Law Changes Improve 2021 Reimbursements

On December 27, President Trump signed the fourth major COVID-19 emergency funding bills into law, providing approximately $900 billion in funding. The bipartisan agreement offers several key provisions critical to medical practices in 2021. Here is a summary of the law's impact on medical practice reimbursement:

- Infuses $3 billion into the Medicare Physician Fee Schedule (MPFS), nullifying the mandated MPFS budget neutrality for the year. The newly enacted law states there will be a 3.75% increase in the payment schedule applied across the board in 2021, counteracting the 10% cut announced earlier last month. The conversion factor, instead, drops from $36.09 to $34.8931. This represents a 5% cut that reflects the infusion of funding, as well as the delay of the HCPCS add-on code G2211 for three years. The G2211 code was meant for office-based medical specialties to achieve a $10 to $15 per visit payment boost for the "inherent complexity" of primary care and other office visits. This delay had a significant impact on Medicare pay-outs, thereby softening the original cuts.

- Another 90 days of relief from sequestration. The pesky 2% reduction that has been in place for nearly a decade was temporarily suspended between May and December 2020; the new law extends the suspension through March 31, 2021. Please make sure that your Medicare Advantage plans are complying with this dictate; since they are administered by commercial payers, it's possible they may not be in compliance.
- Extends the work geographic practice cost index (GPCI) floor through 2023, mainly benefiting physicians practicing in the Midwest.
- Expands telehealth access further for mental health services, updating the list of CPT codes on the telehealth services eligible for reimbursement beyond the public health emergency (PHE). Scroll to the bottom of this link to find the newly-updated list at: CY 2021 PFS Final Rule List of Medicare Telehealth Services (updated 12/21/2020) (ZIP).
- Provides for the establishment of new Medicare funded residency positions.
- Allows providers to pursue independent dispute resolution tactics with insurance payers if an out-of-network medical bill is generated during a patient emergency. This finalizes the "surprise bill" legislation that has been floating around Washington, DC for several years, giving a pathway to reimbursement for practices that bill out-of-network, albeit an arguably time-intensive, arduous one.
- Enhances the reimbursement for Rural Health Clinics (RHC)s, raising the statutory cap to $100 on April 1, 2021 – and increasing the amount through 2028 until it reaches $190.
- Infuses more money into the FCC COVID-19 Telehealth Program Funding, a grant program for non-profit health care organizations. There is consideration that additional applications will be accepted.

In addition to these opportunities, some medical practices may be able to benefit from a second Payment Protection Program, being made available to small businesses. Discuss this option with your CPA.

What changed with the new law is as important as what did not – the boost in work relative value units (RVUs) for the office-based evaluation and management (E/M) codes remains. Seven of the office-based E/M codes – 99212, 99213, 99214, 99215, 99203, 99204, and 99205 received increases; for example, the work RVU for 99213 rose from 0.97 to 1.30, making the total RVUs sum to 2.65. As Medicare – and most commercial payers – rely on RVUs to pay for professional services, reimbursement will proportionately rise for these codes. In addition to the boost to RVUs, the new documentation requirements announced in 2019, but implemented on January 1, 2021, will remain unchanged. A history and physical will no longer be required; total time can be the factor for the choice of the code level. Indeed, in the newly-released 2021 fee schedule, CMS denotes: "Office o/p est low 20-29 min" to describe 99213. For more detail on these changes – and more, see the American Medical Association's E/M code and guideline changes. SVMIC also has a recorded session on E/M coding changes which members can watch here.

Read the communication from the Centers for Medicare and Medicaid Services (CMS) about the Medicare reimbursement schedule for 2021.

Public Health Emergency Extended

On Friday, January 8, Secretary of Health & Human Services Alex Azar renewed the Public Health Emergency (PHE) for 90 days. The importance of this renewal is that it extends the regulations that have been eased for telemedicine. The extension allows the PHE-based regulatory relaxations to be valid through April 20. The relaxations include patient location; communication device (e.g., smartphone can be used); covered services; privacy rules; and more.

Informed Refusal

While physicians are familiar with the concept of informed consent, they may not be familiar with the concept of informed refusal. Informed refusal is the flip side of informed consent and recognizes that competent patients have the right to refuse recommended treatment after receiving sufficient information regarding the potential risks of such refusal. The key in any informed refusal discussion is to explain the medical rationale for the physician's recommended course of treatment and to adequately explain the potential negative consequences for refusing such recommended treatment. It is also vitally important for physicians to document a patient's informed refusal to undergo recommended treatment in the medical record, as demonstrated by the closed claim outlined below.

The 55-year-old female patient was referred to gastroenterologist Dr. Brees[1] due to abdominal pain, bloody stool, constipation, and weight loss. After an initial consultation appointment, Dr. Brees performed a colonoscopy with polypectomy. Unfortunately, the patient's polyp specimens were lost by pathology. Dr. Brees notified the patient that the polyp specimens were lost and recommended additional work up and testing to determine the cause of the patient's symptoms and to rule out colon cancer.

The patient declined further work up and testing at that time as the severity of her symptoms had improved. Dr. Brees documented the patient's refusal and his discussion

with the patient outlining the potential risks of refusing recommended treatment in the medical record. Unfortunately, the patient was diagnosed with colon cancer 15 months later by another gastroenterologist, and Dr. Brees, along with other health care providers, received a pre-suit letter from the patient's attorney alleging medical negligence and demanding compensation for delay in diagnosis and treatment.

After SVMIC hired defense counsel to review the patient's allegations and medical records with Dr. Brees, defense counsel was able to demonstrate to the patient's attorney that the alleged delay in diagnosis and treatment was not due to any negligence on the part of Dr. Brees or due to his failure to recommend additional testing to rule out colon cancer. Because Dr. Brees documented his informed refusal discussion with the patient in the medical record, defense counsel was able to show that Dr. Brees properly informed the patient of the potential risks and negative consequences for refusing recommended treatment. The patient's attorney ultimately did not file a medical malpractice lawsuit against Dr. Brees, presumably because of the documentation in the medical record of the patient's informed refusal.

As demonstrated by this closed claim, informed refusal discussions should be documented in the patient's medical record because a well-documented medical record not only promotes quality medical care but can also prevent a lawsuit from ever being filed in the first place. Physicians may also consider having the patient sign an informed refusal form (SVMIC policyholders may download a sample informed refusal form template here) and/or sending a letter to the patient outlining the expected benefits of the recommended treatment plan and explaining the potential risks of foregoing the recommended treatment plan. These extra steps not only provide additional documentation of the patient's refusal but also serve as a point of emphasis to the patient that his/her refusal to follow recommended treatment could potentially have serious and negative consequences for his/her health. Finally, policyholders are encouraged to contact SVMIC, and a claims attorney will be happy to answer any questions and assist with any situations involving informed refusal.

[1] The name of the physician and patient specifics have been altered.

Risk Matters: Telemedicine

When practicing telemedicine, keep in mind that the medical services are being rendered at the **patient's** location. Therefore, the provider must:

1. be licensed in the state where the patient is located;
2. be familiar with the standard of care in the patient's location **and** comply with that standard of care; **and**
3. be prepared to be sued in the patient's location in the event of a claim.

SVMIC provides coverage for telemedicine services. If you would like more information, please contact us at 800.342.2239 or ContactSVMIC@svmic.com.

February 1 Deadline for QPP Hardship

The Quality Payment Program imposes a 9% reduction to Medicare payments across the board for physicians who do not participate in the federal government's initiative. There's one easy method to avoid the penalty in 2022, if you did not keep track of your 2020 data – or your efforts weren't comprehensive. The performance year (PY) 2020 Extreme and Uncontrollable Circumstances Exception Application deadline was extended, so you have time to apply now. You can request relief from one – or all – of the Quality Payment Program's four categories. Should you change your mind and submit your 2020 data, your application will be ignored. Therefore, it is a no-brainer to apply, as it guarantees you'll be relieved from next year's penalty. Monday, February 1 is the last day to apply. Submit your application here: https://qpp.cms.gov/mips/exception-applications.