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Biden Admin reaffirms Covid testing must be covered without cost-sharing

CMS issued guidance on Feb. 26 reminding providers and insurers that almost all instances of Covid-19 diagnostic testing must be covered without cost-sharing obligations for patients throughout the duration of the Covid-19 Public Health Emergency.

The guidance comes on the heels of an executive order signed by President Biden in January that strengthened and reaffirmed several portions of the CARES Act and Family First Coronavirus Response Act (FFCRA). Specifically, it states that insurers cannot use medical screening criteria to deny or impose cost-sharing requirements on a patient who receives a Covid-19 test, even if that person is asymptomatic.

"When an individual seeks and receives a COVID-19 diagnostic test from a licensed or authorized health care provider, or when a licensed or authorized health care provider refers an individual for a COVID-19 diagnostic test, plans and issuers generally must assume that the receipt of the test reflects an "individualized clinical assessment" and the test should be covered without cost sharing, prior authorization, or other medical management requirements," CMS said in its FAQ.

This includes drive-through sites or other state or locally administered test sites, which should significantly expand the types of testing that can be billed to insurers.

--Covid cost-sharing, 3

Recent audit and coding news

- Do you know how clean your accounts receivable is? One client we recently audited has an extremely efficient AR of 11% aged greater than 90 days by billed date. Typically, we see an average of 15% to upwards of 40% aged out, depending on region, payer mix and success of the billing agency. AR is a major artery for any independent lab, so be sure to reach out directly if you'd like to see how you're performing!

- Imagine receiving a medical bill eight months after your date of service. That's what one patient experienced after our audit showed a claim from April of 2020 was denied for a bad demographics. After being sent to a client rep for review, no statement was sent to the patient until December!

  Not only did they miss the timely filing limit, but the No Surprise Act will also bar this type of late patient billing starting next year.

Free webinar: What's next for Covid labs?

Mike Ricciardi, founder of Miami Medical Consulting Corp, will join Vachette CEO Mick Raich and President Ann Lambrix to discuss new strategies for utilizing antibody testing to measure the effectiveness of Covid-19 vaccines. With the general public eager to understand their immune response to the vaccine, this could be a significant line of business in the near future. The webinar will take place at 3 p.m., Tuesday, March 16. **Sign up today!**

Medicare to begin recouping advances

If you accepted a Medicare Advance last year and have not yet paid it off, those payments will soon be automatically deducted from your future Medicare payments. Starting one year after the issuance date, Medicare will recoup 25% of your Medicare payments for up to 11 months. After that, recoupment increases to 50% for six months.

MIPS deadline approaching

Don't forget, 2020 MIPS submissions are due by March 31. That includes Improvement Activity attestations for groups still reporting via the QPP portal.

Starting June 1, **UHC will deny multiplex PCR respiratory viral panels of six or more targets,** bringing the payer in line with the current CMS LCD.

At Vachette, we specialize in consulting and auditing for labs and pathology practices

We have been working with hospitals, laboratories, and hospital-based groups for more than 16 years.

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Medicare clarifies billing rules for second-run Covid variant tests

When re-testing Covid-19 specimens to check for variants, Medicare has indicated you may bill U0004 for the second-run test.

For example, if a specimen tests positive, you may run the sample again to check for variants and bill U0004 (Covid-19 test using high-throughput technology) with a quantity of two. The accompanying diagnosis code must be for a positive Covid-19 result.

The variant test would only need to be run once for a positive sample. If the patient remains positive when they are later retested, that sample would not need to be re-tested for variants since the previous test determined whether a variant existed or not.

While we have yet to see this policy officially published, this practice has been confirmed as compliant through conversations with Medicare reps.

Feel free to reach out with additional questions.

--Covid cost-sharing, continued

However, this may not be the clarification many were seeking as the FAQ goes on to specifically state insurers are still allowed to distinguish between testing for individualized diagnosis or treatment, as opposed to testing for workplace screening or public health surveillance. In those instances, CMS said insurers are not required to provide coverage, although they are not prohibited from doing so, either.

“Plans and issuers are not required to provide coverage of testing such as for public health surveillance or employment purposes. But there is also no prohibition or limitation on plans and issuers providing coverage for such tests,” CMS said. “Plans and issuers are encouraged to ensure communications about the circumstances in which testing is covered are clear.”

The FAQ also outlines that approved vaccines must be covered without cost-sharing and reminds labs who are providing Covid testing of the potential penalties for not posting their test cash price online.

So, what changes? This may slow down the trend of insurance plans not paying for individual Covid testing and forcing co-pays or deductibles to their enrollees. What this doesn’t do is give blanket coverage for all workplace screening tests to be paid without medical necessity and documentation. On an individual basis, CMS has clarified all tests must be covered and cannot be denied or balanced billed. Yet, this does not give carte-blanche coverage for all screening tests performed. While this may not be the crystal-clear guidance many were hoping for, it is at least a step in the right direction in terms of clarifying exactly when a test must be covered.

Timely filing extension set to continue with extension of National Emergency declaration

Timely filing extensions for claim submissions that were instituted by the IRS/DOL last March as part of a Covid-19 National Emergency declaration will be extended after President Joe Biden said he would extend the emergency in a Feb. 24 letter to Congress.

After the Trump Administration issued the emergency declaration on March 1, 2020 (keep in mind this is distinct from the HHS Public Health Emergency), the Internal Revenue Service (IRS) and Department of Labor (DOL) issued a regulation that paused the timely filing requirements clock for claims that would have exceeded filing limitations during the national emergency period. Once the declaration is allowed to expire, a corresponding “outbreak period” extends 60 days past the end of the national emergency, at which time the timely filing exception expires.

Commercial payers were not required to implement this policy, although many have. This includes Aetna, UnitedHealthcare, Cigna, and several BCBS products. Most payers typically allow a 180-day time frame from the date of service for a provider to submit a claim and be eligible for payment.

Webinar: Strategies for maximizing Covid opportunities in 2021

With the Covid-19 Public Health Emergency now set to stretch into at least mid-April 2021, labs and pathologists working to meet the testing demand must continue to refine their strategies as it becomes increasingly clear this will be a significant line of business throughout 2021.

Testing providers must work not only to meet public demand, but also must contend with ever-shifting payer policies and the recent Medicare payment reductions brought on by the U0005 add-on code.

This webinar is now available to view for free on our website. And don't forget to sign up for our next webinar on March 16.

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HHS to expand Covid testing opportunities under new initiative

HHS is seeking labs who can assist in expanding testing to K-8 schools and under-served populations in the coming months.

The goal of the effort is to ensure schools remain open by "establishing three or four direct hubs or 'coordinating centers' to organize COVID-19 laboratory testing networks to increase testing capacity," according to a call for interested parties emailed recently by HHS.

Once the centers are established, they will partner with up to 36 labs to collect specimens, perform tests and report results for up to an additional 25 million tests per month, HHS said. A "few small-to-medium" commercial labs will also be engaged to provide testing at the local level and provide assistance in the event of a testing surge.

For questions regarding this initiative, you may email the HHS Testing and Diagnostic Working Group at **COVID-Testing-RFI@hhs.gov.**

Automatic 2020 MIPS exemption offered by CMS

Due to Covid-19, CMS has announced it will automatically extend its extreme and uncontrollable circumstances policy to all 2020 Merit-based Incentive Payment System (MIPS) clinicians who have only submitted limited data.

Previously, individuals and groups impacted by the Covid Public Health Emergency in 2020 had the opportunity to apply by Feb. 1 to have one or all of their MIPS categories re-weighted to zero, meaning they would receive a neutral Medicare payment adjustment in the corresponding 2022 payment year. However, CMS is electing to re-open the application period for those who have already submitted some data and apply a blanket exception for anyone who has not yet submitted 2020 data.

Individuals who have submitted no data or have only submitted data for one category (such as claims-based Quality submissions) will automatically be exempted from the program. However, individuals who have submitted data for two or more categories will be scored in those categories and are not eligible to apply for an exemption.

Groups who have already submitted data in one category must complete an exception application by 8 p.m. March 31 in order to request reweighting of one or all of their MIPS categories. Groups who have already submitted data in two or more categories are not eligible to apply for an exception at this point and will be scored on all categories they are eligible to report on.

UHC to require new status for non-patient payments

Update: Following a meeting with College of American Pathologists reps, UHC announced it is delaying the deadline for labs to complete the quality survey to March 10.

Beginning July 1, 2021, UnitedHealthcare will only cover outpatient diagnostic lab services for commercial members when performed by a Designated Diagnostic Provider, a new quality status the insurer is asking labs to meet in an effort to tighten its network.

Per UHC, to participate, in-network hospital-affiliated and independent labs must meet certain quality and efficiency criteria and complete the associated survey by March 10.

- Complete the Designated Diagnostic Provider lab quality questionnaire by March 10, 2021
- If you meet the lab quality and efficiency requirements, you will become a Designated Diagnostic Provider for lab services and be notified accordingly
- If you do not meet the lab Designated Diagnostic Provider requirements for lab services, a dedicated network representative will reach out to follow up and support the process

Labs who do not receive designated provider status will remain in-network with UHC, however, outpatient diagnostic lab services will be denied non-covered. Non-participating labs are prevented from applying for designated provider status.

The Designated Diagnostic Provider status will not affect lab services rendered as part of inpatient admissions, emergency room visits or outpatient surgery pre-operation testing when billed as part of a global surgical package, according to UHC.

The following are the places of service with ancillary agreements we've confirmed will be impacted:

- 11 (office)
- 19 (Off-campus outpatient hospital)
- 22 (On-campus hospital outpatient)
- 81 (lab)

Medical groups, meanwhile, will only be in-scope of the policy if billing POS 81. Groups unsure of their agreement type should contact UHC.

In 2022, UHC said it intends to extend this program to major radiology services (MR, CT, PET/Nuclear Medicine).

“We are continuing our work toward the Triple Aim of better care, better health and lower costs for UnitedHealthcare members,” UHC said in a statement on its website. “Designated Diagnostic Provider benefit designs are intended to maximize member benefits for lab services and ensure laboratory services are performed by providers that meets both efficiency and quality requirements.”

However, the American Hospital Association recently expressed displeasure with UHC's practices in a letter to CMS.

In the letter, pointed out that UHC could be attempting to game the system by redefining what in-network means. “If a patient obtains care at a non-designated laboratory – even those supposedly “in-network” – coverage for their services will be denied, and the patient will be responsible for payment in full,” AHA said in its Feb. 4 letter. “In short, the DDP program is attempting to redefine the concept of an “in-network” provider and limit patient access to a much smaller pool of laboratory service providers."