

NEWS
ON
RHEUMATOLOGY
MATTERS

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CORONAVIRUS UPENDS AMERICAN LIFE AND ECONOMY; PRACTICES TRY TO COPE



With stunning, unprecedented speed, the global COVID-19 pandemic has killed thousands of Americans, threatened the lives of many thousands more, and shattered the normal routines of life, uniquely disrupting the healthcare economy in a manner that has left small and mid-sized physician practices shell-shocked and scrambling to adjust.

The impact has varied widely by provider specialty and practice type, with primary care providers trying to triage patients with suspected symptoms

of COVID-19 infection to determine whether they need hospital care, while specialists try to focus on staying open to treat the acute and chronic care required by their patient populations.

At Chester County Rheumatology PC in West Chester, Pa., patients have begun cancelling appointments while the entire practice has begun a major effort to adopt telehealth visits, says Andrea Zlatkus, CMPM, CRHC, practice manager and also past president of NORM. Chester County has declared physician offices to be essential businesses, so the practice can stay open even as other businesses close. Nearby her practice, three other providers – an allergist, ophthalmologist, and ASC, all closed. “Our goal as long as we’re able to, is to keep our infusion patients treated in our suite,” Zlatkus says. “Patients have been pretty calm and understanding with delays, with fewer chairs in the waiting rooms to keep everyone spaced further apart.”

Her staff is another story; they’re stressed about being exposed to asymptomatic COVID-19 patients and becoming potentially infected, on top of which they worry about losing hours, money, and even their jobs, Zlatkus reports. On another front, the practice is struggling to keep up stocks of everyday supplies. “Sanitizers have been really hard to get, you wait every day to see if it’s going to be released or not, even soap for the dispensers we can’t get ahold of,” she says.

MOVING TO ADOPT TELEHEALTH

One immediate challenge posed by the pandemic is the possibility of infected

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patients presenting for rheumatology issues without even knowing they are infected. Zlatkus is unaware of any potentially infected patients thus far, but because some COVID-19 patients can be infectious without having symptoms, she worries about the possibility of infection. One of her providers is already performing several telehealth visits a day, though they have only barely started the new visits.



So far, their infusion patients have all been coming in for treatment, and telehealth wouldn't help with infusion. The telehealth visits have been conducted using a HIPAA-compliant solution called

Doxy.me, but Zlatkus has to occasionally remind providers to shut their doors when on a telehealth call.

It is no small irony that the coronavirus pandemic has placed physicians and other providers at the forefront of public and media attention, while also posing a potentially existential risk to physician practices as small businesses. "If it starts spreading much more quickly here, we'd start losing patients too," Zlatkus says. With some of their patients on immunosuppressing medication, the coronavirus would pose a major risk. For now, her plan is to double down on telehealth visits while dusting off her staff's telework plan in case she has to send people home. **N**

TO FIGHT COVID-19, CMS UNLEASHES SLEW OF REGULATORY BREAKS

With the federal government projecting many more deaths due to the COVID-19 coronavirus pandemic, CMS is doubling down on telehealth services, adding inpatient, observation, critical care, and many more E/M codes to its telehealth-eligible list. The agency is also taking unprecedented action to relax a slew of other unrelated regulations, including physician supervision requirements, state licensing rules, and Stark self-referral law.

The goals of these actions, which are staggering in their breadth and scope – affecting nearly every facet of the CMS regulatory framework and instantly eliminating longstanding rules – are to ensure that local health systems can build up their surge capacity for COVID-19 cases, expand the size of the healthcare workforce, increase safe patient

accessibility to care via telehealth, and relax the administrative and compliance burden on providers. "Made possible by President Trump's recent emergency declaration and emergency rule making, these temporary changes will apply immediately across the entire U.S. healthcare system for the duration of the emergency declaration," CMS states in [a lengthy press release](#) announcing the new policies.

Below is a summary of the major highlights.

MORE THAN 80 SERVICES BECOME TELEHEALTH- ELIGIBLE

CMS has opened the floodgates in terms of services that are temporarily

eligible to be furnished via telehealth. To report these codes as telehealth services, use Place of Service code "02" on the claim form. Providers may now waive Medicare copayments for telehealth services to Part B (original) Medicare patients. CMS is also eliminating telehealth frequency limitations for subsequent hospital care services and skilled nursing visits (**99231-99233** and **99307-99310** respectively). The following services are now billable via telehealth:

- Emergency department visits (**99281-99285**)
- All observation codes (**99217-99220; 99224-99226; 99234-99236**)
- All hospital care (inpatient) codes (**99221-99223; 99238** and **99239**)
- Critical care and inpatient neonatal/pediatric critical care (**99291** and **99292; 99468-99473; 99475** and **99476**)

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- Domiciliary, rest home, and custodial care services (99237 and 99238; 99334-99337)
- Home visits (99341-99345; 99347-99350)
- Intensive care services (99477 and 99478)
- Care planning for patients with cognitive impairment (99483)
- Psychology and neuropsychological testing (96130-96133; 96136-96139)
- PT/OT services (97161-97168; 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507)
- Radiation treatment management (77427)

Furthermore, virtual check-ins (G2010, G2012) are billable for new and established patients (formerly only established patients were eligible). Licensed clinical social workers, clinical psychologists, physical and occupational therapists, and speech language pathologists can now bill for e-visits (G2061-G2063). A broad range of clinicians including physicians can bill for telephone services (98966-98968; 99441-99443). Finally, the issue of patient consent for telehealth services has been clarified; CMS says that “annual consent may be obtained at the same time, and not necessarily before, the time that services are furnished.”

Supervision and enrollment. CMS is relaxing supervision requirements across the board:

- Direct physician supervision can now be provided virtually using real-time audio/video technology.
- Auxiliary personnel may enter a contractual agreement with the practitioner who bills Medicare to provide services that would ordinarily be rendered on an incident-to basis and receive payment directly from the billing practitioner without submitting claims to Medicare.
- Medicare patients in the hospital no longer need to be under the care of a physician, meaning that other providers including nurse practitioners and physician assistants can fill that role.
- Providers no longer need to be licensed in the state where they are providing services. State laws will still apply, but CMS is waiving the Medicare requirement regarding state licensure. Providers must still be enrolled with Medicare and licensed in the state relating to their Medicare enrollment.
- CMS has created toll-free hotlines for providers to enroll and receive temporary Medicare billing privileges. All revalidation actions are postponed, and all new and pending enrollment applications will be expedited.
- For telehealth visits, providers may render telehealth services from their home without having to report their home address on their Medicare enrollment while continuing to bill from their currently enrolled location.

STARK LAW AND COMPLIANCE

Certain referrals and claims will be permitted that would ordinarily violate the Stark self-referral law:



- Hospitals can pay above or below fair market value to rent equipment or receive services from physicians (or vice versa). For example, a practice could rent or sell needed equipment and supplies to a hospital at a price lower than what the practice would charge another party. Or a hospital may provide physicians space on their campus at no charge if the physicians treat patients seeking care at the hospital who are not appropriate for emergency department care or admission.
- Hospitals can provide benefits to their clinicians such as daily meals, laundry service, or childcare services while those clinicians are treating patients.
- Physician-owned hospitals can temporarily increase the number of licensed beds and operating rooms even though this would normally violate Stark, in order to surge capacity due to the COVID-19 crisis.

MISCELLANEOUS CHANGES TO RELAX RULES

CMS is altering multiple other aspects of its regulatory scheme, from faster reimbursement to more discretionary application of its coverage determinations, to easing the burden of its appeals process:

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- CMS is expanding its Accelerated and Advance Payment Program to increase cash flow to providers affected by COVID-19. All Medicare Administrative Contractors will review requests for advance payments within 7 calendar days of receiving the requests.
- Medicare national and local coverage determinations (NCDs and LCDs) that restrict the use of respiratory devices, oxygen and oxygen equipment, home infusion pumps and home anticoagulation therapy can be ignored at the discretion of clinicians. CMS will cover non-invasive ventilators, respiratory assist devices and CPAP devices based on clinician assessments of patients even if the assessed conditions and circumstances do not meet NCD/LCD guidelines.
- Signature requirements are waived for Part B drugs and durable medical equipment when



a signature can't be obtained. Supplies still need to document date of delivery and that a signature could not be obtained due to COVID-19.

- The Merit-based Incentive Payment System (MIPS) categories for the 2019 reporting year can be reweighted at providers' request if they claim they were adversely affected by the COVID-19 pandemic. This would potentially allow affected providers to ensure a neutral MIPS payment adjustment for the 2021 payment year. CMS is also adding one new Improvement Activity for the 2020 MIPS reporting year, for providers who participate in a clinical trial utilizing a drug or biological to treat a COVID-19 patient and then report their findings to a clinical data repository or clinical data registry.
- Medicare allow extensions for appeals filing for Part B, Medicare Advantage, and Part D claims. Medicare contractors and entities will be allowed to utilize all flexibilities available in the appeals process as if good cause requirements are satisfied, whether they were or were not.

The complete CMS release can be found at www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf. 

PANDEMIC FINALLY LETS TELEHEALTH SERVICES TAKE CENTER STAGE

The audio-video communications technology required for telehealth services has been widely used for decades, but it took a global pandemic for CMS to finally cast off the regulatory shackles that have relegated telemedicine to something of a curiosity for the average small to mid-size physician practice.



Prior to the COVID-19 coronavirus outbreak, telehealth services where a physician interacts in real-time with a patient using video and audio was highly limited, with CMS requiring patients to be located at specific "originating sites" it designated. These sites were almost all required to be outside of metropolitan statistical areas (MSAs), and were usually a hospital, nursing facility, rural health clinic, or other healthcare provider location. That often limited telehealth services – for practical purposes – to consults by specialists who would evaluate and manage the patient remotely while the patient was with another provider, often one who acted in a primary care role. Mental health providers also benefitted from telehealth, as did hospitals doing post-discharge follow-ups, but the restrictions hampered widespread adoption.

Now, in just a few dizzying weeks as the COVID-19 pandemic poured past American borders, telehealth services have suddenly become the hottest topic in healthcare thanks to a series of sweeping declarations by CMS to greatly expand access to telehealth services. As a result of the new policy, Medicare will pay for office and hospital visits rendered via telehealth across the country and in patients' homes, eliminating the requirement for specific originating sites. The agency will also allow a wider range of

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provider types to offer telehealth services, including clinical psychologists and licensed clinical social workers.

“There is an urgency to expand the use of technology to help people who need routine care, and keep vulnerable beneficiaries and beneficiaries with mild symptoms in their homes while maintaining access to the care they need,” the agency states in a public fact sheet announcing the new policy. “Limiting community spread of the virus, as well as limiting the exposure to other patients and staff members will slow viral spread.”

Now that telehealth has become the primary method of care delivery for a variety of specialties and patient complaints, let’s review the latest policy updates from CMS so you understand how your practice and providers can

continue seeing patients via telehealth during the COVID-19 Public Health Emergency (PHE).

THE NEW RULES

CMS issued a series of policy declarations throughout the last two weeks of March, stating that its goal was to expand telehealth services as a way for patients to access care without risk of COVID-19 infection, as well as to insure continuity of care for patients who need non-COVID-19 care. The agency also wanted to give COVID-19 patients, including those who suspect infection, a safe way to be triaged to determine whether access to a limited supply of COVID-19 tests was necessary.

- **All settings can now be telehealth sites.** This is the single largest game-changer for telehealth during the COVID-19 PHE. For the duration of the crisis, CMS is allowing patients to be located anywhere – a doctor’s office, hospital room, even their own homes – and receive telehealth services. Providers

who render telehealth may also be at any location, including their homes should they be quarantined due to COVID-19 exposure.

- **Platforms that are not HIPAA-compliant may be used.** While there are dedicated HIPAA-compliant, secure telecommunications software such as Doxy.me and VSee, providers can use more readily available but non-compliant software (e.g. Apple FaceTime, Skype) if they are acting “in good faith” during the COVID-19 PHE, according to [a CMS release](#). This means that the HHS Office of Civil Rights (OCR) will use its discretionary powers to essentially waive penalties for HIPAA violations in using programs such as Skype.
- **Patients do not need to be established.** Telehealth services are normally limited to patients who are established to the rendering provider, but during the coronavirus public emergency, HHS “will not conduct audits to ensure

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CMS WILL ALLOW TIME OR MDM TO DRIVE TELEHEALTH E/M LEVELS

Your providers can now bill for new patient visits using telehealth technology, which sounds fantastic until you consider the issue of documenting the physical exam. How can any provider possibly capture a comprehensive level of physical exam, which is required under the E/M guidelines for higher-level, new patient E/M codes?

CMS has answered in its COVID-19 Public Health Emergency PHE Interim Final Rule (IFR), a 236-page document that answers crucial questions regarding a variety of regulatory “flexibility” measures the agency has undertaken at record speed in response to the coronavirus pandemic.

The bottom line is that providers will be allowed to select E/M code levels based on medical decision making (MDM) or time, and no history or exam requirements will be made, CMS says in the IFR. “This policy is similar to the policy that will apply to all office/outpatient E/Ms beginning in 2021 under policies finalized in the CY 2020 [Physician Fee Schedule] final rule.” What’s more, CMS says that the total time used will be defined as “all of the time associated with the E/M on the day of the encounter,” not merely face time or unit/floor time.

Indeed, this looks very much like a preview of the 2021 E/M changes, which have been covered extensively in previous issues of *News On Rheumatology Matters*. The 2021 changes to MDM will not be in effect for telehealth codes, and MDM will be scored in the same way as it is now. CMS goes on to issue a warning against lack of documentation, saying that: “It remains our expectation that practitioners will document E/M visits as necessary to ensure quality and continuity of care.” **N**

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that such a prior relationship existed.”

- **Telehealth payment.** CMS will consider telehealth visits the same as regular, face-to-face visits and will pay them at the same rate. Medicare coinsurance and deductible amounts will apply to these services, however the HHS Office of Inspector General (OIG) will allow providers to reduce or waive cost-sharing for beneficiaries.
- **Additional provider types may now bill for telehealth.** This includes physical therapists, occupational therapists, and speech language pathology providers. All of these providers can now bill for e-visits (**G2061-G2063**). A broad range of clinicians including physicians can bill for telephone services (**98966-98968; 99441-99443**).

NOT ALL REMOTE SERVICES ARE CONSIDERED ‘TELEHEALTH’

It’s important to note that CMS and most private payers cover a variety of non-face-to-face services using communications technology that are not actually categorized as “telehealth,” and this distinction carries with it important coding and billing implications.

For starters, there are two previously existing types of communications-based non-telehealth services that CMS is promoting during the COVID-19 PHE, “virtual check-ins” and “e-visits,” with the same goal of expanding patient access and to help relieve the pressure of in-person patient visits on providers and facilities.

Virtual check-ins are brief visits lasting 5-10 minutes that providers can conduct remotely using telecommunications or even a simple phone call. The check-in is intended to help determine whether an office visit or other service is needed. These services can only be applied to established patients and for medical issues that are not related to a visit within the previous 7 days and do not result in a medical visit within the next 24 hours. These services are billed using HCPCS codes G2012 for an interactive session and G2010 for a remote evaluation of patient-submitted images or video.

Online “e-visits” are for established patients who must initiate an inquiry with the provider using patient portals. E-visits can be billed for an inquiry and communications that occur over a single 7-day period. For Medicare patients, physicians would bill for these services using CPT codes 99421-99423 (time-based codes) while non-physician providers would bill using HCPCS codes G2061-G2063 (also time-based).

BILLING FOR TELEHEALTH – BEWARE OF OUTDATED RULES

One downside to CMS’ frenzied relaxation of longstanding regulations over the month of March has been the release of vague and sometimes contradictory guidance. This has affected the telehealth rules most of all. Let’s review some of the most confusing elements and clarify them.

- **There no special codes for telehealth services.** Instead of using special CPT codes for telehealth, you actually report existing E/M codes like **99213** and use a modifier (see bullet below) to designate the encounter as having been conducted via telehealth. Thanks to



another CMS rule change, inpatient codes such as initial hospital care (e.g. **99223**) and observation services (e.g. **99217-99220**) are now billable via telehealth.

- **Place of Service (POS) code.** This has arguably been the greatest area of confusion. The current CMS guidance as of April 1, 2020 is to report the POS code representing the actual location of the provider rendering the telehealth service. In addition, report modifier **95** (synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system). There was earlier guidance instructing providers to report POS code “02” for telehealth and to not use any special modifier. That would result in lower payment because POS 02 is designated as a facility setting. If you did use “02” for some claims, CMS will still pay them at the facility rate.

- **Obtaining and documenting patient consent.** There was confusion over whether providers need to obtain verbal patient consent and document that consent at every single telehealth (or virtual check-in and e-visit) encounter. Some providers wondered whether a single consent form could be created and used to save a significant amount of time. Now CMS says that “annual consent may be obtained at the same time, and not necessarily before, the time that services are furnished.” **N**

RHEUMATOLOGY REGISTRY HAS BIG PLANS BEYOND MIPS REPORTING

For many rheumatology practices, submitting clinical data is something they were prodded into doing by Medicare requiring their providers’ participation in the Merit-based Incentive Payment System (MIPS), with a carrot-and-stick financial incentive structure. For others, such data submission is part of a metrics-based self-improvement process aimed at improving the clinical outcomes – something they’d be doing without the threat of CMS docking their Part B payments.

At least 50% of rheumatology practices participating with the [RISE qualified clinical data registry](#) (QCDR) are not using the database for MIPS reporting. “The non-MIPS users are people who are interested in using the registry for quality improvement purposes,” says Tracy Johansson, MS, director, registry analytics for RISE. “When it comes down to it, that is actually the heart of the RISE registry, to help providers keep track of how well they’re taking care of their patients and how they can improve.”

RISE, which is owned by the American College of Rheumatology, was created in 2009 when Medicare’s primary quality reporting mechanism was the Physician Quality Reporting System or PQRS. With a membership of 1,100 providers (including MD/DO physicians as well as non-physician practitioners), the registry has grown each year and does not require that providers be members of ACR or the Association of Rheumatology Professionals (ARP).

LOOKING BEYOND MIPS

With three full years of MIPS reporting in the books, many providers across a variety of specialties have come to believe that the program has no practical upside in terms of bonus payments, which are limited by a statutory budget neutrality

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HOW COVID-19 HAS AFFECTED MIPS REPORTING

Quality reporting is probably one of the last things on providers’ minds amid the deepening coronavirus crisis, but CMS has been thinking about ways to address its statutory responsibilities to continue the Merit-based Incentive Payment System (MIPS) even in these times.

The good news is, CMS is including MIPS in its overall effort to offer regulatory “flexibility” to providers during the COVID-19 Public Health Emergency (PHE). This is coming in several forms: delaying the reporting deadline for 2019 data, granting an automatic hardship exemption for those who fail to report, and adding a COVID-19 measure for the 2020 performance year.

Here’s the full list of changes:

- **Deadline extension for 2019 reporting.** CMS has extended the deadline for submission of 2019 MIPS data from March 31, 2020, to April 30, 2020. Second, and perhaps most significantly, if no MIPS data is submitted by MIPS-eligible clinicians by the April 30 deadline, those clinicians will automatically qualify for the existing “extreme and uncontrollable circumstances

policy” and will be guaranteed a neutral (0%) Medicare Part B payment adjustment for the 2021 MIPS payment year. This will be done by CMS reweighting their categories to 0%. “CMS recognizes that quality measure data collection and reporting for services furnished during this time period may not be reflective of their true level of performance on measures such as cost, readmissions and patient experience during this time of emergency and seeks to hold organizations harmless for not submitting data during this period,” the agency states in an [accompanying press release](#).

- **New improvement activity for 2020 performance year.** For practices that intend to carry on with MIPS reporting this year, CMS is adding a new high-weight Improvement Activity for that component of the MIPS program. The new activity will be for clinicians that participate in a clinical trial utilizing a drug or biologic to treat a COVID-19 patient and then report those findings to a clinical data repository or clinical data registry. “This would help contribute to a clinician’s overall MIPS final score, while providing important data to help treat patients and address the current COVID-19 pandemic,” [CMS states](#). **N**

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provision. Instead, MIPS participation is seen by these providers as an exercise in doing the bare minimum reporting required to avoid a Medicare pay cut.

Even CMS is looking beyond MIPS, with language in its latest Physician Fee Schedule final rule that describes using MIPS as a pathway to increasing provider participation in alternative payment models that reimburse based on quality rather than quantity (as opposed to traditional fee-for-service Medicare).

The ACR has developed quality measures for RISE that have been accepted for MIPS reporting, but also on clinical measures designed around rheumatology needs rather than getting CMS approval for MIPS. “We’re developing measures that we have gotten feedback from the rheumatology community on that are areas of important to them in treating their

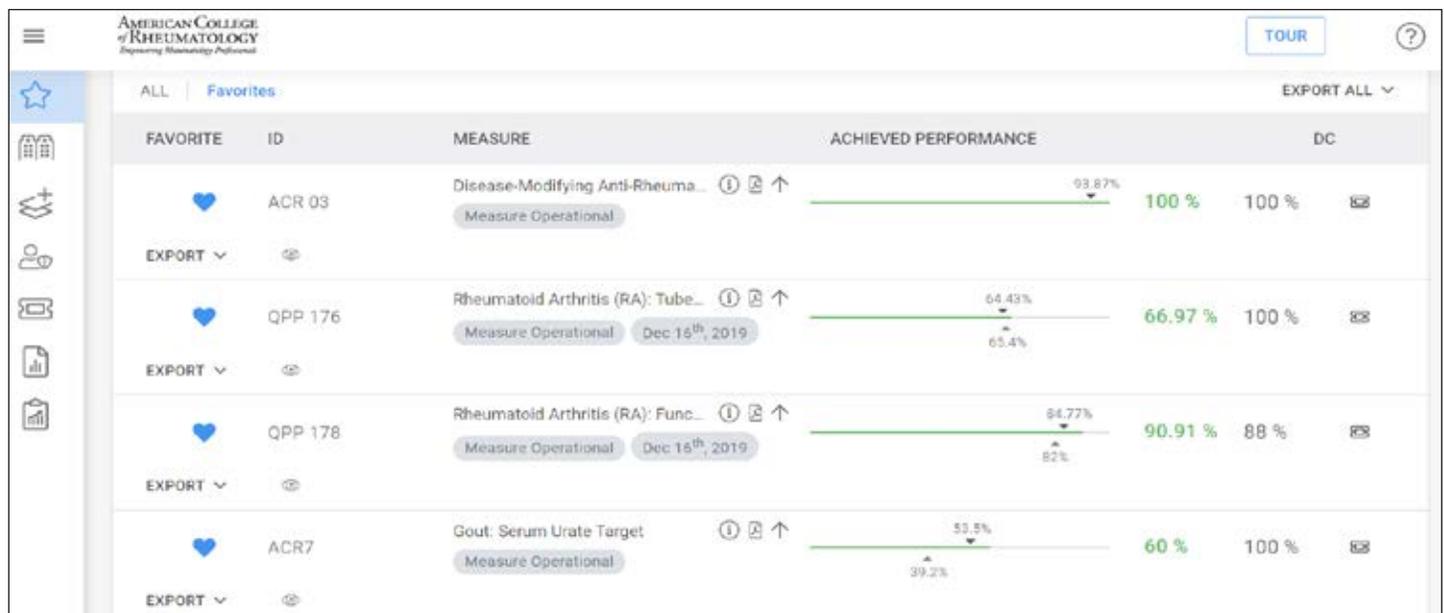
patients,” Johansson says.

For example, the RISE dashboard, which is the online platform RISE participants use to track their data, shows performance on quality measures at a practice level and provider level, Johansson says. It allows organizations to measure individual provider performance against their internal benchmarks, or against the overall RISE registry average, or the CMS average (for those quality measures that are used by both MIPS and RISE).

“The goal is being able to track how your patients are doing over time and we can tell you based on the data you have, that you have a percentage of patients who are improving under your care, or that you are 50/50 [on improvement] and you need to look at specific patients who may need something different,” Johansson explains. One practice tracked patients’ body mass index (BMI) every month over a five-year span and implemented interventions, such as physician reminders to exercise or diet at each visit, to improve outcomes.

DATA ANALYTICS HAVE BEEN ‘A LONG TIME COMING’

While the underwhelming nature of MIPS bonus payments may have turned some providers off to the program, RISE is betting that physicians will become increasingly interested in quality reporting in an era of data-driven medicine. By developing quality measures that are highly attuned to the clinical measures that matter to rheumatologists, RISE and the ACR hope that providers will sign up because they see the value of tracking those measures, regardless of whether or not CMS accepts them for MIPS reporting. The industry-wide movement towards pay-for-performance is pushing providers to gather data over time and use it to “react appropriately in a way they haven’t ever really been able to do before,” Johansson believes. “It’s about having data that is analyzable, and it’s really been a long time coming.” 



THE RISE ONLINE DASHBOARD can measure individual providers’ performances on various rheumatology quality measures down to the patient level. *Source:* RISE registry.