Who's Watching Your Wallet?

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COVID relief and appropriations package includes surprise billing fix, $3 billion for provider relief

President Trump signed off on a $2.3 trillion spending package Dec. 27 that covers appropriation funding for the 2021 fiscal year and also includes an additional $900 billion for COVID-19-related relief efforts.

The package also moves to end the practice of surprise billing beginning in 2022 through the No Surprises Act (see pg. 7), which will establish an arbitration process for providers and payers to settle payment disputes over out-of-network claims.

The deal includes an additional $3 billion for the HHS Provider Relief Fund, which offers grants to Medicare or Medicaid-enrolled hospital and health care providers to be reimbursed for health care related expenses or lost revenue directly attributable to the public health emergency resulting from coronavirus. For comparison, the CARES Act, which passed in March, included $175 billion for the fund.

While this agreement initially seemed like a done deal after months of compromising between Democrats and Republicans, passage of the package was thrown into question after being approved by both chambers when Trump released a video stating he was unhappy with several portions of the package. He primarily expressed displeasure over the $600 direct checks most Americans would receive, an amount Trump said was far too low. However, he eventually signed the deal to avoid a government funding shutdown.

-- Continued on COVID relief, 6

Recent audit and coding news

- Recently, we had a client whose biller was not billing the correct physician on their claims. This can lead to major compliance issues. Often when we see this, it's caused by billers who accept a claim electronically and never actually checking the physician documentation to see who did the work.

- Don't forget, if you're billing Medicare for high-throughput COVID-19 testing, the U0005 add-on code for two-day turnaround times is now in effect! To recap: The payment for COVID-19 testing using high-throughput tech was dropped from $100 to $75 on Jan. 1, 2021. However, labs that report test results within two calendar days of collection are eligible to apply U0005 for an additional $25 payment IF they also returned results within two days for at least 51% of all COVID-19 tests performed using high-throughput tech the previous month, regardless of payer.

Revised* 2021 Medicare Physician Fee Schedule

CPT Code	Initial 2021	Revised 2021	Current 2020	% Change 20-21
88112 - Global	$63.52	$67.69	$68.57	-1.3%
88112 - TC	$37.92	$39.77	$39.70	0.2%
88112 - 26	$25.60	$27.91	$28.87	-3.3%
88120 - Global	$604.12	$632.90	$589.34	7.4%
88120 - TC	$550.00	$574.64	$529.07	8.6%
88120 - 26	$54.12	$58.27	$60.27	-3.3%
88121 - Global	$434.94	$456.71	$450.40	1.4%
88121 - TC	$390.22	$408.21	$399.51	2.2%
88121 - 26	$44.73	$48.50	$50.89	-4.7%
88184	$67.41	$69.78	$68.21	2.3%
88185	$22.36	$23.03	$22.38	2.9%
88187	$34.03	$36.63	$39.34	-6.9%
88188	$58.99	$62.80	$66.04	-4.9%
88189	$78.76	$85.13	$88.78	-4.1%
88305 - Global	$66.76	$71.52	$71.46	0.1%
88305 - TC	$32.09	$33.84	$32.12	5.4%
88305 - 26	$34.68	$37.68	$39.34	-4.2%
88307 - Global	$272.89	$290.28	$281.50	3.1%
88307 - TC	$196.40	$206.90	$194.88	6.2%
88307 - 26	$76.49	$83.39	$86.62	-3.7%
88309 - Global	$414.52	$441.70	$427.66	3.3%
88309 - TC	$279.37	$294.82	$275.00	7.2%
88309 - 26	$135.15	$146.89	$152.66	-3.8%
88312 - Global	$106.63	$113.04	$107.19	5.5%
88312 - TC	$82.00	$86.18	$79.40	8.5%
88312 - 26	$24.63	$26.87	$27.79	-3.3%
88313 - Global	$77.46	$81.64	$77.23	5.7%
88313 - TC	$66.12	$69.43	$64.60	7.5%
88313 - 26	$11.34	$12.21	$12.63	-3.3%
88341 - Global	$88.80	$93.85	$94.19	-0.4%
88341 - TC	$62.55	$65.24	$64.60	1.0%
88341 - 26	$26.25	$28.61	$29.59	-3.3%
88342 - Global	$99.82	$106.07	$107.19	-1.0%
88342 - TC	$67.41	$70.82	$70.37	0.6%
88342 - 26	$32.41	$35.24	$36.81	-4.3%
88367 - Global	$109.87	$115.83	$115.13	0.6%
88367 - TC	$78.43	$81.99	$79.40	3.3%
88367 - 26	$31.44	$33.84	$35.73	-5.3%
88368 - Global	$129.64	$137.12	$133.89	2.4%
88368 - TC	$91.40	$95.60	$90.58	5.5%
88368 - 26	$38.24	$41.44	$43.31	-4.3%
G0416 - Global	$332.85	$354.13	$347.90	1.8%
G0416 - TC	$167.24	$175.50	$162.40	8.1%
G0416 - 26	$165.62	$178.64	$185.50	-3.7%
G0452 - Global	$46.02	$49.54	N/A	
G0452 - TC	$2.92	$3.14	N/A	
G0452 - 26	$43.11	$46.40	$19.12	142.7%

**As part of the COVID relief and appropriations package signed on Dec. 27, the MPFS will receive a 3.75% increase over previously published 2021 payment rates. The new conversion factor for 2021 is $34.89.*

Changes on the horizon for prior-authorizations?

Last month, CMS released a proposed rule that would limit the amount of time payers have to issue prior authorization decisions to a maximum of 72 hours for urgent requests, while allowing seven calendar days to reach a decision on non-urgent requests. Payers would also be required to provide a specific reason for any denial and publicly release metrics that show how many procedures they are authorizing. Public comments are now being accepted.

MIPS COVID Exemption

Clinicians who have been significantly impacted by COVID-19 now have until Feb. 1, 2021 to submit a hardship application for 2020 reporting.

If you **participated in a COVID-19 clinical trial in 2020**, you're eligible to attest to the new corresponding high-weighted MIPS Improvement Activity.

2021 Clinical Lab Fee Schedule remains frozen at 2020 rates

As a reminder, The 2021 Clinical Lab Fee Schedule (CLFS) rates have been frozen at 2020 levels. In 2022, test rates will be subject to cuts of up to 15% based on the initial PAMA reporting round. The next round of payer data (Jan-June 2019) will be reported by affected labs in the first quarter of 2022.

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PNPL Survey

The Panel of National Pathology Leaders (PNPL), a national non-profit thinktank dedicated to advancing best practices in pathology and laboratory medicine, is soliciting input on a series of monthly pathology management roundtables to be held throughout 2021.

"PNPL Current Topics in Pathology Management" is a monthly virtual roundtable providing timely discussion of Pathology management topics. The attendees of the live event will hear a series of 5-10 minute presentations by a national subject-matter expert, followed by an opportunity to ask questions.

Potential attendees are invited to participate in a four-question survey to explore what topics they may be interested in hearing speakers address.

The mission of PNPL is to develop innovative strategies and solutions for the pathology and lab medicine industry in response to operational and financial challenges, and to demonstrate value in an increasingly value-based healthcare delivery system.

--ACCESS THE SURVEY ONLINE HERE

HHS distributing $24.5 billion in Phase 3 Provider Relief funding

Providers anxiously waiting for additional government funding to offset pandemic-related losses received a salve last month when HHS announced it is now distributing more than $24 billion in Phase 3 Provider Relief Fund payments.

During this round, HHS prioritized applicants that had not already received a baseline payment of 2 percent of their annual revenue from patient care. HHS also enhanced the Phase 3 distribution to consider the actual revenue losses and expenses experienced by providers that were attributable to COVID-19. Because submissions for lost revenue exceeded HHS's initial expectations, the total Phase 3 distribution was increased to $24.5 billion, up from the $20 billion originally planned.

The funding will cover providers for up to 88 percent of their reported losses. More than 35,000 applicants will not receive an additional payment either because they experienced no change in revenues or net expenses attributable to COVID-19, or because they have already received funds that equal or exceed reimbursement of 88 percent of reported losses, according to a press release issued by HHS.

A state-by-state breakdown on the first batch of Phase 3 payments can be found here – PDF. This data will be updated through January as Phase 3 payments are completed. The state-by-state data is tied to the state in which a recipient's TIN is registered. Once the attestation is completed, providers will be listed publicly.

As COVID-19 testing receives more scrutiny, don't forget about liabilities under EKRA

It's not exactly bold to predict payments for COVID-19 testing will be closely scrutinized by CMS and private payers throughout 2021, especially once the vaccine is more widely distributed and the Public Health Emergency expires.

EKRA, which prevents volume-based compensation arrangements, even for bonafide sales employees, is one potential law that could be used to prosecute bad actors. However, it remains to be seen how the DOJ may utilize EKRA as a tool for prosecuting COVID-19-related fraud, making it imperative that you ensure your sales and referral policies are compliant with the relatively new statute.

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Anthem reportedly undergoing Georgia DOI market conduct review, reports MAG

The Medical Association of Georgia (MAG) is reporting that the Georgia Department of Insurance (DOI) may be conducting a review of Anthem's conduct within the state.

As part of this announcement, MAG is encouraging providers to report instances where Anthem has failed to live up to its contractual obligations to the DOI.

In a press release announcing this action, MAG Corporate Relations Director Ryan Larosa said the DOI and Commissioner John King have broad powers to protect consumers. Georgia law allows the commissioner to examine the conduct of any licensee when deemed necessary to protect the interests of the public.

Providers and their staff should contact DOI's Gregg Conley at gconley@oci.ga.gov to report every instance that Anthem has not fulfilled its contractual obligations.

New COVID diagnosis codes now in effect

The CDC has implemented additions to the ICD-10-CM that are effective Jan. 1, 2021 for conditions resulting from COVID-19. The new codes aim to provide easier monitoring and tracking of COVID-19 through the claims process.

"There is an ongoing and urgent need to capture more information about this condition in our surveillance data and the nation's health care claims," the CDC said in a press release announcing the new codes.

They include:

- Encounter for screening for COVID-19 (Z11.52)
- Contact with and (suspected) exposure to COVID-19 (Z20.822)
- Personal History of COVID-19 (Z86.16)
- Multisystem inflammatory syndrome (MIS) (M35.81)
- Other specified systemic involvement of connective tissue (M35.89)
- Pneumonia due to coronavirus disease 2019 (J12.82)

ICD-10-CM interim coding guidance can be found at https://www.cdc.gov/nchs/icd/icd10cm.htm. If you're seeking additional guidance on how to utilize these new diagnosis codes, don't hesitate to reach out to us directly.

-- COVID relief package, continued

Here's how the remainder of the package will affect health care providers:

- Three month delay of the 2% Medicare sequester cuts that were scheduled to resume January 1, 2021

- $3 billion to partially offset changes to the MPFS
    - To reduce previously announced cuts, all codes will receive a 3.75% increase for 2021 paid for by $3 billion from the Trust Fund.
    - To partially fund this increase, a complexity add-on G-code (Visit complexity inherent to certain office/outpatient E/M) is delayed for three years until 2024.

- $3 billion in additional provider relief grants for Medicare or Medicaid-enrolled hospital and health care providers, including laboratories, to be reimbursed for health care related expenses or lost revenue directly attributable to the public health emergency resulting from COVID

- Exclusion of forgiven Paycheck Protection Program (PPP) loans from gross income
    - Permits deduction of otherwise deductible expenses paid with the proceeds of a forgiven PPP loan
    - Expands allowable expenses under the PPP to include certain operations expenditures, property damage costs, supplier costs, and worker protection

- Freezes the Advanced Alternative Payment Model thresholds at current levels for the 2021 and 2022 Quality Payment Program performance years. Currently, 50% of providers' revenue must be received through an Advanced APM in order to qualify for the reporting track. Without this delay, the threshold would have jumped 75% in January.

- Creates and appropriates $284.45 billion for a "PPP second draw loan" with a maximum amount of $2 million
    - To be eligible for a PPP second draw loan, eligible entities must
        - Employ 300 or fewer employees
        - Have used or will use the full amount of their first PPP loan
        - Demonstrate at least a 25% reduction in gross receipts in the first, second or third quarter of 2020 relative to the same 2019 quarter
    - PPP second draw loans are eligible for forgiveness equal to the sum of payroll costs, as well as covered mortgage, rent, and utility payments, covered operations expenditures, covered property damage costs, covered supplier costs, and covered worker protection expenditures incurred during the covered period.

- Extends the work geographic index floor under the Medicare program through Dec. 31, 2023.

- Provides a six-month statutory delay to the start of the Centers for Medicare & Medicaid Services (CMS) Model until Jan. 1, 2022, six months beyond what CMS advanced in recent rule making.

- Authorizes a Medicare Payment Advisory Commission (MedPAC) study on establishing a prototype value-based payment program

Overall, the package includes $8.75 billion to federal and local agencies to administer and track the coronavirus vaccine; $22.4 billion to support testing and tracing of COVID-19, and $3.25 billion for the Strategic National Stockpile.

No Surprises Act aims to provide national surprise billing fix

After years of back and forth discussion, a national surprise billing fix will be implemented in 2022 as part of the recently passed COVID relief and appropriations package.

Last month, a group of bipartisan legislators reached a deal over the latest solution to end surprise billing when patients receive out-of-network services. The No Surprises Act will prevent patients from being billed in emergency scenarios or non-emergent situations where the patient did not have reasonable access to an in-network provider. In such situations, patients will be responsible only for their in-network cost sharing responsibility. Payers and providers would then negotiate the remainder of the bill.

Providers would be required to provide good faith estimates of all scheduled services when requested by a patient. For nonemergency care, patient-informed consent is required for patients to be balance billed.

Providers and facilities that are out-of-network are prohibited from sending patients bills for more than the in-network cost-sharing amounts unless a patient has provided informed consent after receiving a notice of their network status and an estimate of charges 72 hours prior to receiving out-of-network services. For appointments within 72 hours of receiving services, the patient must receive notice the day the appointment is made and provide informed consent to receive out-of-network care.

An independent dispute resolution process is available when both sides can't reach an agreement on an out-of-network payment rate within 30 days. During the process, a third-party will consider the rates proposed by each side, the median in-network rate for the service provided, and a number of other variables, including:

- Provider's training and experience
- Patient acuity and complexity of the item or service
- Demonstrations of good faith efforts (or lack thereof) to enter into a network agreement
- Prior contracted rates during the four prior years

Unlike previous versions of the legislation, there will be no minimum threshold to enter resolution. Claims may also be batched together for resolution.

Finally, the legislation will restrict patient billing to 90 days from the date of service. Providers or facilities found to be in violation of the law would be subject to civil monetary penalties of up to $10,000 per violation.

Specifically, The legislative language amends three different statutes – Public Health Service Act, Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code (IRC).

However, the bill did receive some pushback from provider groups, including the American Hospital Association, who said in a letter to the House Ways and Means Committee that while the group supports "provisions to protect the patient from surprise medical bills," it still has significant concerns with several portions of the dispute resolution process, the new billing timeline restrictions, and the fact that the bill does not establish penalties for insurers who fail to reimburse providers for out-of-network services.

Notably, the AHA pointed out the fact that providers have no control over how quickly payers respond to claims and that delays on the payer's end could lead to tight billing timeframes or penalties for providers who miss the 90-day billing window.