Aug. 27, 2021: National Advocacy Update

DOJ should close regulatory loophole for unserialized "ghost guns”

The AMA sent a letter (PDF) to the U.S. Department of Justice (DOJ) in response to a proposed rule issued by the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF), which would update the definitions of "firearm" and related parts for the first time since 1968 and modernize the definition of "frame or receiver," which would help close a regulatory loophole associated with the unserialized, privately made firearms that are increasingly being recovered at crime scenes across the country.

These unmarked firearms, known as “ghost guns,” are often assembled from kits that are sold without background checks, making them easily acquired by criminals who otherwise would not be permitted to possess a firearm.

Ghost guns are firearms that anyone can buy in parts and kits and assemble at home, and because they are unserialized, they are nearly impossible for law enforcement to trace. They are a growing murder weapon of choice in America and are increasingly being used in robberies, mass shootings and homicides across the country. According to the ATF, more than 23,000 unserialized firearms were reported to have been recovered from 2016 to 2020 by law enforcement from potential crime scenes, including in connection with 325 homicides or attempted homicides. The proposed rule would help address the proliferation of these unserialized firearms in three ways:

- To help keep guns from being sold to convicted felons and other prohibited purchasers, the rule would make clear that retailers must run background checks before selling kits that contain the parts necessary for someone to readily make a gun at home.
- To help law enforcement trace guns used in a crime, the rule would require that manufacturers include a serial number on the firearm “frame or receiver” in easy-to-build firearm kits.
- To help reduce the number of “ghost guns” on the streets, the rule would set out requirements for federally licensed firearms dealers to have a serial number added to 3D-printed guns or other unserialized firearms they take into inventory.

The AMA is urging the DOJ to finalize this proposed rule without delay.

AMA urges FDA to act against introduction of new menthol cigarettes and flavored cigars

The AMA recently joined with the Campaign for Tobacco-Free Kids and several medical specialty organizations and anti-tobacco groups in bringing attention to and urging the Food and Drug Administration's (FDA) Center for Tobacco Products to take action against the continued introduction of new menthol and flavored cigars without FDA marketing authorization. Under the Family Smoking Prevention and Tobacco Control Act (TCA), "new tobacco products" (those introduced or modified after Feb. 15, 2007) are not authorized to be introduced without rigorous premarket review by FDA and issuance of premarket orders authorizing their sale. The letter to FDA (PDF) specifically raises concern over two companies' recent introduction of new flavored tobacco products and urges the agency to:

- Prioritize enforcement against both sets of flavored "new tobacco products" that appear to be adulterated and misbranded without the required FDA marketing authorization.
- Expedite the issuance of proposed and final rules to establish menthol cigarette and flavored cigar product standards to eliminate these products from the marketplace.

The AMA is a party to a lawsuit brought in 2020 against the FDA requesting that the court compel the FDA to fulfill its mandate to take action on FDA's own conclusions that it would benefit the public health to add menthol to the list of prohibited characterizing tobacco flavors and therefore ban it from sale. The lawsuit led to a long-overdue announcement by FDA that it will promulgate a rule banning menthol cigarettes, finally responding to a citizen petition submitted to the agency in 2013 by 19 public health organizations.

AMA urges OSHA to exempt physician practices from COVID-19 emergency temporary standard

On Aug. 20, the AMA filed a comment letter responding (PDF) to the Occupational Health and Safety Administration's (OSHA) Exposure to COVID-19 Emergency Temporary Standard (ETS) Interim Final Rule (IFR). The rule, which went into effect on June 21, requires health care providers to comply with new requirements focused on preventing the spread of COVID-19 in the workplace and offering paid leave to employees impacted by a COVID-19 diagnosis.

The letter urges OSHA to not make the ETS permanent given the duplicative nature of many of the requirements, which align with existing guidance from the Centers for Disease Control and Prevention. Many of the remaining requirements are burdensome and unclear unfunded mandates that may be appropriate for the inpatient setting but not for struggling physician practices, according to the letter. Accordingly, the letter urges OSHA to completely exempt physician practices and other non-hospital ambulatory settings in the event the ETS is made permanent.

House bill requires telehealth coverage for ERISA plans

As the United States continues to grapple with the ongoing COVID-19 pandemic, telehealth remains a critical lifeline for patients and their treating physicians. The temporary flexibilities offered to Medicare patients following the enactment of various federal COVID-19 relief bills have been crucial to ensuring these beneficiaries retain access to care while helping minimize community spread of SARS-CoV-2. While select private health plans have taken voluntary steps to increase access to telehealth services both during the current public health emergency and beyond, these efforts as a whole remain insufficient, especially for individuals receiving coverage from health plans regulated under the Employee Retirement Income Security Act of 1974 (ERISA). As a result, the AMA sent a letter on Aug. 18 in support (PDF) of H.R. 4480, the Telehealth Coverage and Payment Parity Act.

Introduced by Representatives Dean Phillips (D-MN) and Steve Chabot (R-OH), this bipartisan bill ensures telehealth coverage is permanently provided to all patients, including individuals covered by ERISA plans. More specifically, H.R. 4480 will:

- Ensure all medically necessary benefits in ERISA plans are covered via telehealth.
- Prohibit restrictions on which conditions can be managed remotely (e.g., ERISA plans are not permitted to prohibit physicians who provide in-person care from treating patients via telehealth).
- Permit the use of expanded telehealth modalities (e.g., audio-only) in addition to traditional two-way audio-visual technology, where appropriate.
- Require payment parity between telehealth and in-person services for physicians, as well as uniform cost-sharing requirements for patients.
- Enable physicians to offer telehealth services to new and established patients.

AMA is pleased to support this legislation as part of its broader lobbying efforts to continue telehealth flexibilities beyond the end of the COVID-19 public health emergency.

UnitedHealthcare reverses incident-to billing policy

In response to strong objections (PDF) from the AMA, state medical associations and national medical specialty societies, UnitedHealthcare (UHC) adjusted its payment policy effective Aug. 1 to allow nonphysician providers to continue billing services meeting incident-to criteria under the supervising physician's National Provider Identifier (NPI). UHC previously implemented a new commercial payment policy effective March 1 that required advanced practice health care providers to bill under their own NPIs. This change prohibited advanced practice providers from billing services meeting Medicare's incident-to criteria under the supervising physician's NPI, which translated to a 15% payment reduction for most practices.

UHC implemented this welcome reversal through a revision to its advanced practice health care provider policy (PDF) and creating a separate services incident-to a supervising health care provider policy (PDF). UHC representatives have stated that any claims that were billed under an advanced practice provider's NPI despite meeting the incident-to criteria between March 1 and Aug. 1 can be submitted for reprocessing under the supervising physician's NPI.

CMS updates guidance to providers administering third doses of COVID-19 vaccines

The Centers for Medicare and Medicaid Services (CMS) last week announced new guidance on payment, coverage and coding for administration of third doses of COVID-19 vaccines in certain immunocompromised individuals. Effective Aug. 12, CMS will pay to administer additional doses of the Pfizer or Moderna vaccines consistent with the Food and Drug Administration's (FDA) Emergency Use Authorizations for immunocompromised individuals, using CPT codes 0003A for the third dose of Pfizer's vaccine and 0013A for Moderna's.

CMS also released a statement assuring enrollees in Medicaid, the Children's Health Insurance Program (CHIP) and those enrolled with private payors that those who qualify for the additional dose will receive it at no cost. Medicaid and CHIP agencies must cover the additional dose in immunocompromised populations with no cost-sharing during the COVID-19 public health emergency and for a year after it ends. Additionally, the COVID-19 vaccine is free for people enrolled in most private health plans. Coverage must be provided both in-network and out-of-network during the public health emergency.

Medicare recalculating 2020 MIPS scores and corresponding payment adjustments

After initially releasing the 2020 Merit-based Incentive Payment System (MIPS) feedback reports that included final scores and corresponding payment adjustment information earlier this month, CMS is now recalculating MIPS participant scores due to a technical issue that impacts some physicians. CMS is recalculating all scores to ensure their accuracy and plans to update both the 2020 scores and corresponding 2022 payment adjustment information for affected physicians and groups in the next few weeks. As a result, CMS is also planning to extend the deadline to submit an appeal, also known as a targeted review request, which was originally Oct. 1.

Medicare increased payment for cognitive assessment and care plan services

If a patient shows signs of cognitive impairment during a routine visit, Medicare covers a separate visit to more thoroughly assess a patient's cognitive function and develop a care plan. The visit can be conducted in an office or outpatient setting, a private residence, a care facility, a rest home or via telehealth. Effective Jan. 1, 2021, Medicare made three key updates related to the separate visit to assess a patient for cognitive function:

1. Increased payment for these services to $282 (subject to geographic adjustment) when provided in an office setting.
2. Added these services to the definition of primary care services in the Medicare Shared Savings Program.
3. Permanently covered these services via telehealth.

Physicians may use CPT code 99483 to bill for both in-person and telehealth services.

For more information, please visit CMS Cognitive Assessment & Care Plan Services.

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