DOCTORS' RESOURCE SPECIALISTS

Client Memo
April 2022

"The day the Lord created hope was probably the same day he created Spring."

-- Bernard Williams

NEWS Update

COVID-19 Uninsured Program Claims

The HRSA COVID-19 Uninsured Program (UIP) has already stopped accepting claims for COVID-19 testing and treatment and will stop accepting claims for vaccine administration due to a lack of sufficient funds. The program already stopped accepting claims for testing and treatment on March 22, 2022 and will continue to accept claims for vaccine administration until 11:59 PM on April 5, 2022.

Any testing and treatment claims submitted in the Portal after March 22, 2022, will not be adjudicated for payment. Any vaccine administration claims submitted in the Portal after April 5, 2022, will not be adjudicated for payment.

Claims submitted by the deadline for each category of service will be adjudicated and paid subject to their eligibility and the availability of funds.

2022 MIPS Policies for Small Practices

With MIPS 2021 now over and done with, providers need to focus on the MIPS requirements for 2022. The Quality Payment Program's pamphlet "2022 MIPS Policies for Small Practices" outlines what's new for small practices for 2022. A small practice consists of 15 or fewer clinicians.

Information pertaining to all provider types is also included.

Eligibility & Performance Category Requirements

Clinical social workers and certified nurse midwives are now eligible to report MIPS data. No other changes have been made to the eligibility criteria.

Cost Performance Category:

There are 5 new episode-based measures for 2022:

- 2 procedural measures: Melanoma Resection and Colon and Rectal Resection
- 1 acute inpatient measure (Sepsis)
- 2 chronic measures: Diabetes, Asthma/COPD

Quality Measure Performance Category:

Medicare Part B claims measures: will only calculate a group-level quality performance category score from claims measures if a practice also submits data for another performance category as a group (signaling its intent to participate as a group.)

Removal of bonus points for:

- Reporting additional Outcome, Patient Experience, and High Priority Measures beyond the 1 required
- Measures that meet end-to-end electronic reporting criteria

NO CHANGE to the small practice bonus. If you submit at least 1 quality measure, you will continue to earn 6 bonus points in this category.

Promoting Interoperability Performance Category:

This performance category is automatically reweighted to 0% for small practices beginning with the performance year:

- You're not required to report Promoting Interoperability data.
- You no longer need to submit a Promoting Interoperability Hardship Exception Application for this category to be reweighted.

If you choose to report data for this performance category:

- There is a new SAFER Guides attestation measure and changes to the information blocking attestation.

- Requirements for the Public Health and Clinical Data Exchange Registry objective were updated to require reporting on these measures:
  - Immunization Registry Reporting and Electronic Case Reporting measures.
  - You will earn 5 bonus points for reporting any of the other 3, now optional, measures in this objective.

Final Score: Performance Thresholds & Adjustments

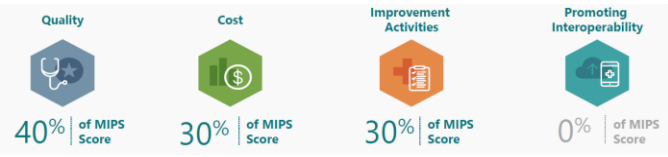
Performance Thresholds for 2022

- The performance threshold is set at **75 points**
  - This is the minimum final score needed to avoid a negative payment adjustment in 2024.
- The additional performance threshold for exceptional performance is set at **89 points**
- The final score will be compared to the performance threshold (and exceptional performance threshold) to determine your payment adjustment

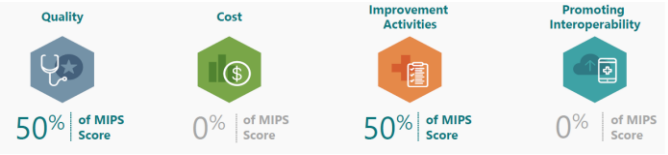
Redistribution Policies for Small Practices

For performance year 2022, the performance category redistribution policies have been updated for small practices only to more heavily weight the Improvement Activities performance category when other performance categories are reweighted.

Standard weighting for small practices (Promoting Interoperability automatically reweighted)



When both the Cost and the Promoting Interoperability performance categories are reweighted:



When both the Quality and the Promoting Interoperability performance categories are reweighted:

NOTE: The above redistribution scenario applies to everyone, not just small practices.

Provider Relief Fund Post-Payment Reporting Requirements – *HRSA Bulletin*

HRSA Provider Relief Fund (PRF) Recipients who received one or more payments exceeding $10,000 in the aggregate during a **Payment Received Period** are required to report in each applicable **Reporting Time Period.**

These reporting requirements apply to PRF General and Targeted Distributions (including the Skilled Nursing Facilities (SNF) and Nursing Home Infection Control Distribution). These reporting requirements do not apply to the Rural Health Clinic COVID-19 Testing Program or claims reimbursements from the HRSA COVID-19 Uninsured Program and the HRSA COVID-19 Coverage Assistance Fund.

Reporting must be completed and submitted to HRSA by the last date of the reporting time period. PRF recipients that do not report within the respective reporting time period are out of compliance with payment terms and conditions and may be subject to recoupment.

	Payment Received Period (Payments Exceeding $10,000 in Aggregate Received)	Deadline to Use Funds	Reporting Time Period
Period 1	April 10, 2020 to June 30, 2020	June 30, 2021	July 1, 2021 to September 30, 2021
Period 2	July 1, 2020 to December 31, 2020	December 31, 2021	January 1, 2022 to March 31, 2022
Period 3	January 1, 2021 to June 30, 2021	June 30, 2022	July 1, 2022 to September 30, 2022
Period 4	July 1, 2021 to December 31, 2021	December 31, 2022	January 1, 2023 to March 31, 2023

Please note that the next reporting deadline is September 30, 2022 as shown above. Reporting entities will report on their use of funds using their normal basis of accounting (e.g. cash basis, accrual basis).

For more information, please follow this link: https://www.hrsa.gov/sites/default/files/hrsa/provider-relief/provider-post-payment-notice-of-reporting-requirements-january-2021.pdf

AMA Urges Update of Medicare Physician Payment System

The AMA urged congressional leaders to lift the freeze on Medicare physician payments and provide updates that reflect inflation and practice costs, reports Victoria Bailey, in her March 17, 2022, article for *RevCycle Intelligence.*

In a letter to congressional leaders, the organization expressed concerns about the MedPAC recommendation to continue the freeze on Medicare physician payment rates and the lack of an adequate annual update for the payment system.

The MedPAC report, sent to Congress on March 15, 2022, recommended that federal officials maintain Medicare reimbursement rates for physicians and not provide any increases for 2023.

The AMA noted that MedPAC cannot justify freezing Medicare physician payment rates as CMS projects an 80% increase for Medicare Advantage plans in 2023. Data from the Medicare Trustees showed that Medicare physician pay has increased by only 11% between 2001 and 2021. Around one-third of that increase includes the temporary 3.75% update set to expire this year.

In contrast, Medicare hospital and skilled nursing facility payments rates increased by more than 6% over the same period.

After being adjusted for inflation, Medicare physician payment rates have declined 2% over the last two decades, the letter noted. Meanwhile, the cost of running a medical practice has increased 39% since 2001.

The Medicare physician payment freeze is scheduled to last until 2026. Once the freeze ends, payment updates are set to resume at a rate of 0.25% per year, which is significantly below the rate of medical or consumer price index inflation, the AMA stated in the letter.

Unless Congress provides Medicare physicians with an update that reflects inflation, the gap between physician payment rates and rising inflation in medical practice costs will widen.

While the AMA expressed its gratitude to Congress for providing financial relief during the pandemic and preventing the 10% physician payment cuts in 2022, the organization urged officials to work with the physician community to develop solutions to the systematic problems with the Medicare physician payment system.

Audit Telehealth Claims for Compliance

-- Renee Dustman, BS, *AAPC Healthcare Business Monthly,* April 2022

At AUDITCON, a virtual medical auditing conference held November 2, 2021, Leonta Williams, MBA, CPC, CPCO, CEMC, CHONC, CRC, CCS, CCDS, RHIA, Education Director at AAPC, helped conference attendees understand what the OIG and CMS are looking for in their medical reviews and audits with her presentation "Auditing Telemedicine/Telehealth," excerpts of which are presented below.

An auditor's job is to compare the provider's medical documentation to what was coded on the claim to make sure charges are accurate and services are supported by medical necessity. The problem with telehealth is that the rules for coverage are different depending on facility type and location, as well as payer.

The purpose of an internal policy is to establish which guidelines everyone in the office should follow. The auditor can then refer to the organization's internal policy for providing such services to determine compliance.

A telehealth internal policy should include:

- Clear statements of how the organization defines telehealth/telemedicine
- Role expectations
- Standards of care
- Delivery mode
- Documentation requirements
- Billing protocol

Everyone within the organization should understand what the requirements are for providing telehealth services before, during, and after the PHE.

Documentation should generally include:

- Service type, reflected by the CPT code;
- Patient/provider location;
- Mode of delivery;
- Patient consent;
- Visit time; and
- All services must meet the code description requirements

TIP: An up-to-date list of telehealth services is available for download from CMS.gov/Medicare under General Information/Telehealth. The list identifies which codes may be performed via telehealth, Medicare coverage status, whether the service can be furnished using audio-only interaction, and any Medicare payment limitations.

Nuances of the No Surprises Act

Don't let this 2022 regulation catch your organization off guard, writes John Aaron, AAS, CPC, AAPC *Healthcare Business Monthly,* April 2022.

Here are a few key takeaways from the No Surprises Act (NSA).

The NSA generally prohibits out-of-network healthcare providers, facilities, and air ambulance services from billing patients more than the in-network cost-sharing limits for covered non-emergency services furnished in an in-network facility.

The law also adds new notice, consent, and disclosure requirements on the part of providers and plans. For example, providers must disclose information regarding federal and state balance billing protections and how to report violations (except in emergent cases).

Providers must also post this information where the public can see it and in a way the public can decipher it. Standard notice and consent forms for nonparticipating providers and emergency facilities, a model disclosure notice for providers, facilities,health plans, and insurers, and required contact information are available on the CMS website: https://www.cms.gov/nosurprises

The No Surprises Act can impose civil monetary penalties of up to $10,000 per violation. However, penalties can be waived for providers and facilities that do not knowingly act in violation. There's also a hardship exemption available to providers.

Note: The NSA does not supersede the laws in place by states offering surprise billing protections. The NSA only triggers when state laws are not sufficient for patient protections. Federal healthcare program beneficiaries are not protected under the NSA because of existing surprise billing protections.

Good Faith Estimate May Be Required

An important part of the NSA is the requirement for providers to furnish good faith estimates of charges for scheduled non-emergent care to uninsured or self-pay individuals in advance, or upon request.

You'll want to pay specific attention to the following details:

- Patient status (self-pay or uninsured)
- Descriptive listings of qualified items and services
    - Each item or service has to have specific details such as the procedure and supply codes and fees.
- Time frame notification requirements
- Differences between the convening and co-provider requirements
    - A convening provider or convening facility is the provider or facility that schedules an item or service or that receives the initial request for a good faith estimate from an uninsured or self-pay individual.
    - A co-provider or co-facility is a provider or facility that furnishes items or services in conjunction with a primary item or service such as labs and anesthesia.
        - In 2022, these providers must provide patients with a separate good faith estimate upon request.
        - Beginning Jan. 1, 2023, convening providers' good faith estimates must include coproviders' good faith estimates.

CMS has published assistive documents to help providers stay in compliance with good faith estimate requirements, available for download at:

https://www.cms.gov/files/document/standard-notice-consent-forms-nonparticipating-providers-emergency-facilities-regarding-consumer.pdf

Advanced Explanation of Benefits May Be Required

For individuals with certain types of coverage, providers must submit good faith estimates to the individual's plan or issuer. In this case, the NSA requires the health plan or issuer to send the member an Advanced Explanation of Benefits (AEOB).

The patient must receive the AEOB at least three business days before the scheduled service. The AEOB must provide some very specific information, including the good faith estimate from the provider or facility.

Independent Dispute Resolution Process Available

A major piece of the No Surprises Act revolves around the Independent Dispute Resolution Process (IDRP). In the event of unsatisfactory reimbursement levels or out right denial of payment for services rendered, providers may initiate an arbitration process that enlists the services of a certified IDR entity.

Potential Risks, Benefits of Patient Access to EHR Clinical Notes – Hannah Nelson, *EHR Intelligence,* February 8, 2022

Patient access to EHR clinical notes has the potential to improve malpractice liability risks, according to a *JAMA Network Open Op-ed* written by Charlotte Blease, PhD of Beth Israel Deaconess Medical Center.

ONC's information blocking provisions mandate patient access to eight kinds of EHR notes: those relating to consultation, discharge, history and physical examination, imaging, laboratory tests, pathology, procedures, and progress.

Enhanced patient access to clinical notes could reduce malpractice claims by reducing diagnostic delays, mitigating medical errors, and improving patient-clinician relationships, Dr. Blease noted.

Misdiagnosis and delayed diagnosis are leading causes of malpractice claims. Access to EHR data may boost caregiver and patient engagement in the diagnosis and treatment processes, which could potentially help reduce the risk of delays and missed diagnoses.

"Under the law, a finding of malpractice liability requires a finding of patient injury," Dr. Blease said. "Patients who report errors in their health information could therefore prevent physicians from relying on erroneous data that may lead to poor diagnostic or treatment decisions and legal liability."

Additionally, EHR clinical note access could make it easier for patients to obtain legal advice about potential malpractice cases. Access to patients' clinical notes could potentially enable attorneys to perform that function more accurately.

However, offering patients full access to their health information could invite new legal concerns for clinicians as well. Litigation risks could increase if physicians make changes to their clinical notes that reduce documentation quality.

Medical records that are tailored to satisfy patients could mislead other treating clinicians and diminish the quality of care. On the other hand, failure to adjust the tone or content of EHR documentation in light of sharing notes could strain patient-provider relationships and impact decisions to pursue claims. Sharing clinical notes could contribute to clinician burnout due to increased patient queries related to EHR notes.

Dr. Blease also suggested that healthcare organizations provide clinicians with resources to help ensure efficient documentation while maintaining accuracy, clarity, and sensitivity to patients' needs.

Additionally, healthcare organizations should provide patients with training on how to use their patient portals and report documentation errors to clinicians.

Avoid Employee Handbook Crises

Many healthcare businesses have an employee handbook but fail to update them on a regular basis, reports Carol Gibbons and Logan Lutton in their January 24, 2022, article for *Physicians Practice.*

There have been a large number of changes to employment law over the past couple of years. Your handbook should be reviewed every year after the Supreme Court has ruled on all pending cases and released all their rulings at the end of June, they write.

Excerpted from their article, and summarized below, are some items that you should include in your handbook.

1. **Social Media Policy** -- If you have one, you might be surprised to learn that you cannot prohibit employees from posting negative comments about your business on social media, but you can prohibit the use of social media in the work area on business time.

2. **At-Will Employment** – If your state has an at-will employment law, you should also have a statement that the handbook cannot be considered a contract and that only the head of the company or organization can negotiate changes in an employee's status when necessary. The word 'permanent' can be construed as generating a contract, so don't use it in your handbook.

3. **Disciplinary Action** – Review this policy carefully. Less is nearly always better than extensive. You should always have a statement that your disciplinary process, while liberal in nature, could result in immediate termination depending on the seriousness of the infraction.

4. **Harassment** – The handbook should make clear that you will not tolerate harassment and if any employee experiences or observes harassment it should be reported immediately.

5. **Benefits** – Review your benefits to make sure they comply with federal and state laws. If you have to comply with the Family Medical Leave Act, make sure your employees are told who to contact and that they must fill out the proper forms to be eligible.

6. **Vacation, Sick Leave, PTO** -- The handbook should tell the employee when they are eligible for these benefits and how they will be calculated. It should also include a statement that the benefits could change at any time.

7. **Compensation** – If your handbook prevents employees from discussing their wages with other employees, the National Labor Relations Board (NLRB) has ruled that companies cannot ban employees from doing this. You need to make sure your handbook is consistent with the current laws in your state as well as the latest rulings from the NLRB.

As a business owner, you should review the handbook yearly and consult your company attorney to review any changes to make sure you have adequately protected your company from employee lawsuits.

MIPS Update

CMS will be suppressing the MIPS Clinical Quality Measures (CQM) collection type for #326/NQF 1525: Atrial Fibrillation and Atrial Flutter: Chronic Anti-coagulation Therapy during the 2022 performance period. Please note, the CQM collection type is the only collection type available for this measure. A typo-graphical error was introduced into the measure specifications by the measure steward during the annual measure update. This led to an incorrect denominator exception, which will likely impact reporting and performance of this measure.

MEDICARE NEWS

Congress Extends Telehealth Coverage for 151 Days After PHE

While we still do not know whether the PHE will be extended to July, Congress has gone ahead and given telehealth services a new lease on life, at least for five months beyond the end of the COVID-19 public health emergency, whenever that may be, through the $1.5 trillion bill that funds the federal government through September. The bill extends Medicare coverage for telehealth services delivered in patients' homes, audio-only telehealth services and other flexibilities that are products of the PHE and its waivers. It was passed by the House March 9 and the Senate March 10 and is expected to be signed quickly by President Joe Biden.

Without this measure in the 2022 Consolidated Appropriations Act (CAA), providers and patients faced an abrupt loss of broad Medicare coverage for telehealth services when the PHE ends, which could be as early as mid-April or maybe mid-July, depending on whether the COVID-19 picture improves.

2020 Quality Payment Program Performance Information Now Available on Care Compare

CMS added new Quality Payment Program (QPP) performance information for doctors, clinicians, groups, and Accountable Care Organizations (ACOs) to the Doctors and Clinicians section of Medicare Care Compare and in the Provider Data Catalog (PDC). Medicare Care Compare can be found at:
https://www.medicare.gov/care-compare/

DRS New Address:

Doctors Resource Specialists
11022 N 28th Drive, Suite 100
Phoenix, AZ 85029
602.439.6780

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