March 10, 2023: National Advocacy Update

CMS issues new guidance on PHE unwinding, including important implications for audio-only services

The Centers for Medicare & Medicaid Services (CMS) released new guidance (PDF) intended to help physician practices prepare and plan for the end of the COVID-19 Public Health Emergency (PHE), which is slated to occur on May 11.

The guidance addresses the following key areas (among others):

- **Telehealth:** Several (but not all) telehealth flexibilities will extend through Dec. 31, 2024, from previously passed legislation including geographic and site of service flexibilities, expanded clinician types and use of audio-only technology. Consistent with AMA advocacy, codes that were slated to be removed from the Medicare telehealth list later this year will now continue to be available via telehealth at least through the end of 2023, including the CPT codes for telephone visits (CPT codes 99441-99443). Once the PHE ends, established patient, service frequency and face-to-face requirements for certain services will generally resume. Following the PHE, CMS will also defer to state law regarding state licensure requirements. Though not addressed in this guidance, flexibilities for prescribing of controlled substances and for use of non-HIPAA compliant telehealth platforms will also generally end with the PHE.

- **Supervision:** “Virtual presence” will no longer satisfy Medicare physician supervision requirements after Dec. 31, 2023. However, CMS permanently loosened a select set of supervision requirements and student documentation standards.

- **COVID tests and vaccines:** Medicare covering the cost of over-the-counter COVID tests will end with the PHE, as will pharmacists being able to order COVID lab tests. CMS will continue to pay $40 per dose for administering the COVID-19 vaccine in most cases through the end of 2023, at which point it is expected to be reduced to $30.

- **Coverage determinations:** Enforcement discretion for certain products including respiratory devices, home infusion pumps and home anticoagulation therapy will expire with the PHE, as will signature and proof of delivery requirements for Part B drugs and durable medical equipment. However, certain flexibilities regarding oxygen were made permanent.

- **Medicare appeal extensions and flexibilities** will continue to apply, provided existing regulatory requirements are met, including good cause.


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Enrollment: Following the PHE, CMS will suspend expedited enrollment applications and temporary Medicare billing privileges.

Stark waivers are scheduled to end with the PHE.

For more information on any of these changes, access the new guidance (PDF).

**DEA publishes proposed rules on telehealth prescribing of controlled substances**

The U.S. Drug Enforcement Administration (DEA) has issued two proposed rules outlining policies that would replace the waivers that have allowed controlled substances to be prescribed based on telehealth visits once the COVID-19 Public Health Emergency (PHE) ends on May 11. One rule focuses solely on buprenorphine prescriptions for opioid use disorder and the other outlines policies for all other controlled substances in Schedules III-V.

Under the buprenorphine proposal (PDF), patients could be provided with an initial prescription for buprenorphine based on an audio-visual or audio-only visit with their physician. The prescription based on the telehealth visit could be for no more than 30 days and the patient would need to have an in-person visit with the physician within that 30-day period in order for the physician to provide prescriptions to refill the patient’s buprenorphine. Alternatively, if the physician prescribing buprenorphine has telehealth visits with a patient who has been referred to them by another physician who has evaluated the patient in-person, the patient would not need to also have an in-person visit with the physician prescribing buprenorphine. Additional proposals would require physicians to check prescription drug monitoring program data before prescribing buprenorphine and to maintain records in the location where they are registered with the DEA, among other administrative requirements.

The other proposal (PDF) limits the initial prescriptions of controlled substance medications in Schedules III-V issued to a patient via telehealth, to a total quantity of less than or equal to a 30-day supply. This proposal would similarly allow these specific scheduled controlled substance medications to be initially prescribed based on telehealth visits, but would require an in-person examination with their physician within 30 days before they could be prescribed medication refills.

The deadline for submission of comments on both proposals is March 31. The AMA is evaluating how the proposals support hybrid models of care delivery with a mix of in-person, telehealth and remote monitoring services to best meet patients’ needs for care. The AMA has concerns about disruptions to care based on the 30-day requirement, which will likely require DEA to provide a longer period of time for patients to arrange in-person visits with their physicians so that they do not risk a lapse in needed medications.


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IDR processing of claims dated prior to October 2022 to resume

According to new guidance, Independent Dispute Resolution (IDR) Entities may resume processing of IDR payment disputes involving items or services dated prior to Oct. 25, 2022. Claims processing was suspended after the administration was sued for a second time by the Texas Medical Association over its most recent final rule released in Aug. 2022. A federal judge ruled earlier this month that the final regulation defied the original intent of the No Surprises Act by instructing arbiters to weigh the Qualified Payment Amount (QPA) more heavily than other factors or circumstances included in the law, despite “nothing in the Act” directing them to do so.

The new guidance explains that disputes involving items or services before Oct. 25, 2022, “are not affected” by the Feb. 6, 2023, ruling so they can resume processing. All disputes involving services dated on or after Oct. 25, 2022 (the date the lawsuit was filed) on the other hand will be held by IDR entities until updated guidance can be issued that reflects the recent ruling. However, federal IDR process timelines will continue to apply for all disputes, including those with dates of service on/after Oct. 25, 2022. Accordingly, physicians and practices should continue to abide by all previously established timeframes (PDF) with regard to initiating the IDR process, submitting fees and responding to information requests.

Also of note, there are two outstanding cases before the District Court in the Eastern District of Texas regarding the methodology for calculating the QPA, claims batching rules and the recent seven-fold increase in the IDR administrative fee. Additional updates will be provided as new information becomes available.

Register for March 23 webinar: How prior authorization disrupts patient care—and how we can fix it

93% of physicians surveyed by the AMA in 2021 said that prior authorization delays access to necessary care, and even worse, 34% of physicians reported that prior authorization has led to a serious adverse event for a patient in their care. Physicians know they spend an inordinate amount of time dealing with the hassles of prior authorization, but when patients are being harmed because of it—it is clear something has to change.

AMA President Jack Resneck Jr., MD, hosts a webinar on Thursday, March 23 at 11 a.m. Central, to dig further into the current state of prior authorization and how the AMA is working to fix it. Heather
McComas, PharmD, director, Administrative Simplification Initiatives, AMA, and Emily Carroll, JD, senior attorney, Advocacy Resource Center, AMA, will join Dr. Resneck to talk about the latest reform efforts and how you can get involved. You will also hear about results of the AMA’s latest prior authorization survey conducted at the end of 2022.

Register now.

**Physicians recommend improvements to MIPS Value Pathways**

The AMA and 36 national medical specialty societies sent a letter (PDF) to CMS urging the agency to propose changes in the 2024 Quality Payment Program notice of proposed rulemaking to fulfill the objectives of MIPS Value Pathways (MVPs) to reduce burden and create a bridge to alternate payment models. Specifically, the letter recommends that:

- CMS score the Promoting Interoperability (PI) performance category based on physicians either attesting that they are using certified electronic health record technology (CEHRT) or health IT that interacts with CEHRT or alternatively this would be automatically met by submitting their quality data electronically using a Qualified Clinical Data Registry.
- CMS develop MVPs around conditions, episodes of care and clinical priority areas, such as the Improving Care for Lower Extremity Joint Repair MVP and not just around a specialty. CMS should work with the national medical specialty societies to develop MVPs with appropriate measures, rather than developing MVPs at the broad specialty level and simply repackaging problematic measures. MVPs should move us closer to patient-centered care, not further from it.
- CMS ensure MVPs remain voluntary and retain traditional MIPS as an option for physicians.

**AMA calls for more transparency over proposal to remove more than 2,000 codes from Medicare Advantage risk adjustment**

On March 6, the AMA submitted comments (PDF) in response to the Centers for Medicare & Medicaid Services (CMS) Advance Notice of Medicare Advantage (MA) payment and policy changes for calendar year 2024. The comments focused on CMS’ proposal to remove more than 2,000 codes from the risk scoring model, including mild depression, diabetes and other chronic condition service codes.

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According to the rule, the codes were proposed for removal because they are “subject to more coding variation.” In light of the magnitude of the number of codes proposed for removal, the AMA called for “further exploration and consideration with input from physicians and other relevant stakeholders.” In particular, the AMA urged CMS to provide more transparent information on how it selected the codes, allow time to gather robust feedback from stakeholders and model the impact on specific patient populations to ensure certain groups are not disproportionately impacted by the changes.

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