FMLA forms issued by the U.S. Department of Labor Wage and Hour Division are titled "Certification of Health Care Provider for Employee's [or Family Member's] Serious Health Condition under the Family and Medical Leave Act."

FMLA form questions are fairly standardized, but in 2020 the Department of Labor revised the forms in an attempt to simplify them. Employers and employees are permitted to use any version of the forms, so you may see either the older version or the newer version come across your desk.

Read each question carefully when completing the form. Subtle changes in wording or differences in formatting of the forms can cause a physician who is trying to work quickly to answer incorrectly.

The first two sections of the FMLA form are generally for the employer and employee to complete. The third section is for the physician or other health care provider to complete, and it is usually divided into two parts:

PART A: MEDICAL FACTS OR INFORMATION

Historically, Part A has had eight to 10 one or two-part questions about the medical condition and treatment; however, the 2020 version of the form simplified this section.

PART B: AMOUNT OF LEAVE NEEDED

Part B of the provider section of the form asks a series of questions to quantify the amount of leave needed. Leave blank any questions that do not apply.

Here are some common questions about the FMLA form completion process.

Will a patient ever need more than one form? Yes. Most employers require separate forms for separate medical conditions.

Can I complete the form during an office visit? Yes. Requiring an office visit for first-time completion of an FMLA form allows you to review each question with the patient and make decisions together regarding the amount of leave needed.

How do I handle renewals? After completion of the initial form, add it to the patient's medical record so you have easy access to it during renewals. For renewals with no changes requested by the patient, office staff can assist by transcribing answers from the prior form onto the new form.

Unlike many forms you're likely asked to fill out, FMLA forms have a purpose, and physicians play an important role in the medical certification process. It helps prevent

employees from losing their jobs if they are out of work for a medical reason or to care for an ill family member. The certification also gives patients needed time off for doctor appointments, therapy sessions, and coping with episodic exacerbations of medical conditions.

MIPS UPDATE

Now Available: 2020 MIPS Performance Feedback, Final Score, and 2022 MIPS Payment Adjustment Information

CMS has released MIPS performance feedback and final scores for performance year 2020 and associated MIPS payment adjustment information for payment year 2022.

You can access your 2020 MIPS performance feedback, 2020 final score, and 2022 payment adjustment information by:

- Going to: <https://qpp.cms.gov>
- Logging in using your HCQIS Access Roles and Profile (HARP) system credentials; these are the same credentials that allowed you to submit your 2020 MIPS data

If you don't have a HARP account, please refer to the "Register for a HARP Account and Connect to an Organization documents" in the QPP Access User Guide on the website.

For Shared Savings Program ACOs, please note that beginning August 5, 2021, you will be able to create a HARP account and manage your account in the ACO Management System (ACO-MS). Contact your ACO to find out how you can obtain a HARP account via ACO-MS. If you have any questions, please contact the ACO Information Center at: SharedSavingsProgram@cms.hhs.gov

To learn more about the information in your performance feedback, review 2020 MIPS Performance Feedback Resources in the QPP website.

Now Available: 2020 MIPS Targeted Review

You can now review your performance feedback, including your MIPS final score and payment adjustment factor(s), on the Quality Payment Program website.

For MIPS eligible clinicians, your 2020 final score determines the payment adjustment you'll receive in 2022, with a positive, negative, or neutral payment adjustment being applied to the Medicare paid amount for covered professional services furnished in 2022.

When to Request a Targeted Review

If you believe an error has been made in the calculation of your MIPS payment adjustment factor(s), you can request a targeted review **until October 1, 2021**.

How to Request a Targeted Review

You can access your MIPS final score and performance feedback and request a targeted review by:

- Going to the Quality Payment Program website.
- Logging in using your HCQIS Access Roles and Profile System (HARP) credentials; these are the same credentials that allowed you to submit your MIPS data. Please refer to the QPP Access Guide for additional details.

CMS generally requires documentation to support a targeted review request, which varies by circumstance. You'll be contacted by a representative with information about any specific documentation required.

If the targeted review request is approved and results in a scoring change, we'll update your final score and/or associated payment adjustment (if applicable), as soon as technically feasible. Please note that targeted review decisions are final and not eligible for further review.

2021 APM Incentive Payments

Eligible clinicians who were Qualifying APM Participants should have begun receiving their 2021 5% APM Incentive Payments earlier this summer.

You can now log in to the QPP website to see the amount and the organization paid by using the 10-digit NPI number and the organization name.

You will not need to do anything to receive your payment, unless CMS is unable to verify your Medicare billing information.

If you have not yet received your payment, you should check for your name on this public notice to see if you will need to verify your Medicare billing information. **If you do not verify your Medicare billing information by November 1, 2021, then CMS will not be able to issue your APM Incentive Payment.**

For questions, please contact the Quality Payment Program at QPP@cms.hhs.gov or call 1-866-288-8292.

MEDICARE NEWS

Provider Enrollment Activities Resume in October

Beginning October 2021, CMS will resume some provider enrollment activities that were paused during the COVID-19 public health emergency, including:

- Application Fees – 42 C.F.R. 424.514
- Criminal background checks associated with fingerprint-based criminal background checks– 42 C.F.R. 424.518
- Revalidation – 42 C.F.R. 424.515

For more information, see the COVID-19 Medicare Provider Enrollment Relief FAQs (PDF) pp 19, 20, 26, and 27: <https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf>

OIG audit revealed millions in Medicare overpayments for chronic care management services.

The auditors examined over 7.8 million claims from physicians and 240,000 claims from hospitals for CCM services provided in 2017 and 2018. OIG found \$1.9 million in overpayments due to noncompliance with federal requirements across over 50,000 claims. Medicare beneficiaries' cost sharing for these over-payments totaled \$540,680.

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.

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