Week in Review: 3-7 August 2020

BRIEF19

A daily review of covid-19 research and policy.

POLICY BRIEFING

In the quest to understand immunity, immunity passports lose favor.

We still have much to learn regarding immunity conferred from a prior covid-19 infection, and there are many potential implications. At this point, we know that a positive SARS-CoV-2 antibody test reveals a prior covid-19 infection, whether or not that individual was symptomatic. However, there are concerns that positive antibodies may not completely prevent re-infection, putting a wrench in the proposal of granting "immunity certificates" to those with a reported positive antibody test, allowing them to move about more freely.

Seroprevalence is a measure of the percentage of individuals in the population who have tested positive for antibodies to a particular pathogen—in this case covid-19. This information can help researchers estimate how many individuals in the greater population have likely been infected and track other characteristics such as geographic location and age distribution of cases. Current testing provides either qualitative results, a simple positive or negative, or quantitative results, which reports the concentration of antibodies.

Recently, the Food and Drug Administration (FDA) released an Emergency Use Authorization for Siemens' ADVIA Centaur SARS-CoV-2 IgG (COV2G) and Atellica IM SARS-CoV-2 IgG (COV2G) tests. These tests Siemens are semi-quantitative blood tests which provide an estimate of the covid-19 antibodies present in an individual. Epidemiologists hope that these quantitative antibody tests will provide a better understanding of potential covid-19 immunity and the presence of covid-19 in the general population. However, given potential testing inaccuracies, positive individuals are still encouraged to continue with social distancing precautions. *Various*. *7 August 2020*. —*Onyeka Otugo, MD MPH*

The legalities of state-by-state travel restrictions.

Both at the beginning of the covid-19 pandemic and more recently, many states have sought to impose interstate travel restrictions, including mandatory quarantine for travelers from other states. These restrictions have included all states at some point but have typically been enacted towards states with a high rate of covid-19 diagnoses. An article in *The New England Journal of Medicine* discusses the legal limbo that these mandates fall into. Citing previous judicial decisions, the authors note that bans on interstate travel are highly scrutinized. Laws must both serve an important government interest and be no more restrictive than absolutely necessary to serve the intended purpose. The Supreme Court of the United States has previously upheld a Constitutional right to travel including the ability to travel between states, to be treated not as an "unwelcome alien," and to establish residence in whichever state one chooses.

The authors mention three challenges to state mandates in court during the covid-19 crisis. In Kentucky, an order to self-quarantine following out-of-state travel was struck down under the pretense that the law was too broad. A second mandate in Maine was upheld after the court found that the alternatives offered by the plaintiffs as less restrictive alternatives were not practically feasible. A federal court in Hawaii also upheld that state's mandatory quarantine orders on two occasions in July. Perhaps most interestingly, the authors note that the case in Maine found that the state's order was discriminatory against those who were not homeowners within the state, as they would have a more difficult time finding a location for quarantine.

Noting that the historical trend of anti-travel laws was often to prevent minorities and people with low income from migrating to a state, the authors reason that states imposing restrictions on all travelers may find more favor in judicial thought. The article also quips that interstate travel restrictions would likely not be necessary if not for such slipshod federal leadership in response to the ongoing public health crisis. *7 August 2020*. *—Jordan M. Warchol, MD, MPH*

Pay cuts for heroes? 2021 proposed physician fee schedule published.

As it does each year, the Centers for Medicare and Medicaid Services (CMS) has opened the comment period for its proposed Physician Fee for the upcoming year, and covid-19 has made a predictable impact. The Physician Fee Schedule, first used in 1992, establishes reimbursement for physicians and other healthcare providers based on the setting of the intervention, equipment available, and a variety of other factors. Termed Relative Value Units (RVUs), the number of units provided determines the rate of reimbursement. As part of "budget neutrality" mandated by law, a conversion factor is modified based on changing RVUs to prevent excessive expenditures each year. Amidst the 1353 pages encompassing this year's proposal are several significant coronavirus-related highlights.

First, the conversion factor has a negative correction of $3.83, which if finalized would lead to decreased reimbursements across the board. Seemingly the hardest hit specialties are emergency medicine (-6 percent), critical care (-8 percent), anesthesiology (-8 percent), interventional radiology (-9 percent) and diagnostic radiology (-11 percent). Another questionable proposal is granting permanence of autonomy to "Non-Physician Providers" such as Nurse Practitioners and Physician Assistants that has been enacted during the current covid-19 Public Health Emergency (PHE). With respect to diagnostic testing, this would mean that PAs and NPs could furnish and administer diagnostic tests without physician supervision. The rule also proposes permanent codes for telehealth reimbursement, which would be beneficial in its ability to encourage further practicing socially distanced medicine. Some additional telehealth billables have been added to the temporary list with final determination to come.

Furthermore, in the past, the fee schedule has required direct, in-person supervision of medical residents by attending physicians to allow for billing. But in the proposal, starting in 2021, CMS will change this to allow attendings the ability to conduct this oversight remotely, as long as proper adequate audio/visual equipment is used. While meant to be temporary for the duration of the PHE, the rule seeks feedback in terms of permanence and any restrictions on qualified use.

Aside from the covid-19 related proposals, a long list of other proposed changes are included in next year's Physician Fee Schedule, including new billing codes and funding for opioid use disorder treatment services, requirements for electronic prescribing for all Schedule II-V medications and delaying MIPS Value Pathways implementations until 2022. *The Center for Medicare and Medicaid Services. 6 August 2020*. *—Joshua Lesko, MD*

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Brief19 is a daily executive summary of covid-19-related medical research, news, and public policy. It was founded and created by frontline emergency medicine physicians with expertise in medical research critique, health policy, and public policy.