DOCTORS' RESOURCE SPECIALISTS

"Science and technology will and should be the heart of modern medicine, but you must add the soul." -- Paul Farmer, MD, PhD

Client Memo June 2021

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Arizona's New Telehealth Law

Governor Doug Ducey's signature on HB 2454 pushes Arizona to the front of the line in post-COVID-19 telehealth policy, providing guidance on a number of connected health issues.

Arizona Governor Doug Ducey has signed legislation that greatly expands telehealth coverage in the state, including allowing audio-only telehealth services in certain circumstances and permitting providers from other states to treat Arizona residents, writes Eric Wicklund in his May 6, 2021, article for *mHealth Intelligence*.

HB 2454 essentially makes permanent emergency measures that were put in place in March 2020 to deal with COVID-19. State officials say the new law puts Arizona at or near the front in state-based telehealth policy.

Telehealth expands access to medical services for low-income families and those living in rural areas, protects vulnerable populations, and allows snowbirds visiting our state to receive telemedicine from their home state, Governor Ducey said in his press release.

Among other things, the new law establishes payment parity for many telehealth services, especially telemental health treatments, and it permits the use of virtual exams in worker's comp cases as long as both sides agree to the service. It also prevents healthcare boards from requiring an in-person exam before a telehealth visit.

The new law also redefines telemedicine as telehealth, and continues to exclude faxes, e-mails, voice mails and instant messages.

Arizona's new law extends coverage for audio-only telehealth as long as it's covered by Medicare or the state's Medicaid program through this year. Beginning in 2022, coverage will be determined by a state telehealth advisory committee, whose formation is part of the new law.

For now, coverage is allowed for audio-only services between a provider and patient who have an existing healthcare relationship, and where access to audio-visual services is not reasonably available to the patient. For telemental health providers, there is no requirement for an existing health-care relationship.

During the pandemic many states passed emergency measures recognizing medical licenses issued in other states, so that providers in other states could treat patients in that state, often through telehealth. The strategy bypasses the complex process of applying for a license in each state.

Arizona's new law allows providers in good standing with their own state medical boards to treat Arizona residents, as long as several conditions are met. They include registering with the applicable state-based regulatory board and the controlled substances prescription monitoring program, paying a registration fee and agreeing not to have a physical office in Arizona.

The passage of telehealth legislation in Arizona and several other states puts pressure on Congress and the federal government to develop a national telehealth policy that extends past the COVID-19 public health emergency.

Incident-To Billing Not Allowed for IPPE and AWV

Please note that Medicare RAC audits are targeting incident-to billing for AWV's.

Providers are reminded that the IPPE and AWV are Medicare-covered services within their own benefit category. As such, they are not subject to standard "incident to" billing guidelines and **must be billed by the performing provider,** whether this is a physician or NPP. *National Government Services Bulletin*, February 20, 2020.

The Evolution of "Incident to' Billing

'Incident to' billing has been a challenging topic since its creation by Medicare, writes Elizabeth Woodcock in her February 2021 article for *SVMIC.com.*

The rules – which allow advanced practice providers (APPs) to be reimbursed at the full physician rate by Medicare when seeing patients in an office and directly supervised by a physician – are complex and, arguably, subject to interpretation. There have been a bevy of practices found in non-compliance with the rules, which has resulted in expensive paybacks.

The Medicare Payment Advisory Commission (MedPAC) issued their recommendation to eliminate the provision. Although Medicare did not move forward with the 2019 recommendation, there are signs that other insurers are. United Healthcare, for example, announced a new policy titled: "Advanced Practice Health Care Provider Policy, Professional," with an effective date of March 1, 2021.

For some practices, this policy change won't matter as they have already transferred their APPs to independent status. This indeed is the trend, as practices have assessed the cost/benefit of this manner of billing. At issue is the loss of 15% of revenue, as an independent APP is paid by most insurers at 85% of the fee schedule.

UHC Advanced Practice Health Care Provider Policy -- *Commercial Reimbursement Policy Number 2021R5009A*, effective March 1, 2021

This policy sets forth the requirements for reporting the services of Advanced Practice Health Care Providers and other Nonphysician Providers, within a medical or other healthcare practice.

An Advanced Practice Health Care Provider must report services rendered, within the scope of their licensure or certification, pursuant to applicable state laws and regulations, using the Advance Practice Health Care Provider's own NPI number, unless the Advanced Practice Health Care Provider is ineligible for their own NPI number and the "Incident to" guidelines described in this policy, are met.

For Advanced Practice Health Care Providers ineligible for their own NPI number, services that meet the "Incident-to" criteria above should be **reported under the supervising physician's NPI number with the SA modifier appended.**

Unless otherwise contracted with a Medical Group Nonphysician Provider fee schedule, UnitedHealthcare applies a reduction of 15% to the applicable fee schedule or allowed amount for the reimbursement of the following Advanced Practice Health Care Providers: Physician Assistants (PA), Nurse Practitioners (NP), and Clinical Nurse Specialists (CNS).

AHCCCS Policy Regarding Billing for Mid-Level Practitioners – March 16, 2018

This communication serves as a reminder of the AHCCCS Rules and Policy regarding billing for Arizona Physicians and Mid-Level Practitioners. In accordance with AHCCCS's guidelines, all rendering providers must bill under their own NPI number. As a result, **incident-to billing is not permissible for mid-level practitioners.** (A rendering provider is defined as the individual who provided care to the client and needs to be reported as such in box 24J of the CMS 1500 claim form.)

Per the AHCCCS participating Provider Agreement General Terms and Conditions: "**No provider may bill with another provider's ID number, except in locum tenens situations.** Locum Tenens provider must submit claims using the AHCCCS provider ID number of the physician for whom the Locum Tenens provider is substituting or temporarily assisting." Locum Tenens arrangements will be recognized and restricted to the length of the Locum Tenens registration with the AMA.

Failure to Adhere to Incident-to Rules Can be Costly – Health Law Offices of Anthony Vitale, November 9, 2020

The U.S. Department of Justice recently announced that two physicians and their family medicine practices located in Tennessee will pay $341,690 to resolve allegations that they violated the False Claims Act by knowingly charging Medicare for services rendered by nurse practitioners at the higher reimbursement rate for physician services.

The providers are alleged to have violated what is known as the "incident-to" rule. Under that rule, Medicare pays 85% of the physician fee schedule (PFS) when a service is billed under the NP's or PA's own National Provider Identifier (NPI).

Medicare pays 100% of the PFS rate when the same service provided by an NP or PA is billed "incident to" a supervising physician. It is important to note that the physician must be present in the office suite while the

services are being provided and immediately available to provide assistance if needed.

In addition to the direct supervision provision, the incident-to rule only allows physicians to bill Medicare at the full physician fee schedule amount for the services that are performed by a non-physician practitioner, if the services are:

- Included in a treatment plan for an injury or illness where the physician performs an initial service and is involved actively in the course of treatment.
- The Medicare-credentialed physician must initiate the patient's care. If the patient has a new or worsened complaint, a physician must conduct an initial E/M service for that complaint and must establish the diagnosis and plan of care.
- The physician must see the patient at a frequency that reflects his/her active involvement in the patient's case.

Justice Department Cracks Down on COVID-Related Fraud Cases

The Justice Department has made fighting COVID-related fraud cases a priority, especially with the passing of the CARES Act last year.

The CARES Act, which included $2.2. trillion in economic aid, was intended to provide financial assistance to Americans and their businesses struggling under the economic hardships caused by the COVID-19 pandemic.

Within weeks of the CARES Act's passage, the Department of Justice immediately began efforts to investigate and prosecute related fraud. The Department focused initially on the most egregious instances of COVID-19 related wrongdoing, but it has since cast a wider net, warns Marissa Koblitz and Matthew Lee with Fox Rothschild, LLP in its April 21, 2021 news bulletin.

By the end of March 2021, the Department of Justice had charged over 470 defendants with criminal offenses based on fraud schemes connected to the COVID-19 pandemic. The Justice Department's Criminal Division Fraud Section has prosecuted approximately 120 defendants charged with PPP fraud. The accused include:

- those who lied about payroll costs, employees or even having a business;
- individuals who misappropriated loan proceeds by using the money to purchase cars, boats and houses;
- fraudsters who applied for EIDL advances; and
- over 140 defendants charged and arrested for federal offenses related to UI fraud.

The government has also prosecuted or secured civil injunctions against dozens of defendants who sold products such as fake vitamin supplements and silver ointments, making false claims about the products' abilities to prevent or treat COVID-19 infections.

On May 26, 2021, Rich Mendez of *CNBS.com* reported that the DOJ had charged 14 people — including a medical doctor and owners of laboratories, pharmacies and a home health agency — in multiple fraud schemes that allegedly bilked consumers and insurers out of $143 million.

In addition, the Center for Program Integrity at CMS announced it took administrative action against more than 50 medical providers for their involvement in health-care fraud schemes relating to Covid-19.

The law enforcement actions involved the Justice Department's criminal division, the FBI, seven U.S. attorney's offices in six states, as well as the HHS inspector general's office and other agencies.

Billing for Novavax

The AMA has created unique CPT codes for the Novavax COVID-19 vaccine and its administration.

The vaccine from Novavax Inc. has yet to receive authorization for use in the US by the FDA. The vaccine called NVX-CoV2373 is currently undergoing two Phase 3 clinical trials, one of which recently expanded to include pediatric patients.

- **91304:** Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine
- **0041A**: Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (corona-virus disease [COVID-19]) vaccine, first dose
- **0042A:** Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (corona-virus disease [COVID-19]) vaccine, second dose

Adding House Calls to Your Practice

As payment rates for house calls increase, technology improves, and the population ages, interest in home-based primary care is growing.

Under Medicare rules, house call patients are *not* required to meet the homebound definition required for receiving skilled nursing and therapy services in the home.

And as of January 2019, Medicare no longer requires documentation of medical necessity for every home visit, describing why a house call was needed in "lieu of an office visit."

In the May/June 2021 issue of *Family Practice Management,* Thomas Cornwell, MD, and Brianna Plencner, CPC, write that the best candidates are patients with complex or high-risk conditions who have difficulty getting to the office, as well as:

- Frail older adults with multiple (often five or more) chronic conditions and deficiencies in activities of daily living (ADL).
- Younger homebound patients, usually with one principal neuromuscular condition such as multiple sclerosis, amyotrophic lateral sclerosis, or cervical spine injuries (some on ventilators).
- Patients with high-risk diagnoses like congestive heart failure and chronic obstructive pulmonary disease.
- Patients with high hospital and emergency department (ED) utilization in the past six to 12 months.

Here are four tips for getting started with home visits.

1. **Set geographical limits** -- A geographic radius should be determined for home visits based on driving time (e.g., no more than 20 minutes from the physician's office or home).

   For more distant patients, telehealth may be the better option for providing care, at least while it is allowed under the public health emergency.

   If you also offer house calls to patients in domiciliary settings (e.g., assisted living facilities or group homes), you can realize economies of scale by seeing multiple patients in the same location on the same day.

2. **Follow scheduling best practices** -- Efficient scheduling is critical, and can be achieved through the following steps:
   - Start with a half day or one full day of house calls per week. Then increase that time as volume demands.
   - Schedule patients in close proximity by assigning days to specific geographic areas and using mapping/routing software.
   - Call when enroute to the visit so the patient is ready.
   - Have staff record special instructions on the schedule (e.g., "enter through side door").

3. **Complete certain tasks before the visit** -- Make sure that clerical tasks are done by staff ahead of time, including obtaining signed forms and medical records (e.g., HIPAA forms, consent for treatment, or medical history forms) when possible.

   Also, review charts before the home visit to see if fasting blood work or any unique supplies, such as injections or immunizations, are needed. It's also a good idea to review charts for complex, new, and transitional care management patients ahead of the visit and start pre-charting.

4. **Have your black bag ready to go** -- Unlike in the office, you cannot walk down the hall to a supply closet if you run out of something during a home visit. Have your "black bag" stocked and ready.

Detecting and Diagnosing Cognitive Impairment

Medicare covers a separate visit for a cognitive assessment so providers can more thoroughly evaluate cognitive function and help with care planning explains the staff at Healthcentric Advisors in *QPP Quick Bits*, May 18, 2021.

Detecting cognitive impairment is a required element of Medicare's Annual Wellness Visit (AWV). Providers can also detect cognitive impairment as part of a routine visit through direct observation or by considering information from the patient, family, friends, caregivers, and others.

If a patient shows signs of cognitive impairment at an Annual Wellness Visit or other routine visit, the provider may perform a more detailed cognitive assessment and develop a care plan.

Details on Medicare coverage requirements and proper billing can be viewed at: https://www.cms.gov/cognitive.

99483: Cognitive Assessment & Care Plan Services

- Replaces HCPCS code G0505
- If cognitive impairment is detected during the AWV or other routine visit, a more detailed cognitive assessment and care plan can be performed.
- Typically start with a 50-minute face-to-face visit.
- Assessment of and care planning for patients with cognitive impairment like dementia, including Alzheimer's disease, at any stage of impairment.
- Any clinician eligible to report E/M services can offer this service.
- Can be billed separately from the AWV.

Effective January 1, 2021, Medicare increased payment for these services to $282 (may be geographically adjusted) when provided in an office setting. These services were also added to the definition of primary care services in the Medicare Shared Savings Program and are permanently covered via telehealth.

Elements of a Cognitive Assessment

Spend 50 minutes face-to-face with the patient and independent historian to perform the following elements during the cognitive assessment;

- ❖ Examine the patient with a focus on observing cognition;
- ❖ Record and review the patient's history, reports, and records;
- ❖ Conduct a functional assessment of Basic and Instrumental Activities of Daily Living, including decision-making capacity;
- ❖ Use standardized instruments for staging of dementia like the Functional Assessment Staging Test (FAST) and Clinical Dementia Rating (CDR);
- ❖ Reconcile and review for high-risk medications, if applicable;
- ❖ Use standardized screening instruments to evaluate for neuropsychiatric and behavioral symptoms, including depression and anxiety;
- ❖ Conduct a safety evaluation for home and motor vehicle operation;
- ❖ Identify social supports including how much caregivers know and are willing to provide care; and
- ❖ Address Advance Care Planning and any palliative care needs.

MIPS UPDATE

2021 MIPS Promoting Interoperability Hardship Exception and Extreme and Uncontrollable Circumstances Exceptions Are Now Open

Applications are now open for the MIPS Promoting Interoperability Performance Category Hardship Exception and Extreme and Uncontrollable Circumstances Exception for the 2021 performance year. Those interested must submit their applications to CMS by December 31, 2021.

Applications can be downloaded or completed on the QPP website: https://qpp.cms.gov

MIPS Tips for Small Specialty Practices

HSAG has released new MIPS Tips, adding Mental/ Behavioral Health, Dermatology, and Chiropractic Medicine, to its list, which already includes:

Cardiology	Chiropractic Medicine
Dermatology	Endocrinology
Family Medicine	Gastroenterology
Nephrology	Ophthalmology
Pulmonology	Rheumatology

Skilled Nursing Facility

Visit the HSAG QPP Tools and Resources webpage to download these tips and share with your MIPS reporting team. They are located under "MIPS Tips for Small Specialty Practices."
https://www.hsag.com/en/quality-payment-program/tools-and-resources/#MIPS_Tips_for_Small_Specialty_Practices

If you would like a Specialty MIPS Tip resource created for your specialty, please let them know via email at: HSAGQPPSupport@hsag.com.

2020 MIPS Cost Performance Category

CMS is reweighting the cost performance category from 15% to 0% for the 2020 performance period. The 15% cost performance category weight will be redistributed to other performance categories in accordance with §414.1380(c)(2)(ii)(D). 2020 Final scores will be out in July 2021.

Analysis of the underlying data for the 2020 performance year, in comparison to prior years' data, shows that the volume of data available to calculate the scores for the cost measures has significantly decreased overall.

As a result, CMS does not believe it can reliably calculate scores for the cost measures that would adequately capture and reflect the performance of MIPS eligible clinicians.

Clinicians do not need to take any action as a result of this decision because the cost performance category relies on administrative claims data.

2021 MIPS Promoting Interoperability

Objectives and Measures for 2021 reporting:

Objectives	Measures
e-Prescribing	e-Prescribing
	Bonus: Query of Prescription Drug Monitoring Program
Health Information Exchange	*Complete A and B or C:* A: Support Electronic Referral Loops by Sending Health Information
	B: Support Electronic Referral Loops by Receiving and Reconciling Health Information
	C: Health Information Exchange Bi-Directional Exchange
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information
Public Health and Clinical Data Exchange	*Choose two of the following:* Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Syndromic Surveillance Reporting

MEDICARE NEWS

Signature Requirements

Documentation must meet Medicare's signature requirements. Medicare claim reviewers look for signed and dated medical documentation meeting Medicare signature requirements. If entries aren't signed and dated, they may deny the associated claims.

Even if a scribe dictates the entry on the provider's behalf, the provider must sign the entry to effectively authenticate the document and the care provided or ordered. It's unnecessary to document who transcribed the entry.

If a provider relies on a medical student's documentation, it's unnecessary to redocument the E/M service, but the provider must review and verify (sign and date) the student's medical record entry.

The medical review guidelines for using an electronic signature are:

- Systems and software products must include protections against modifications and should apply administrative safeguards that meet all standards and laws.
- The individual's name on the alternate signature method and the provider accept responsibility for the authenticity of attested information.
- Part B medications, other than controlled substances, should be ordered through a qualified e-prescribing system.

Providers should check with their attorneys and malpractice insurers before using alternative signature methods.

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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