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Thank you for allowing me the opportunity to serve you, the members of the Utah Medical Association. I appreciate the trust placed in me and feel the weight of representing the physicians and patients of Utah. I know that I follow in the footsteps of amazing physicians who are Past Presidents of this organization including Dr. Russell M. Nelson, who was a world-renowned cardiothoracic surgeon and pioneer in open-heart surgery, and Dr. John C. Nelson, an OB/GYN who later went on to become the President of the AMA, just to name two. UMA has a long history of advocating for physicians and improving the quality of medical care for patients in the state and I will strive to continue pursuing those ideals.

In reviewing the events of the last UMA House of Delegates meeting, I was encouraged that we were able to discuss and debate potentially divisive topics without the arguments turning bitter or rancorous. However, as I looked at the list of the delegates who attended and had influence in determining UMA policy, which is the purpose of the House of Delegates, I became concerned when I realized that the majority of registered delegates, 92 out of 179 were from Salt Lake County. I applaud the physicians in SL County for their participation and enthusiasm, especially given the importance of the topics discussed and policy made, but the rest of the state was underrepresented and therefore did not have as much of a voice.

I know many are thinking, “Of course the majority were from Salt Lake County—that’s where the population center is!” and that is a valid point. Where SL County physicians really showed up was in representation of the specialty societies such as Utah Soc. of Anesthesiologists, UAFP, ACOG - UT section, and others. They also had great representation from Hospital and Practice groups, the UMA Board and other ex-officio members. Another interesting point is that 25 of the delegates from SL County were there for the first time, whereas the rest of the state had only 19 new delegates and seven of those were students from southern Utah.

Again, I applaud all who came and represented their respective organizations. But the UMA represents and advocates for physicians and patients in the ENTIRE state of Utah, not just the Wasatch Front. If we don’t have fair representation from every area of the state, from Cache Valley to St. George, even Blanding, Ephraim and Vernal, then we lose relevance as an organization, as well as the influence to affect any issues for which we will advocate, particularly in rural areas and with rural legislation. If the Association is governed by those from a geographically small area, we miss the opportunity to understand and respond to the needs of those outside of that area, which includes the vast majority of the state.

I encourage you to get involved. We all have busy lives, balancing our daily practice of usual doctor stuff like stamping out disease and saving lives with family time and community activities. However, these are issues that will affect our profession and livelihood, and as has been said before, “If we are not at the table, then we will be on the menu.”

Feedback is a gift; whether positive or negative, there are things that can be learned and improvements made. Are there important issues that we are NOT talking about or addressing? Please let me know. If you feel the UMA does not represent you, then I would like to understand why. In the coming year I will be advocating for and representing Utah physicians at the state and national levels. I would invite you to contact me so that I can best represent you and fulfill the responsibilities of the office of President.

Noel C. Nye, D.O.

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As you read this, it is likely the 2022 Utah Legislative Session is in full swing. For 45 days, elected Representatives and Senators will be debating and making decisions that affect your life and your profession. Some may look upon our imposing State Capitol and the bustling hive of political activity going on inside as an arena with which they have neither acumen nor desire to interfere. But for any state resident, that building is your building. And at least two of those bustling politicos are answerable to you as a constituent whom they are supposed to be representing.

Is Anyone Listening?
Legislators are your elected officials; they work for you. During a typical year, thousands of bills are introduced. No single legislator can be well-informed on all of them. Legislators count on ideas and information from their constituents, using that input to improve state laws. If you think a proposed law misses the mark or a new law is needed, you have every right to share your ideas.

Do I Have to Be an Expert?
No. Legislators are most interested in how a bill will affect the people in their voting districts; let them know how you will be impacted by any proposals you care about. Physicians can be especially compelling when informing legislators about healthcare issues, but you need not limit yourself to only medical topics.

Who Do I Tell?
The legislative power of the State of Utah is vested in the State Legislature which consists of two chambers: the Senate and the House of Representatives. You are represented by one person in each house. To find out who represents you, go to www.votervoice.net/UtahMed/Home and enter your home zip code (and possibly
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Street address) where indicated. Your local representatives will be the last two listed, after the federal and statewide officials.

The Governor and state agency heads also play a role in making and carrying out laws in Utah. There are times when contacting them is also effective.

**THE BEST TIMES TO LOBBY**
The best time to contact your elected representatives about legislation is when the bill is introduced, whether before the legislative session starts or right as it starts. Make the contact as early as possible in the process — when your legislator is more likely to be open to changes. However, until a final vote is cast, it is never too late to make your views known.

Even after a bill passes the Legislature, you can continue to have an impact by urging the Governor to sign or veto it. In the event the Governor issues a veto, you can contact your legislators and ask them to uphold or override the Governor’s action.

**HOW AN IDEA BECOMES A LAW**
The process can appear complicated, but you don’t need to know all the details to lobby effectively. Here’s an overview of the process:

- **First Chamber (either the House or Senate)**
  For an idea to be considered by the Legislature, it must be written in bill form and sponsored by at least one legislator. The bill is given a number, then introduced on the floor of the sponsor’s chamber, either the House or the Senate. It is then assigned to a legislative committee, where it can be scheduled for a hearing and possibly changed (amended). If the committee approves the bill, it goes back to the floor for consideration by the full chamber and, sometimes, further amendment. If it passes in the first chamber, it moves to the other chamber. The bill can be introduced and become a committee bill during the off-season of the legislature when interim legislative meetings are heard. If a bill becomes a committee bill, it may go directly to the floor instead of being assigned to a committee for a hearing.

- **Second Chamber**
  The bill repeats the above process in the second chamber. If it is changed, it must go back to the originating chamber for agreement. If agreement is denied, it may be referred to a conference committee to resolve differences, then go back again to each chamber. A bill must pass both chambers—in identical form—before it can be sent to the Governor.

- **The Governor**
  If the Governor signs a bill or takes no action on it, the bill becomes a law. If the Governor rejects a bill (veto), it goes back to the legislature.

- **Veto Override Session**
  A veto may be overridden by the Legislature by a 2/3 majority vote of both houses. If done, the bill as originally written becomes law. If the Legislature fails to override it, the bill dies.

**WHERE AND HOW TO REACH OUT**
It is not necessary to go to the State Capitol in Salt Lake City while the Legislature is in session to get your message across. Legislators generally welcome communication from their constituents at any time and by any available means.

You may contact them in writing — by sending an email or letter — or verbally by scheduling an office visit or making a phone call. However, make sure you indicate that you are a constituent and include your address otherwise they may not read the email. Say in the subject line that you are a constituent and indicate that you are communicating on whichever bill it is (i.e. HB27 or SB56, etc.).

Also, the Utah Medical Association arranges a special Doctors’ Day at the Legislature annually to give physicians a little extra access to state legislators by providing a meal or reception for legislators and UMA members to hob knob and talk about issues.

**TIPS FOR COMMUNICATING WITH YOUR LEGISLATORS**
Some basic same principles apply no matter how you contact your government official:

- Identify yourself and give your home address when phoning and writing.

- Describe the issue or bill that concerns you.

- Refer to the exact bill number if possible.

- Tell the legislator what action you would like taken.

- Mention any relevant credentials or background you have.

- State key reasons for your views: be brief, clear and concise.

- Stick to 3 or fewer points to get your message across.

- Make it personal; explain how you, your family or community will be affected.

- Stick to facts; don’t stretch the truth.

- Limit each communication to one issue or bill so you have more impact.

- Be courteous and respectful; keep the
door open for future communication.

- Listen to the office holder's views and stay open to compromise. The issue may not be as clear cut as you believe and some progress toward your goal can be better than none.

- Ask for a reply.

- Be patient but persistent. Don't expect an immediate commitment but follow up after your initial contact.

- Send a thank you or follow up letter when appropriate.

- Know the Rules: Never promise campaign contributions or give gifts to officials.

**ADDITIONAL SUGGESTIONS FOR SUCCESSFUL PHONE CALLS OR VISITS WITH YOUR LEGISLATOR:**

- Legislators are often at home during the weekends when the legislature is in session.

- If they are not available when you call, ask to speak to their legislative aide. Leave your name, address and message with that aide.

- Make an appointment or ask for a return call if you wish to have a direct discussion.

- Have your talking points ready and focus on the issue.

- Cultivate cordial relationships with the staff as well as with the legislator.

**UTAH LEGISLATIVE RESOURCES AT YOUR FINGERTIPS**

Use the Utah Legislative Website: https://le.utah.gov/

**STAY WELL INFORMED ABOUT PROPOSED LEGISLATION**

- Decide which bills you wish to follow.

- Read the synopsis and check the sponsors.

- Contact UMA if you have a question on a bill or want to know what position the Association has taken.

- Know the status of the bill — where it is in the legislative process and whether it has been amended.

- Read all amendments — they often change the content of legislation.

- If a bill is headed for a committee hearing, consider submitting testimony, or contacting the committee members. Be sure to coordinate your efforts with UMA in this instance to make sure physicians are not working at cross purposes.

- Keep an eye on your bills and track their movement through the chambers, to the Governor and back if there is a veto.

**HOW CAN I HAVE MORE IMPACT?**

There is strength in numbers. Reaching out to others is the best way to amplify your message:

- Write a letter to your local newspaper, or post comments on your online news outlet and social media.

- Ask friends, neighbors, and colleagues to contact their legislators.

- Write and/or sign online and paper petitions.

- Join a group working on your issue.

- Attend Town Hall meetings.

- Exchange views with candidates.

- Run for office or help a friend run. Contact UMA if you want help with this.

**WHAT IF I DON’T SUCCEED?**

Try again! Good ideas can take a while to show up on the legislative radar. Increasing legislators' awareness of an issue and establishing your own credibility can help lay the groundwork for future success.
As reported in earlier articles and UMA MediByte newsletters, Utah passed a law mandating that, as of January 1, 2022, most prescriptions for controlled substances be transmitted as an electronic prescription. As also reported, the Division of Occupational and Professional Licensing (DOPL) temporarily suspended enforcement of these new requirements at the beginning of the year. As of this writing (mid-January 2022), that suspension is still in force, but will be lifted in the next few months.

The reason for the suspension was because Medicare e-prescribing was delayed. Thus, UMA and others pushed back since the rules would only have been in place for a week or so before being enforced.

The physician licensing boards had not reviewed the final rules and the sponsors of the bills were OK with delaying implementation because of these issues. However, DOPL will not wait forever. Utah physicians should prepare now to make sure they are able to use electronic means to transmit prescriptions for controlled substances to their patients’ pharmacies.

Utah pharmacies are similarly under the gun to assure they can receive electronic transmission of these prescriptions.

Physicians can request a limited extension (through Dec 31, 2023) to comply with the new requirements using a form available at https://dopl.utah.gov/cs/ElectronicPrescription_LimitedExemption_20211203.pdf. It essentially exempts from the new law those planning to retire from practice between now and the end of 2023. Other exemptions (likely rare) can be granted due to economic hardship or technological barriers (i.e., no internet connection in a rural practice setting).

For those who have already set up or enabled electronic prescribing in their office, the only problem is getting the various pharmacies to accept the electronic transmissions created by your system. That may take some coordination between your I.T. people and the pharmacy’s I.T. people. But it should not be a big problem unless one of you is using a proprietary system that does not recognize standard protocols.

The following is not an endorsement of any particular vendor, but the following companies are known to provide electronic prescribing services that seem to be working in the community. A prescriber may use any vendor (including one not on this list) who can provide compliance for electronic transmission of prescriptions:

Continued on page 12…
Medical professional liability insurance is designed to protect you from the "what if." But who's figuring out the "what"? Using predictive data from our extensive claims database and our proprietary technology we can better determine your risks. Understanding the likelihood of encountering your risks, what you can do to avoid them and what your best options are if you can't, will empower your insurance buying decisions. You'll know you're getting the right coverage for you.
### Vendor

<table>
<thead>
<tr>
<th>Vendor</th>
<th>Cost of ePrescribing*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allscripts Professional</td>
<td>$0.00 (included w/EHR)</td>
</tr>
<tr>
<td>Allscripts Touchworks</td>
<td>$0.00 (included w/EHR)</td>
</tr>
<tr>
<td>Amazing Charts</td>
<td>$0.00 (included w/EHR)</td>
</tr>
<tr>
<td>Athena</td>
<td>$0.00 (included w/EHR)</td>
</tr>
<tr>
<td>CareVend Varies</td>
<td>based upon number of providers</td>
</tr>
<tr>
<td>DrFirst</td>
<td>$799/provider/yr; Discounted pricing with 10+ providers</td>
</tr>
<tr>
<td>eClinical Works</td>
<td>$0.00 (included w/EHR)</td>
</tr>
<tr>
<td>eMDs</td>
<td>$344 initial; $40/provider/month; $120/yr maintenance</td>
</tr>
<tr>
<td>Epic</td>
<td>Varies based upon number of providers</td>
</tr>
<tr>
<td>GE Centricity</td>
<td>$0.00 (included w/EHR)</td>
</tr>
<tr>
<td>Greenway Intergy</td>
<td>$372/provider/yr</td>
</tr>
<tr>
<td>Greenway PrimeSuite</td>
<td>$180/provider/yr</td>
</tr>
<tr>
<td>NewCrop</td>
<td>$20/provider/month</td>
</tr>
<tr>
<td>EPCS</td>
<td>$150/yr</td>
</tr>
<tr>
<td>NextGen</td>
<td>$0.00 (included w/EHR)</td>
</tr>
<tr>
<td>Practice Fusion</td>
<td>$99/provider/month</td>
</tr>
<tr>
<td>iPrescribe</td>
<td>360/yr/provider ($30/mo) + one-time $75 set up fee</td>
</tr>
<tr>
<td>Veradigm (ePrescrib Deluxe w/EPCS)</td>
<td>$33/provider</td>
</tr>
<tr>
<td>MD Toolbox (E-Prescribe Complete)</td>
<td>$38/mo/provider</td>
</tr>
<tr>
<td>Treat</td>
<td>$45/mo/provider</td>
</tr>
<tr>
<td>RXNT (Electronic Prescribing)</td>
<td>$650/yr ($54/mo)</td>
</tr>
</tbody>
</table>

*Cost information is provided for informational purposes only and costs are subject to change at the discretion of the vendors. Accurate as of 1/4/22.

Of course, if you will be prescribing any controlled substances in Utah you will be required to hold a federal DEA license as well as a Utah controlled substance license.
Muffled voices, shuffling feet.
Smell of chlorhexidine.
I never expected the anxiety, the growing panic and shudder that couldn't be stifled, all because of a cough.

The ragged breathing, the machines beeping against stiff lungs.
Are we really not over this?
Every time I walk through the doors, I expect a different scene. Maybe it's my optimism or maybe it's simply foolishness—a foolish hope, a pleading wish for the pandemic to be over.

What started out as sickening fear of the death of my loved ones or even myself while dealing with PPE shortages and the shrouding unknown, has turned into a feeling of overwhelming disappointment and fatigue.

To watch so many perish, feeling defeated, to a profound triumph, with tears of relief after vaccines were released, to a dull heartache and despair when people yell their vaccination fears and leave masks below the chin or off altogether.

So, I enter the double doors, eyes drifting through the glass towards the beeps, the coughs, the ragged breathing, and sigh against the tightness in my own chest. I pull on my gown, the gloves, the N95 and goggles and pause for a moment to quiet the fear banging in my ears. I think of my husband and recheck the seal on my mask.

I turn the handle and the burst of air greets me like an old familiar friend.

ED NOTE: Dr. Tory Toles is from Las Vegas, Nevada. She completed her undergraduate degree at the University of Nevada, Las Vegas and her medical degree at Temple University School of Medicine. Her medical interests include medical education, office-based procedures, and reproductive and women's health.
From tracking diet, sleep, mood, blood pressure and more, health apps have become a huge repository of patient’s personal health information.

But unlike other health information, HIPAA doesn’t protect this sensitive information. These apps weren’t a reality when HIPAA was created in 1996. And, while the California Consumer Privacy Act has attempted to address some patient privacy concerns, there’s nothing at the federal level that has established comprehensive data privacy rules.

Based on the AMA’s Privacy Principles, a recently released AMA-developed guide makes the business case for why developers should be designing their apps with privacy at the forefront. The AMA also is offering a road map on how to implement important privacy protections for patients who are sharing information such as their height, weight, exercise routines, eating habits and glucose readings.

“This kind of information may not seem like medical data when the user was entering it into the app, but as a picture of a person’s health begins to evolve from the information submitted, it starts to look more and more like what be found in a medical record. A marketer, an insurance company, or an employer could have access to that information and use it in ways that the consumer may not have imagined,” according to the guide, Privacy is good business: A case for privacy by design in app development, which is part of the AMA health data privacy framework.

Health insurers could use such data for health scoring and pricing; employers could factor the information into hiring, firing and promotion decisions. Big data can potentially target educational, credit, health care and employment opportunities to historically marginalized communities and those with low income—or it can be used to withhold such opportunities from such communities. Potential inaccuracies and biases in the data can lead to additional detrimental effects.

The guide tells app developers and physicians that “apps can differentiate themselves by building trust with consumers that their personal private data will not be shared with unknown or unwanted parties.”

The Role Physicians Can Play
Patients sometimes ask their physicians for recommendations about apps and a recent Pew Survey found that 90% of respondents said they preferred apps that their physician had pre-approved.

The AMA encourages the physician community to ask app developers whether they are following the AMA principles and to encourage their patients to ask those questions of apps as well.

The AMA-created checklist for app developers looks at privacy policy from several different angles, including a specific focus on how privacy intersects with health equity. The document also includes actions developers can take to implement the principles, some of which are outlined below.

**Individual Rights**

Individuals have the right to control how entities access, use process and disclose their data, including secondary uses—and beyond. For example, systems need to provide configurable setting functions that allow a user to define which entities may have access to their personal data.

Individuals have a right to direct entities not to sell or otherwise share data about them. For example, the default app setting should be to deny sale of a user’s personal data.
Individuals and entities should be able to protect and securely share pieces of information on a granular, as opposed to a document, level. For example, systems should provide a configurable setting for each category of personal information that could potentially be shared.

**EQUITY**
Individuals should be protected from discrimination, stigmatization, discriminatory profiling and exploitation occurring during collection and processing of data, and resulting from use and sharing of data, with particular attention paid to historically marginalized racial and ethnic groups. App developers should have practices in place to protect users from sharing that would lead to such discrimination and profiling. Law enforcement agencies requesting medical information should be given access only with a court order and if the law enforcement entity has shown by clear and convincing evidence that the information sought is necessary to a specific, legitimate law enforcement inquiry. App developers should take steps to ensure that such information is only released to law enforcement agencies in accordance with these processes.

Employers and insurers should be barred from unconsented access to identifiable medical information to assure that knowledge of sensitive facts does not form the basis of adverse decisions against individuals. App developers should prevent information from being shared with employers and insurers absent a user’s specific consent and direction.

**ENTITY RESPONSIBILITY**
All entities that maintain an individual’s health information should have an obligation or “duty of loyalty” to the individual, including the duty to maintain the confidentiality of that information. App developers should implement policies and procedures that protect the user above all other considerations.

Additionally, app developers should disclose to individuals exactly what data it is collecting and the purpose for its collection and should only collect the minimum amount of information needed for a particular purpose, in accordance with regulation or federal guidance.

Endnotes
Previously, one court bluntly characterized the Medicare and Medicaid regulatory landscape as “among the most completely impenetrable texts within human experience.” (Rehab. Ass’n v. Kozlowski, 42 F.3d 1444, 1450 (4th Cir.1994)). And another court colorfully described the Medicare statute as “a law written by James Joyce and edited by E. E. Cummings.” Catholic Health Initiatives – Iowa, Corp. v. Sebelius, 841 F.Supp.2d 270, 271 (D.D.C. 2012), rev’d, 718 F.3d 914 (D.C. Cir. 2013).

In this article, in an effort to assist practitioners, we highlight key provisions from this year’s payment policies. On November 2, 2021, the Centers for Medicare and Medicaid Services (“CMS”) issued its Calendar Year (CY) 2022 Payment Policies Under the Physician Fee Schedule (PFS) and Other Changes to Part B Payment Policies Final Rule.

PAYMENT CUTS
Following the Final Rule’s announcement of steep payment cuts to physicians of up to 9.75% in CY 2022, Congress responded by passing the Protecting Medicare and American Farmers from Sequester Cuts Act. The Act provided a 3% increase in funding for the PFS in CY 2022 to partially offset the expiration of a 3.75% payment increase from CY 2021. It also stopped the imposition of a 4% statutory “pay as you go” budget neutrality sequester and extended a waiver of the Medicare 2% sequestration cut that had been provided during the COVID-19 public health emergency (PHE) through April 1, 2022, followed by a 1% waiver until July 1, 2022. The CY 2022 conversion factor is now $34.60, a 0.82% cut from CY 2021.

TELEHEALTH SERVICES
CMS extended COVID-19 telehealth flexibilities. Coverage of temporary Category 3 telehealth services were extended until the end of CY 2023 to allow additional time to analyze whether such services should be permanently added to the Medicare telehealth services list after the PHE ends. Individuals can request services be added to the list for CY 2023 until February 10, 2022.

Practitioners may now receive reimbursement for mental health services, including treatment of substance use disorders, furnished to established patients and delivered through audio-only means when:
- The beneficiary is at his or her home when the service is delivered;
- The practitioner has the technical capability at the time of the service to furnish two-way, audio/video communications;
- The beneficiary is incapable of, or fails to consent to, the use of two-way audio-video technology;
- The appropriate service level modifier is used; and
- The reason for using audio-only technology is documented in the medical record.

CMS further clarified that every non-mental-health outpatient service provided via telehealth continues to require two-way audio-video technology.

EVALUATION AND MANAGEMENT (E/M SERVICES)
The definition of split (or shared) E/M visits was clarified as those provided in the facility setting by a physician and a non-physician practitioner (NPP) in the same group and billed by the physician or NPP who provides the substantive portion of the visit. For 2022, except for critical care visits, the substantive portion may be the performance of the history, physical exam, or medical decision-making. By 2023, the substantive portion will be defined as more than half of the total time spent. The claim must report a modifier and medical record documentation must identify both individuals who performed the visit and be signed and dated by the individual providing the substantive portion of the visit.
**CRITICAL CARE SERVICES**

Critical care services and other E/M services may be furnished to the same patient on the same day by more than one practitioner when the E/M service(s) was provided prior to the critical care service at the time when the patient did not require critical care, the service was medically necessary, and the service was separate and distinct from the critical care service. Modifier -25 should be reported on the claim.

**VACCINES**

The current COVID-19 vaccine administration rate of $40 per dose, as well as the add-on payment of $35.50 for its administration in the home, will continue through the end of the CY in which the PHE ends. After that, CMS will set a rate that aligns with other Part B preventive vaccines. COVID-19 monoclonal antibody therapeutic products will continue to be treated as vaccines for payment purposes until the end of the CY in which the PHE ends, at which time the products will be treated as typical complex biological products.

**PHYSICIAN ASSISTANT SERVICES**

Physician assistants may now bill the Medicare program and be paid for their services at a rate of 80% of the lesser of the NPPs actual charge or 85% of the amount that would be paid to a physician under the PFS. Physician assistants can reassign their Medicare billing rights and incorporate as a group comprised solely of practitioners in their specialty.

**SUPERVISION**

CMS solicited comments on whether to permanently permit direct supervision requirements to be met through virtual presence using real-time audio/video communication technology after the PHE ends.

ED Note: John Huber offered 27 years of public service as a prosecutor in state and federal courts. From 2015-2021, Mr. Huber served as the United States Attorney for the District of Utah, having been appointed by both President Obama and President Trump and unanimously confirmed twice by the United States Senate. He is now in private practice with global law firm Greenberg Traurig, and is based in Salt Lake City. He is a member of Greenberg Traurig’s health care and government investigations practice groups.

Mackenzie Wortley is an attorney at Greenberg Traurig, based in Dallas, Texas. Ms. Wortley offers health care clients practical legal advice, counseling them on compliance with a complex and changing web of federal and state regulations.
“Sobering,” “Egregious!” “My stomach is still in turmoil!” “We have to DO something!” are some reactions that Utah physicians had when The New York Times published an article titled Where the Despairing Log On and Learn Ways to Die. The article describes a popular social media site where young people are encouraged and given instructions on how to die. They have linked at least 45 deaths to the site and suspect there are several hundred more. The Times article quotes a Utah physician and his wife who shared the story of their 16-year-old son’s death by suicide. Their son received instruction on how to die using a “preservative” as poison.

The website is run by men who go by Marquis and Serge. They have vowed to protect the website using methods such as daily server backups, buying up multiple domain names, and obscuring the names of the companies hosting the website. Germany, Italy and Australia have limited this website within their borders, but “Marquis and Serge” have just moved their servers to other countries. So far, American lawmakers and big technology companies have either not acted or have been reluctant to act. (Lawmakers as well as big tech companies may be concerned regarding possible violations of “free speech” statutes. Law-enforcement officials have not acted because it is not clear that laws have been broken.

The website is particularly dangerous because a lot of young people frequent it. In the Dec. 9 podcast “The Daily,” one person interviewed described the site as “addicting.” It is described as sleek and looks like a typical social media website. Members can use messages, emoji’s and “likes” in order to encourage others to die by suicide. They also offer detailed instructions on how to die. The website is billed as space where people can freely discuss suicide, however, people who are only interested in recovery are usually denied admittance to the site.

Family members have gone to great efforts to get this website shut down. They have gone to lawmakers, law-enforcement officials, and contacted big technology firms. Several states have laws that criminalize assisting suicide. State laws usually require providing “physical means” to count as assisting suicide. Utah amended the definition of manslaughter to include assisting suicide after a Spanish Fork 19-year-old man Tyerell Przybycien assisted 16-year-old Jchandra Brown to die by suicide.

However, cases in which the offender does not provide a “physical means” but rather a digital means of assisting suicide are more difficult to prosecute. In 2014, a 17-year-old Massachusetts teenager, Michelle Carter, encouraged her boyfriend via text, both prior to and the night of, to kill himself. The boyfriend, Conrad Roy, followed Carter’s instructions and died on July 13th. Carter was found guilty of involuntary manslaughter by the New Bedford Juvenile Court. However, being a lower court, its decisions are not binding to other courts and thus no legal precedent has been set. Following this case, a bill known as “Conrad’s Law” has been created. This bill would redefine the definition of coerced suicide to include virtual interactions, however it has yet to be passed. Should this bill eventually be passed, it could hold suicide social media sites accountable for the suicides facilitated by the websites.

Fortunately, lawmakers have made efforts to change things since the initial New York Times article. In a follow up article on December 21, The New York Times2 reported that representatives from New Jersey and Massachusetts have urged Attorney General Merrick Garland to provide legal avenues to combat the issue. Others, such as Senator Richard Blumenthal of Connecticut, have targeted the other front by writing to the search engine companies, Google and Bing directly. This has seen some success with Bing lowering the ranking of the website, however neither company has been willing to remove the website from search results altogether. Following The New York Times’ investigation of


the website, its owners, “Serge” and “Marquis,” have resigned from their roles as administrators of the website. However, the website remains active as new administrators were appointed.

As physicians, we are aware that simply making this website and others like it illegal, is not the answer. Sexual predation has been illegal since 1990 (yes, only since then), but that has not stopped sexual predation from happening. Parents have needed to step up and include in their routine and customary parenting warning of the dangers that exist from which their children will need to learn how to keep themselves safe. That kind of parenting can be really effective.

It is clear that creative solutions are needed to decrease the harm done by websites which encourage suicide like the one described by The New York Times. Big technology companies could help by implementing protections on children’s accounts that block explicit material. Parents will need to step up here just as they have with sexual predation to teach their children about this new danger in the community and how to protect themselves. Parents will also need advice on how to network about this problem and what tools are best to use with their children. The Utah Attorney General’s Office Internet Crimes Against Children taskforce has a list of resources to provide parents such advice and tools. 3 We will need to be creative here, as physicians, to partner with parent groups, schools, churches and community councils to educate others and to make the cruelty of these websites known to our legislators.

ED NOTE: Anne Lin, MD, is a psychiatrist (child, adolescent and adult) from Salt Lake City. Her son, Trevor Skeen, is a first-year student at Trinity University in San Antonio, Texas.

The UMA board would like your thoughts on this issue and suggestions for solutions. Please email us at uma@utahmed.org

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Many of the federal government’s solutions to resolve certain out-of-network billing disputes without balance billing or otherwise involving patients—known as the No Surprises Act—took effect at the start of 2022.

Among other pieces physicians must familiarize themselves with, the new federal law features an independent dispute resolution (IDR) process that was intended to let physicians and insurers both make their case for fair payment. Naturally, plenty of minutiae and arcane exists within the law, and a portion of the rules for the IDR process is under a legal challenge from organized medicine.

To help physician practices understand and navigate the new law, the American Medical Association has created a toolkit, *Preparing for Implementation of the No Surprises Act*. The 20-page toolkit includes information on:

- Operational challenges physicians “will need to address immediately” to be compliant with the law’s new requirements, such as when uninsured and self-pay patients must receive a good faith estimate of charges before they receive services;
- Services and care which fall under the rules of the No Surprises Act;
- Timetables and requirements for the IDR process; and
- When and how facilities and physician practices can obtain a patient’s consent to balance bill for out-of-network care at an in-network facility.

AMA says it will update the toolkit “as additional guidance is available” and will develop new resources on parts of the law not already included in the toolkit. To access the toolkit, visit [www.ama-assn.org/system/files/ama-nsa-toolkit.pdf](http://www.ama-assn.org/system/files/ama-nsa-toolkit.pdf).

*AMA TOOLKIT DISSECTS FEDERAL SURPRISE BILLING LAW*

BY JOEY BERLIN, ASSOCIATE EDITOR, TEXAS MEDICINE
As a close friend of identical twins, I’m well versed in the phenomenon of two lookalike entities exhibiting vast dispersion in behavior at any given time. So, when I encounter substantial short-term performance differences between investment strategies in the same asset class, I am disinclined to infer one is better than the other without more information. Indeed, even strategies with nearly identical construction rules and long-run average returns can deviate meaningfully through time. The lesson for physicians is to remain cautious, as always, when interpreting past performance.

**MATCHING PAIRS**

US small cap value research simulations rebalanced in different months provide perspective on the variation in outcomes arising from minute changes in methodology. Average monthly returns in Exhibit 1 reveal an 11-basis point range in long-run performance depending on the choice of rebalance month, despite identical stock selection criteria, a point we’ve used to highlight the need for caution when interpreting simulated outperformance. But even the simulations with the same long-run average returns have diverged markedly over shorter periods.

Take, for example, the February and November versions, which would appear to be the investment version of monozygotic siblings with average returns identical to two decimal points, 1.53%. And yet, over short periods, these simulations can look more like distant cousins. Rolling one-year return differences, illustrated in Exhibit 2 (page 22), have fluctuated wildly through time. The magnitude of the difference has averaged 2.80% and frequently exceeded 5%. Some of the return deviation spikes have coincided with periods of high cross-sectional dispersion in US stock returns—in fact, Continued on the next page...
the correlation between the return spread of the small cap value simulations and US market cross-sectional dispersion has been 0.48. Turbulent times in markets can magnify contributions from even slight differences in portfolio composition, and that has been true for this pair.

Given the range of outcomes for such similarly constructed simulations, it should be no surprise we observe short-term dispersion between commercial small cap value indices, even ones with nearly identical names. Average calendar year returns for the MSCI USA Small Value Index (gross div.) and the MSCI US Small Value Index (gross div.) from 1998 through 2020 were close, at 10.04% vs. 9.97%, respectively. But calendar year observations illustrated in Exhibit 3 have on occasion revealed meaningful deviations in performance. The average annual magnitude of the return spread between these indices was 2.11%, maxing out at over 13% in the year 2000.

MAKING A SHORT STORY LONG

Noise in returns limits the usefulness of short-term performance in manager evaluation. Because even minute, arbitrary differences between investments can drive huge differences in realized returns, eye-catching short-term relative performance observed in the past may offer little insight into expected value-add. Longer-term results, particularly when achieved across a suite of investment strategies, offer a more reliable evaluation framework. Investors should also consider the manager’s investment process—a robust process built on decades of expertise can add value that is observable without looking to noisy market returns.

Now is a great time to review your investment strategy. Please contact our UMAFS team today at questions@umafs.org or 801-747-0800 for an expert second opinion.
Racial groups are defined by the federal Office of Management and Budget with race and ethnicity data collected using a combination of ethnicity and single or multiple racial identities. Data collection systems may allow recording of only one race, all races that apply, or a recording of two or more races. Ethnicity is recorded as non-Hispanic, Hispanic, or unknown/refused. Variations in how data are collected and reported may influence numbers and percentages reported for various race/ethnicity combinations. The terms American Indian and Alaska Native (AI/AN) in data collection typically describe race without the legal status of enrollment in a federally recognized tribe. Inconsistent racial definitions of the American Indian/Alaska Native race, within and between agencies, can paint dramatically different pictures of health statuses.

As of 11/17/2021, the Utah Department of Health reports racial data, including people who identify as American Indian/Alaska Native, as race alone, non-Hispanic and unknown ethnicity for COVID-19 vaccine analysis to better represent data across all racial and ethnic minority populations. The Centers for Disease Control and Prevention (CDC) reports race alone, non-Hispanic. On August 12, 2021, the CDC Morbidity and Mortality Weekly Report (MMWR) mentioned two alternative methods for race and ethnicity groupings—Method A: American Indian/Alaska Native race alone, non-Hispanic and unknown ethnicity, and Method B: American Indian/Alaska Native race alone, any ethnicity. Each of these methods captures a slightly different American Indian/Alaska Native population, which are not directly comparable (Figure 1).

While some racial groupings of American Indian/Alaska Native more closely represent the race and ethnicity makeup of the population in Utah, none exclusively capture the tribally enrolled population.

For more resources regarding tribe-focused interventions, reports, and discussions contact armerrill@utah.gov.

Footnotes:

FROM THE UTAH DEPARTMENT OF HEALTH

**KEY FINDINGS**

Rural and urban Utah Small Areas (SA) reported increased telehealth claims from providers in 2020 (Figure 1).

In 2020, the total average for telehealth claims increased by 1,557% in areas with previous telehealth claims in 2019 (Figure 2).

Increases in telehealth utilization between 2019 and 2020 were greater for urban areas, with 65% of urban SAs seeing an increase greater than 5,000% versus only 41% of rural areas (Figure 3).

In 2019, 29% of telehealth claims were rural and 44% of Utah Small Areas with no telehealth claims were rural.

Telehealth is an important tool used to help patients access healthcare services. However, utilization was low prior to the COVID-19 pandemic (Figure 1). Healthcare providers have implemented and utilized telehealth more as the COVID-19 pandemic unfolded to support social distancing, protect healthcare workers, and protect patients who may be particularly vulnerable or at high risk for illness. As the COVID-19 pandemic resulted in a public health emergency, updated and emergency federal and state rule changes made the adoption and use of telehealth easier for patients and providers.

As part of a statewide Primary Care Needs Assessment, the Utah Department of Health Office of Primary Care and Rural Health, with the support of Comagine Health Analytic Services, assessed how telehealth use across the state changed from 2019 to 2020. The objective of this assessment was to identify areas where telehealth use is low, so further analyses can be performed to identify barriers to telehealth use in those areas, and subsequently undertake initiatives to increase access to telehealth services to the areas in need.

**DATA**

Healthcare insurance claims from the Utah Department of Health Office of Health Care Statistics All Payer Claims Database were used to collect data. The Utah All Payer Claims Database (APCD) is comprised of medical claims extracted from insurer and major government payer systems. Claims include commercial, Medicaid, and Medicare lines of business but do not represent all Medicare or uninsured patient claims. Payments to healthcare providers outside of these claims systems are not represented in the database such as healthcare paid by charities, some governmental programs (such as Indian Health Services), patients who pay for healthcare out-of-pocket, and some self-funded employer plans. It is estimated the APCD contains data on 65–75% of the population with insurance eligibility for at least part of the year.

Claims from 2019 and 2020 were included in the report with the following telehealth procedure codes in the analysis: 98966, 98967, 98968, 98969, 98970, 98972, 99421, 99422, 99423, 99441, 99442, 99443, 99444, 99495, 99496, G0071, G0406, G0407, G0408, G0425, G0426, G0427, G2061, G2062, G2063. The ZIP code of the billing provider was used to assign the Utah Small Area. Data from Utah Small Areas were then collected between rural and urban areas to assess the change between 2019 and 2020.

**ASSESSMENT OF TELEHEALTH UTILIZATION**

The 99 Utah Small Areas as defined by the Utah Department of Health, had a drastic increase in telehealth claims from 2019 to 2020. This aligns with national trends around telehealth utilization. Urban areas including Salt Lake City (Downtown), Murray, Provo/
BYU, Taylorsville (East)/Murray (West), Layton/South Weber, and Salt Lake/Glendale reported the most telehealth claims. However, both rural and urban Utah Small Areas reported increased telehealth claims in 2020 (Figure 1).

In 2020, the total average for telehealth claims increased by 1,557% in areas with previous telehealth claims in 2019 (Figure 2). The Small Areas with the highest increase in telehealth claims were Sandy (Center) V2 (1 to 3,588), Salt Lake City (Foothill/East Bench) (2 to 5,079), Alpine (1 to 803), Ogden (Downtown) (3 to 1,384), and San Juan County (Other) (1 to 341).⁴

In 2020, 41% of rural Small Areas had an increase in telehealth utilization greater than 5,000% compared with 65% of urban Small Areas, indicating rural areas had a disproportionately lower rate of telehealth increase compared with their higher populated urban counterparts (Figure 2).

Continued on the next page...

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**Percentage Increase of Telehealth Claims by Utah Small Areas, 2019–2020**

*Figure 2.* Sandy (Center) V2, Salt Lake City (Foothill/East Bench), and Alpine reported the highest percentage increase of telehealth claims between 2019 and 2020.

**Telehealth Claims by Rural vs. Urban County Status, Utah Small Areas, 2019–2020**

*Figure 1.* Telehealth claims increased in both rural and urban areas in 2020.

Note: Definitions for rural and urban county classifications include frontier counties with rural telehealth claims.

Source: Utah All Payer Claims Database, 2019-2020

Source: Utah All Payer Claims Database, 2019-2020
While Utah Small Areas reported more telehealth claims in 2020, urban areas demonstrated a higher increase (19,692%) overall, compared with rural areas (8,416%) (Figure 3). Twenty-nine percent of 2019 telehealth claims were in rural Small Areas and 44% of Small Areas with zero telehealth claims in 2019 were rural. Urban Small Areas supported and utilized telehealth more than rural areas. Prior to the COVID-19 pandemic and the emergency expansion of telehealth rules, rural areas disproportionately provided fewer telehealth services.

**RESOURCES:**

- Utah Department of Health Telehealth & Office Visit Trends: A Snapshot from Utah’s All Payer Claims Database, Preliminary COVID-19 Healthcare Trends: A Snapshot from Utah’s All Payer Claims Database & Healthcare Facility Database
- For additional information on Utah rural health please visit: https://ruralhealth.health.utah.gov/.
- For additional analyses of healthcare claims please contact: healthcarestat@utah.gov.

**References:**


**Percentage Increase of Telehealth Claims by Rural vs. Urban County Status, Utah Small Areas, 2019–2020**

*Figure 3.* Telehealth utilization increased in both rural and urban counties resulting in all 99 Utah Small Areas with telehealth claims in 2020.

![Percentage Increase of Telehealth Claims by Rural vs. Urban County Status, Utah Small Areas, 2019–2020](image)

Note: Definitions for rural and urban county classifications include frontier counties with rural telehealth claims. Source: Utah All Payer Claims Database, 2019-2020.
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CME SPOTLIGHT

UPDATED COURSE for 2022

Title: Controlled Substances: Education for the Prescriber (2022)
When: On-demand Webinar
Where: Online at cme.utahmed.org
Provider: UMA Foundation
CME: 3.5 AMA PRA Category 1 Credits™

This education is specifically designed to comply with Utah State Law, which requires health care providers licensed to prescribe controlled substances to complete DOPL-approved continuing education on Schedule II and III controlled substances that are applicable to opioid narcotics, hypnotic depressants, or psychostimulants.

Following this activity, learners should be able to:

- Know existing laws and rules pertaining to prescribing controlled substances;
- Provide patients the care they need to restore and maintain their health;
- Mitigate the burdens of illness, injury and aging, including appropriate prescriptions for controlled substances when indicated;
- Minimize adverse effects of controlled substance use and reduce risks to the public health.
- Know Utah requirements and limitations in recommending medical cannabis.
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ALT Alternative CME, SLC, 801/200-4321
ACOG American College of Obstetrics and Gynecology, UT Chapter, SLC, 801/747-3500
ACP American College of Physicians, UT Chapter, SLC, 801/582-1565 x2441
ACS American College of Surgeons – Email UtahATLS@gmail.com for info about ATLS
AMA American Medical Association, Chicago 312/464-4761
AUCH Association for Utah Community Health, SLC, 801/924-2848
CA Collegium Aesculapium, Orem, 801/802-0449
CM CoMagine, SLC, 801/892-6645
ESI ESI Management Group, SLC, 801/501-9446
IHC Intermountain Healthcare CME, SLC, 800/842-5498
LVH Lakeview Hospital, Bountiful, 801/299-2546
OSMS Ogden Surgical-Medical Society, Ogden, 801/564-5585
PCH Primary Children's Hospital, SLC, 800/910-7262
PRKA Program of Addiction Research, Clinical Care, Knowledge, Advocacy, SLC, 801/585-6667
STW Steward Health Care Utah, South Jordan, 801/984-2384
TRH Timpanogos Regional Hospital, Orem, 801/714-6505
UAFP Utah Academy of Family Physicians, SLC, 801/587-3285
UHLF Utah Healthy Living Foundation, SLC, 801/993-1800 or 801/712-8831
UDS Utah Dermatology Society, SLC, 801/266-8841
UMAF Utah Medical Association Foundation, SLC, 801/747-3500
UMIA Utah Medical Insurance Association, SLC, 801/531-0375
UOS Utah Ophthalmology Society, SLC, 801/747-3500
VA VA Center for Learning, SLC, 801/584-2586
VHLC Utah Healthy Living Foundation, SLC, 801/993-1800 or 801/712-8831

The following websites offer online continuing medical education:

cme.utahmed.org
psnet.ahrq.gov
cme
thedoctorschannel.com
freecme.com
pri-med.com
compoOnlineCME.aspx
medicine.utah.edu
cmelist.com
ama-assn.org/education-center
baylorcme.org
medscape.org
vlh.com
nejm.org/continuing-medical-education
reachmd.com/programs
cms.gov/Outreach-and-EducationLearnEarn-CreditEarn-Credit-page.html
primarycarenetwork.org
emedevents.com

The following sites allow you to search databases to locate medical meetings throughout the country

ama-assn.org
EmedEvents.com
On January 13, 2022, the U.S. Supreme Court "stayed" or stopped two injunctions issued by lower courts that had prevented the implementation of the vaccine mandate issued by the Centers for Medicare and Medicaid Services in 24 states, including Utah. Although the Supreme Court did not technically rule that the CMS mandate was permissible, the rationale of its decision means that it did effectively approve the CMS mandate. As a result, medical practitioners should learn which practitioners and facilities must comply with the CMS mandate when the mandate comes into effect, what it requires, and the applicable exemptions.

What facilities and providers are subject to the CMS mandate?
The CMS mandate applies to all participating facilities, including ambulatory surgical centers, hospices, psychiatric residential treatment facilities, programs of all-inclusive care for the elderly, hospitals, long term care facilities (including nursing facilities commonly referred to as nursing homes), intermediate care facilities for individuals with intellectual disabilities, home health agencies, comprehensive outpatient rehabilitation facilities, critical access hospitals, clinics and other facilities that provide outpatient physical therapy and speech-language pathology services, community mental health centers, home infusion therapy suppliers, rural health clinics, and end-stage renal disease facilities (the "Covered Facilities"). This list does not include, however, ordinary physician practice groups, including what most people would refer to as medical clinics, unless those clinics fall within one of the Covered Facilities categories.

Within these Covered Facilities, the following individuals must be vaccinated in accordance with the mandate: employees of the facility; licensed practitioners; students, trainees, and volunteers; and individuals who provide care, treatment, or other services for the facility and/or its patients, under contract or by other arrangement. Exempted from this requirement are individuals who exclusively provide telehealth or telemedicine services outside the facility and do not have any direct contact with patients and other staff, as well as individuals who provide support services for the facility that are performed exclusively outside of the facility.

It is important to note that this mandate applies to physicians who may be employed by a physician practice group but who provide care to patients at a hospital or other covered facility. For example, although emergency physicians who are employed by or are members of a physician practice group are not required to be vaccinated by virtue of their employment or partnership with the group, they are covered, and are required to be vaccinated because they provide care to patients in the hospital emergency department.

The same requirement would apply to doctors who treat patients in any of the Covered Facilities.

When does the CMS mandate come into effect and what does it require?
CMS issued an updated guidance on January 14, 2022, which specifies that facilities subject to the CMS mandate in the 24 states affected by the Supreme Court ruling, which includes Utah, on or before February 13, 2022, (a) must develop and implement policies and procedures that "all facility staff, regardless of clinical responsibility or patient or resident contact are vaccinated for COVID-19," and (b) must show that "100% of staff have received at least one dose of COVID-19 vaccine, or have a pending request for, or have been granted a qualifying exemption."

Second, on or before March 15, 2022, each such Covered Facility must show that "100% of staff" have been fully vaccinated or have been granted a qualifying exemption.

Notwithstanding the reference to "100% of staff," staff members who work exclusively in telehealth with no patient or co-worker contact are not covered, as noted above. The qualifying exemptions are discussed below.

What are the exemptions and how do they work?
There are two main exemptions to the CMS mandate, both of which are based on federal employment discrimination laws. First, facility employees may be exempted from a duty to be vaccinated if they have a disability that precludes vaccination. Second, facility employees may be exempted if they have a sincerely held religious belief that precludes vaccination. Policies and procedures implemented by covered facilities pursuant to the CMS mandate should include notice to staff members of these exemptions and how they work.

Individuals covered by the CMS mandate and who believe they may be entitled to an exemption have the initial duty to notify the facility of that belief. The details of these two exemptions are somewhat different.

Facility employee who claims to be unable to be vaccinated due to a disability is invoking the protection of the Americans with Disabilities Act. Such individual should be asked to submit a doctor’s note or other appropriate proof of their disability and its impact on their ability to be vaccinated. The facility should then engage in a dialogue with the individual to determine whether a reasonable accommodation is possible that would allow the individual to perform the essential functions of his or her job without posing a threat to the health and safety of others. For example, the individual may be able to perform those functions remotely, away from any contact with others. Or the individual may be able to avoid a substantial risk of contamination to others by being tested at least weekly for the COVID-19 virus, wearing a protective mask while around others, and quarantining in the event they contract the virus or come into contact with an infected person. The facility must allow the reasonable accommodation unless providing the accommodation would be an undue hardship.

A facility employee who claims a religious exemption is invoking the protection of Title VII of the Civil Rights Act of 1964, which prohibits employment discrimination on the basis of religion, among other things. Such individual should be required to give notice that he or she cannot be vaccinated due to a sincerely-held religious belief. The facility must then engage in the same evaluation of reasonable accommodations. However, the definition of “undue hardship” under Title VII is much less stringent for the employer. Instead of “significant difficulty or expense,” the employer need not provide the requested accommodation if it would result in more than minimal difficulty or expense.

All Covered Facilities and providers should be aware of this CMS vaccine mandate because it has such a far-reaching impact. The foregoing gives a general introduction but does not address all issues. Facilities should consult with legal counsel to assess their specific obligations.

Scott A. Hagen is the Chair of the Firm’s Employment and Labor Section. His practice includes labor relations, employment litigation, employee benefits (ERISA) litigation, representation of clients before administrative agencies in discrimination and other kinds of employment and labor cases, and consulting with clients on various employment and labor law issues.

Mr. Hagen has been recognized by Chambers USA in Labor & Employment (Band 1) and Employee Benefits & Executive Compensation (Band 1). For many years he has been recognized in The Best Lawyers in America® in Labor & Management and Employment Law-Mediation. He maintains an AV Preeminent (5.0) rating with Martindale-Hubbell, which is the highest rating awarded to attorneys for professional competence and ethics. For many years, Mr. Hagen has also been selected for inclusion in Mountain States Super Lawyers in the category of Employment & Labor and voted by his peers throughout the state as one of Utah’s “Legal Elite,” as published in Utah Business Magazine.
For over 80 years, Ray Quinney & Nebeker has provided sophisticated and comprehensive legal services both nationally and across the Intermountain West. Our collective expertise and collaborative approach assure our capacity to grow with changing legal markets. We solve problems the right way – with expertise, responsiveness, and integrity. In the end, we not only solve our clients’ problems, we build relationships to help prevent problems in the future.
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