DOCTORS' RESOURCE SPECIALISTS

# Client Memo
# May 2022

"And after winter folweth grene May."
-- Chaucer

***NEWS Update***



**HHS Has Extended the Public Health Emergency for another 90 Days until mid-July 2022. States to be given a 60-day notice before the PHE expires.**

## Current PHE Could Be the Last

The COVID-19 PHE was extended another 90 days, effective April 16, 2022. This means that most waivers under the 1135 Coronavirus Aid, Relief, and Economic Security (CARES) Act will continue to stay in effect through this period, while others are winding down, writes Terry Fletcher in his April 18, 2022, article for *ICD10 Monitor.*

CMS has already alerted providers that many nursing home compliance standards will phase out, while residents continue to be protected. This extension also allows millions of people to keep getting free tests, vaccines, and treatments for at least three more months.

The PHE was initially declared in January 2020 and has been renewed each quarter since. This will make it nine renewals in all, and with over 75% of the over-65 population now vaccinated, and clear protocols for treatment, this could be the last time that HHS Secretary Xavier Becerra extends it, policy experts have said.

HHS said in a statement that it will make every effort to give states 60 days' notice prior to termination or expiration. When the PHE expires, insured people will be subject to co-pays or other costs, while the uninsured will lose easy access to free testing.

Millions of people could also lose Medicaid coverage, as states reinstate stricter enrollment rules that they had loosened in order to qualify for enhanced federal funding.

## CMS Terminating Certain Section 1135 Waivers - Renee Dustma, *AAPC Knowledge Center,* April 11, 2022

CMS announced in an April 7th memorandum that it will be phasing out some of the temporary emergency declaration section 1135 waivers of the Social Security Act that have been in effect throughout the COVID-19 PHE.

CMS is ending temporary emergency declaration section 1135 waivers for certain types of facilities in two waves. The first wave will occur 30 days following the April 7th memorandum and apply to:

- Skilled nursing facilities (SNFs)
- Nursing facilities (NFs).

The second wave will occur 60 days after the April 7th memorandum and apply to:

- Inpatient hospices
- Intermediate care facilities
- End-stage renal dialysis (ESRD) facilities

**First Group of Waivers Being Terminated**

According to the April 7th memorandum, the following requirements will apply for certain facilities when the applicable section 1135 waivers end May 7, 2022:

- Resident Groups
  - Facilities may not restrict in-person meetings.
- Physician Delegation of Tasks in SNFs
  - Physicians may not delegate any tasks to a PA, NP, or clinical nurse specialist when the regulations specify that the physician must perform the task.
- Physician Visits LTCs
  - The regulation at 42 CFR §483.30(c)(3) requires physician visits to be made by the physician personally.

- Physician Visits in SNFs/NFs
    - Physicians and non-physician practitioners must perform in-person visits for nursing home residents.
- Quality Assurance and Performance Improvement (QAPI)
    - LTCs must develop, implement, evaluate, and maintain an effective, comprehensive, data-driven QAPI program.
- Detailed Information Sharing for Discharge Planning for LTC Facilities
    - LTCs must assist residents and their representatives in selecting a post-acute care provider using data such as standardized patient assessment data, quality measures, and resource use.
- Clinical Records
    - When requested, LTCs must provide residents a copy of their medical records within **two** working days. While the waiver was in effect, facilities had 10 days to oblige such requests.

**Second Group of Waivers Being Terminated**

Listed below are a few of the requirements that will no longer be waived:

- Physical Environment for SNF/NFs
    - When the waiver ends, so will the flexibilities that allowed for a non-SNF building to be temporarily certified and available for use by a SNF for COVID-19 positive residents; opening a NF as a temporary COVID-19 isolation and treatment location; and LTC facilities to be used to accommodate resident care in emergencies and situations needed to help with surge capacity.
- Outside Windows and Doors for Inpatient Hospice, ICF/IIDs and SFNs/NFs
    - An outside window or outside door is required in every sleeping room.
- Life Safety Code for Inpatient Hospice, ICF/IIDs, and SNFs/NFs
    - Specific LSC provisions, such as fire drills and temporary construction requirements will be reinstated.
- In-Service Training for LTC facilities
    - SNFs and NFs require nursing assistants to receive at least 12 hours of in-service training annually.
    - Nurse aides for SNF and NFs may not be employed longer than 4 months unless they have met the training and certification requirements.

## Telehealth Flexibilities Extended

Thomas B. Ferrante and Rachel B. Goodman, of Foley & Lardner LLP, explain these flexibilities in their March 17, 2022, article "Congress Extends Telehealth Flexibilities: 7 Things You Need to Know" for *Foley's Health Care Law Today.*

The 2022 Consolidated Appropriations Act was passed by the U.S. House and Senate on March 9th and 10th, 2022, and signed into law by the President on March 15, 2022.

**The Act extends certain telehealth flexibilities for Medicare patients for 151 days after the official end of the federal public health emergency.**

(*Note: the PHE has been extended into mid-July 2022.*)

Whether the PHE ends in April or at some later date, telehealth stakeholders will have a brief 5-month glide path for certain telehealth flexibilities instituted during the PHE. Legislation is essential because without Congressional action, CMS does not have the authority to allow most of the flexibilities to continue once the PHE ends.

Thus, the newly adopted law will prevent a "telehealth cliff" in Medicare when the PHE expires, while also enabling Congress to review further data from CMS and other sources regarding the use of telehealth to enact permanent policy changes.

Here are the key takeaways on how the new legislation will affect the telehealth industry:

### Medicare Pays for Telehealth Provided at Home

Perhaps the biggest change provided by the Act is the new definition of "originating site" to mean "any site in the United States at which the eligible telehealth individual is located at the time the service is furnished…including the home of an individual."

Before the PHE, the statute restricted Medicare coverage to services delivered to patients located at hospitals and other provider facilities (i.e., not the patient's home).

The PHE flexibilities waived the originating site requirement for telehealth services, allowing providers to receive Medicare payment for delivering telehealth services to patients at home. The new law continues this flexibility for 151 days past the end of the PHE.

### Expands List of Telehealth Practitioners

Prior to COVID-19, only physicians, nurse practitioners, physician assistants, and other specified providers could deliver Medicare covered telehealth services. Under the new law, the list of telehealth practitioners will continue to be expanded to include qualified occupational therapists, physical therapists, speech language pathologists, and audiologists for 151 days past the end of the PHE.

### Payment for Audio-Only Telehealth Continues

Currently, Medicare covers audio-only telehealth under temporary waivers that will expire when the PHE ends. In the new legislation, Medicare coverage of audio-only telehealth services remains for 151 days after the PHE ends.

Without this extension, *once the PHE concludes, the emergency waiver authority ends, and so would have audio-only telehealth.*

### In-Person Requirement for Mental Health Services via Telehealth Delayed

In December 2020, Congress imposed new conditions on telemental health coverage under Medicare, creating an in-person exam requirement alongside coverage of telemental health services at a patient's home that was intended to go into effect when the PHE ends. The law included a requirement for an in-person visit within six months of the first telehealth service and subsequent in-person visits every 12 months thereafter.

Now, this in-person requirement for mental health services furnished through telehealth is delayed until the 152nd day after the PHE sunsets.

### Extension for FQHCs and RHCs

Prior to the pandemic, federally qualified health centers (FQHCs) and rural health clinics (RHCs) were limited to serving as an originating site (the location of the patient) for telehealth services. The proposed legislation would extend flexibilities put into place by the CARES Act, allowing FQHCs and RHCs to serve as distant sites (the location of the practitioner) for an additional 151 days after the expiration of the PHE.

### Extension of First Dollar Coverage for Telehealth under HDHP/HSA Plans

During the COVID-19 PHE, Congress issued temporary relief for telehealth and High Deductible Health Plans and Health Savings Accounts, allowing coverage for telehealth services without plan members incurring costs even before plan members' deductibles are met (i.e., first-dollar coverage).

This relief initially expired on December 31, 2021. *Now, under the new law, this flexibility is reinstated for the period of March 31, 2022, through December 31, 2022.*

### Study COVID-19 Related Telehealth Changes under Medicare & Medicaid

The new Act directs MedPAC, the Medicare Payment Advisory Commission, to conduct a study on the expansion of telehealth services and to analyze:

(i) the utilization of telehealth;
(ii) Medicare program expenditures on telehealth services;
(iii) Medicare payment policies for telehealth services and alternate approaches to such payment policies;
(iv) implications of expanded Medicare coverage of telehealth services on beneficiary access to care and the quality of care; and
(v) other areas determined by MedPAC.

While the flexibilities contained in the Consolidated Appropriations Act of 2022 should help the industry avoid a "telehealth cliff," like other flexibilities, they are temporary. Thus, telehealth stakeholders must continue to wait for more permanent changes to open access and reimbursement for providing telehealth services to Medicare beneficiaries.

## Surprise Billing Arbitration Portal Open

The online portal for resolving payment disputes between payers and providers for certain out-of-network charges is now open, CMS announced April 18th.

The portal initiates what's known as the federal independent dispute resolution process, a key part of the No Surprises Act that outlaws balance bills in most cases. As a last resort, it allows payers and providers to resolve payment disputes using an arbitration style similar to the model adopted by Major League Baseball in salary negotiations, writes Samantha Liss in her *Healthcare Dive* April 29, 2022, article.

Providers have taken issue with the arbitration process outlined in an interim rule, which has resulted in numerous lawsuits from various provider groups, including the AHA and the AMA.

The interim final rule instructed third-party arbiters to start with the presumption that the qualifying payment amount, or median in-network rate, is the appropriate

payment amount for providers when disputes between payers and providers arise.

A federal judge sided with providers in their lawsuit and struck down this piece of the rule, noting that the law as written by Congress, unlike the rule, did not "weigh any one factor ... more heavily than the others."

That ruling forced regulators to pull back guidance for arbiters online and delayed the opening of the portal.

The revised guidance online does not instruct arbiters to begin with the presumption that the qualifying payment amount is the correct amount. However, it does outline what arbiters must consider in choosing an offer amount from either the payer or providers. The arbiter must consider the qualifying payment amount and additional credible information, according to the guidance.

## New COVID-19 Vaccine Codes

The March 2022 issue of *CPT® Assistant Special Edition* introduces and provides guidance on the appropriate use of the new Moderna booster dose–specific COVID-19 vaccine product code 91309 and its associated vaccine administration code 0094A.

Effective March 29, 2022. when administering the new Moderna booster (vaccine CPT code 91309), the new administration code is:

**#●0094A** Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.5 mL dosage, booster dose

►(Report 0094A for the administration of vaccine 91309)◄

Please note that using administration code 0013A is only for the 3rd dose of the Moderna vaccine (cpt code 91301).

| Vaccine Code | Administration Code | Name | NDC Code |
|---|---|---|---|
| 91301 | 0013A 3rd dose | Moderna | 80777-0273-10 |
| 91309 | 0094A Booster | Moderna | 80777-0275-05 |
| 91307 | 0073A 3rd dose | Pfizer | 59267-1055-01 |
| 91307 | 0074A Booster | Pfizer | 59267-1055-01 |
| 91310 | 0104A Booster | Sanofi Past | 49281-0618-20 |

The April 2022 issue announced new CPT codes that will be effective upon receiving Emergency Use Authorization or approval from the FDA.

Code 0074A is the new vaccine booster dose administration code to be reported with Pfizer's already established vaccine product code 91307 for patients aged 5 through 11 years of age.

**#●0074A** Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; booster dose

The new Sanofi Pasteur vaccine product booster dose code 91310 is associated with vaccine administration code 0104A.

**#●0104A** Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, monovalent, preservative free, 5 mcg/0.5 mL dosage, adjuvant AS03 emulsion; booster dose

►(Report 0104A for the administration of vaccine 91310)◄

The full list of all COVID-19 vaccine and administration codes, along with NDC numbers, can be viewed at: https://www.ama-assn.org/find-covid-19-vaccine-codes

## The Problem with Problem Lists

Problem lists are a problem because often they are not updated, states Rose T. Dunn in her April 18, 2022, article for *ICD10 Monitor.*

Over the last year, we have heard much about Medicare Advantage health plans being investigated or fined by the government for false claims. The government has focused on the reporting of unsupported chronic conditions and the reporting of acute conditions, such as acute stroke, that really should have been coded as "history of."

The reader needs to keep in mind that MA payers are paid more by CMS for reported conditions.

**First,** just because a condition appears on the problem list doesn't mean that the provider addressed it during the encounter.

We all know that problem lists are a problem in themselves, because **often they are not updated, and some conditions listed on the problem list have long ago been resolved and are no longer active.**

**Second**, every encounter's documentation must stand on its own. We should expect that the encounter's documentation supports MEAT – **M for monitoring, E for evaluating, A for assessing, and T for treatment** – for *any condition that is reported on the claim*. If the MEAT documentation is not there for each of the conditions, then only those conditions that are recorded and supported by the provider's documentation should be coded.


**Only those conditions that are recorded and supported by the provider's documentation should be coded.**

The U.S. Department of Health and Human Services Office of the Inspector General (OIG) lists in its top 25 recommendations to reduce healthcare fraud its intention to provide targeted oversight of Medicare Advantage organizations.

To stay out of the OIG crossfire, coding professsionals need to uphold the integrity of each claim by ensuring claims are supported by the documentation that occurred at the time of the patient's visit – and they just need to say "no" when they are being pressured to do something that is not compliant. (Rose T. Dunn, MBA, RHIA, CPA, FACHE, FHFMA, CHP is an AHIMA-approved ICD-10-CM/PCS Trainer)

## Risk Adjustment Fraud in Healthcare

The law firm of Constantine Cannon offers insights into risk adjustment fraud and how to avoid it. Risk adjustment fraud occurs when insurers who contract with the government to provide coverage for beneficiaries, and others working with those insurers, seek to game the healthcare system by inflating the risk profile of patients, because inflated risk profiles mean more money for the insurers and others.

CMS recognizes that beneficiaries with particular conditions are more expensive to treat than healthy beneficiaries. Accordingly, CMS makes additional "risk adjustment" payments for beneficiaries treated for certain costly diseases, reducing incentives for plans to avoid enrolling sicker beneficiaries.

These risk adjustment payments are calculated based on members' diagnoses. Medicare and Medicaid are vulnerable to a variety of fraudulent practices aimed at improperly inflating members' diagnostic data, and thus inappropriately increasing risk adjustment payments.

Both MA plans and providers face FCA liability for fraudulent risk adjustment practices. MA plans are responsible for the content of all risk adjustment data they submit to CMS, whether those codes were identified by providers or by the MA plan itself during a retrospective review of patient medical charts.

Providers may be held liable for causing false risk adjustment submissions, particularly where the provider shares in the fraudulently obtained payments.

**Upcoding** is one of the recurring examples of fraudulent risk adjustment healthcare practices listed on the Constantine Cannon webpage.

Upcoding as risk adjustment fraud includes:

- Making it up, i.e., submitting claims for payment when the patient does not have, or was not treated for the condition.
- Exaggerating the severity of the patient's condition by submitting codes that risk adjust at a higher rate: for example, substituting major depression for a depressive episode, or malnutrition for weight loss.
- Claiming current treatment of a condition rather than *past history of treatment*.
- Submitting claims based on improper provider or service type (e.g., laboratory or radiology) in violation of CMS's requirement that diagnoses codes must be supported by a record that reflects a face-to-face encounter with an eligible provider type.
- Inferring diagnoses from unacceptable medical record documentation without evidence the condition required or affected the patient's care, treatment, or management on the visit in question, including coding from problem lists, patient history, or prescription drugs.
- Improperly linking complications or conditions without sufficient evidence the complications or additional conditions stem from the underlying diagnosis where doing so results in a higher reimbursement: for example, coding diabetes with complication where the medical record does not support linked conditions.

THE POTENTIAL FOR RISK ADJUSTMENT FRAUD GOES BEYOND MEDICARE.

A majority of states contract with managed care organizations to deliver care to Medicaid beneficiaries. Some of those states' Medicaid programs also utilize risk adjustment principles, exposing Medicaid to similar fraudulent practices.

Information on additional forms of risk adjustment fraud, including examples, is available on Constantine Cannon's website:
https://constantinecannon.com/practice/whistleblower/whistleblower-types/healthcare-fraud/risk-adjustment-fraud/

## MIPS Update

### CMS Reweighting 2021 MIPS Cost Performance Category

Due to COVID-19's impact on cost measures, CMS is reweighting the cost performance category from 20% to 0% for the 2021 performance period. The 20% cost performance category weight will be redistributed to other performance categories.

## MEDICARE NEWS

### Telehealth Place of Service Code

Effective for date of service on or after January 1, 2022, CMS allowed the new telehealth place of service (POS) code 10 - telehealth provided in patient's home. The telehealth POS change was implemented on April 4, 2022.

**CMS will continue to accept POS 02 for all telehealth services.** However, if a claim is received with POS 10 indicating the telehealth service was performed in the patient's home, the service will process appropriately.

- POS 02: Telehealth Provided Other than in Patient's Home. The patient is not located in their home when receiving health services or health related services through telecommunication technology.
- POS 10: Telehealth Provided in Patient's Home

The Change Request bulletin 12427, issued October 13, 2021, states that Medicare has not identified a need for new POS code 10. MACs will instruct providers to continue to use the Medicare billing instructions for Telehealth claims found in the "Medicare Claims Processing Manual," Chapter 12, Section 190.

### The CMS NPPES

The CMS NPPES public reporting of Missing Digital Contact Information has been updated. The report includes the names and NPI numbers of providers who did NOT update their digital contact information (endpoints) in NPPES as of March 31, 2022.

If you are on the list, you will need to add your digital contact information to NPPES now. Endpoints allow providers to send authenticated, encrypted health information directly to trusted recipients securely over the internet.

### DRS New Address:

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**602.439.6780**

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