AQREVA
Medical Billing & Consulting

Client Memo
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"Strive for progress, not perfection."

-- David Perlmutter

NEWS Update

2020 ICD-10-CM Changes Released

The CDC has released the FY 2020 ICD-10-CM final code set which will be effective October 1, 2019 through September 30, 2020. There were no changes to the proposed list of 273 new, 30 revised and 21 invalidated codes (*Revenue Cycle Advisor*, June 24, 2019).

There are also nearly 1,500 changes to the complication or comorbidity/major complication or comorbidity (CC/MMC) designation and most of the severity changes are downgraded, states Natalie Sartori, in the *AHIMA Journal*, posted May 28, 2019.

Coders will have new ICD-10-CM codes to report pressure-induced deep tissue damage, acute versus chronic embolism and thrombosis and fractures of the facial bones around the eye, among other changes.

In addition, conditions such as eating disorders of nonorganic origin (F50.-) and malnutrition (E40-E46) with codes from the symptoms and signs concerning food and fluid intake family (R63) can also be reported.

Some of the new codes and changes are listed below.

Chapter 9: Diseases of the circulatory system (I00-I99)

There are four new atrial fibrillation codes and two existing codes (I48.1, I48.2) have been deleted. The new codes are:

- I48.11 Longstanding persistent atrial fibrillation
- I48.19 Other persistent atrial fibrillation
- I48.20 Chronic atrial fibrillation, unspecified
- I48.21 Permanent atrial fibrillation

There are eight new codes added to subcategory I80.2, Phlebitis and thrombophlebitis of other and unspecified deep vessels of lower extremities, to identify phlebitis and thrombophlebitis of the peroneal vein and calf muscle veins.

Specific codes for these lower extremity veins have also been added to subcategories:

- I82.451 Acute embolism and thrombosis of right peroneal vein
- I82.551 Chronic embolism and thrombosis of right peroneal vein

Chapter 12: Diseases of the skin and subcutaneous tissue (L00-L99)

Category L89, Pressure ulcer, has been expanded with a sixth character of "6" which indicates pressure-induced deep tissue damage of various anatomic sites. Currently, deep tissue injuries code to "pressure ulcer unstageable," but there can be significant clinical differences between unstageable ulcers and deep tissue injuries. Deep tissue injuries often have dual etiology that include pressure and ischemia and do not always result in tissue loss. These new codes will have a severity status of Complication/ Comorbidity (CC).

Chapter 19: Injury, poisoning and certain other consequences of external causes (S00-T88)

Several new subcategories have been added to specify fractures of the orbital roof and individual orbital walls frequently seen in facial trauma cases. Poisoning codes have been added for poisoning by multiple medicaments (T50.91-) and heatstroke/sunstroke (T67.0-).

A few of the 21 code deletions for October 1, 2019 and ending September 30, 2020 are:

- H81.41 Vertigo of central origin, right ear
- H814.2 Vertigo of central origin, left ear
- I48.1 Persistent atrial fibrillation
- I48.2 Chronic atrial fibrillation
- R82.8 Abnormal findings on cytological and histological examination of urine
- T670XXA Heatstroke and sunstroke, initial encounter

More information is available on the Medicare website: https://www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-CM.html

AMA Releases 2020 CPT® code set

The AMA announced the release of the 2020 CPT code set on September 4, 2019. There are 394 code changes in the 2020 CPT code set, including 248 new codes, 71 deletions, and 75 revisions.

Among this year's important additions to CPT are new medical services sparked by novel digital communication tools, such as patient portals, that allow health care professionals to more efficiently connect with patients at home and exchange information.

Remote patient monitoring (RPM) and telehealth play prominently in the 2020 CPT codes unveiled this month by the AMA, writes Eric Wicklund for *mHealth Intelligence* in his September 9, 2019 article: "AMA Supports Remote Patient Monitoring, Telehealth in 2020 CPT Codes."

Among the 248 new codes added to the list for the coming year, the AMA has created six for online digital evaluation services, or e-visits, in which care providers can connect with patients at home to exchange information.

Three codes – 99421, 99422 and 99423 – relate to patient-initiated digital communication provided by a physician or other qualified healthcare professional, while three others – 98970, 98971 and 98972 – focus on communications with a "non-physician healthcare professional."

In addition, the AMA has added two codes – 99473 and 99474 – to cover self-reported blood pressure monitoring.

Several new codes – 95700 to 95726 – relate to reporting long term electroencephalographic (EEG) monitoring services, critical to care management for patients living with epilepsy, in both the hospital and the home. Some 23 codes have been created, and four older ones eliminated, to clarify the services reported by a technologist, physician or another qualified healthcare provider.

Finally, in a nod to the use of telehealth to enable collaboration by a multidisciplinary care team, the AMA has created new codes for health and behavior assessment and intervention services (96156, 96158, 96164, 96167, 96170 and add-on codes 96159, 96165, 96168, 96171).

Aside from the 248 new codes, the AMA deleted 71 old or obsolete codes and revised 75 more. To help explain the new codes, which go into effect at the beginning of 2020, the AMA is marketing an "insider's view" on its website.

CMS Finalizes Rule to Crack Down on Medicare, Medicaid Fraud

A new rule has been finalized giving CMS greater authority to require providers and suppliers to notify CMS if they have ever been affiliated with a company or individual that exhibits any fraudulent behaviors.

In addition to these new stipulations, the rule gives CMS more authority to crack down on fraudulent providers and suppliers.

Kelsey Waddill describes fraudulent behaviors as failure to pay back debt, having payments for a federal healthcare program withheld, being denied entry to Medicare, Medicaid, or CHIP, or having "disclosable events," which occur when CMS revokes a provider or supplier's ability to bill Medicare, Medicaid, or CHIP. (*Health Payer Intelligence,* September 6, 2019)

Under the new regulations, a provider or supplier can be denied entry to Medicare, Medicaid, or CHIP or their position can be revoked if they attempt to return to the program with a different identity, make a payment to a non-compliant site, have a history of inappropriate ordering or certifying of Medicare Parts A or B products or services, or receive an overpayment from the Treasury Department and fail to repay it.

For providers and suppliers who are accepted into the Medicare program but then have their status revoked, CMS can also extend their re-enrollment bar for up to a decade, as opposed to three years which was the previous maximum.

The second time that a provider or supplier is revoked, they can face up to a 20 year wait before they are allowed to re-enroll, according to the new regulations

Providers and suppliers who have a history of termination or suspension in a state Medicaid program or if they are unable to practice in a state due to their license being suspended will be blocked from enrolling in Medicare.

CMS projects that 2,600 providers and suppliers will be revoked each year. Over the course of the next decade, this could save $4.16 million.

Individual cases of fraud can cost taxpayers millions of dollars. However, with these new stipulations and height-

ened enforcement capabilities, CMS foresees major savings over the course of the next two decades.

Getting paid for the new virtual check-in code – Bill Dacey, MBA, CPC, *Medical Economics*, August 25, 2019

Q: In 2019, there is a new Medicare code for virtual check-ins, G2012. It appears to be for when the patient calls to see if he needs an office visit. I want to use it for those weekend calls while on-call, but our management says we shouldn't. Can you please give me your interpretation of this code?

CMS describes code G2012 as "a brief communication technology-based service when the patient checks in with the practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed." Under certain circumstances, there is no reason you couldn't use this code when patients contact you while you are on-call.

But there are several qualifying descriptors for this code as well as some circumstances to consider. This new G2012 code, similar to the codes in the CPT manual for telephone and other electronic contacts, requires that these communications:

- are limited to established patients;
- can't be related to an office visit in the previous seven days;
- can't result in being seen for a next available office appointment or within 24 hours; and
- must have 5 to 10 minutes of medical discussion.

After discussion, you might end up sending the patient to a specialist, a more acute setting, or even advising them to make (or keep) a future appointment with you to address the problem. If all the above conditions are met, you can code for a virtual check-in.

Payers like virtual check-ins because the provider is prescreening a problem to determine whether the patient needs an office visit soon or not. If the patient does need an appointment, the call is bundled into that visit.

One reason not to use this code might be as simple as the copay. Even though the Medicare copay on this would be around $2.50, patients are sensitive to billing. You can imagine how patients might perceive this when they receive a bill: "You mean I can't even call my doctor without you charging me $2.50 for the phone call?!"

The 5 Most Denied Prior Authorization Requests and How to Prevent These Denials

When it comes to prior authorizations for imaging studies, there are five specific requests that incur the greatest number of denials, writes Robert Neaderthal in his September 17, 2019, article for *Medscape Medical News*.

By reviewing these five examples, you can also get a general idea of the thinking process needed to get approval for any request.

Most Denied Request #1: MRI of the Lumbar Spine

More requests for MRI of the lumbar spine are denied than any other imaging study. They are almost always denied for one of two reasons:

i. Lack of a "red flag" symptom or other sign in the patient, which would allow for immediate approval; or,
ii. Lack of 6 weeks of unsuccessful conservative therapy directed by a provider, the usual way to get approval.

Most Denied Request #2: CT Scan to Evaluate Abdominal Pain

A CT scan to evaluate abdominal pain is the second most denied imaging request. RBM guidelines tend to favor an ultrasound as the initial imaging study, and only then resort to a CT scan if the ultra-sound results are inconclusive.

There are exceptions, and depending upon the location of the pain and other symptoms, a CT scan may be the recommended initial test.

For patients with right or left upper quadrant pain, ultrasound of the abdomen should nearly always come first. A CT scan should come first in patients with right or left lower quadrant pain because ultrasound has not proven to be useful in these cases.

As with MRI guidelines of the lumbar spine, there are red flag signs that allow the patient to go directly to receiving a CT scan. These include fever, elevated white blood cell count, a mass, gastrointestinal bleeding, moderate to severe tenderness, guarding or rebound tenderness, history of cancer, and a past history of bariatric surgery.

Only one of these signs is needed to obtain approval of a CT scan, and the specific abdominal location does not matter.

Most Denied Request #3: CT Scan of the Chest

The third most commonly denied imaging study for primary care physicians is a CT scan of the chest. One common mistake is to request this study before ordering a plain chest x-ray.

There are a few exceptions when a chest x-ray is not required, such as for lung cancer screening when a CT scan is used. However, the patient must meet every one of the guideline criteria, which include a detailed smoking history of at least 30 pack-years (cigarette packs smoked per day multiplied by the number of years a person has smoked) or having smoked within the past 15 years.

Additionally, the patient must be 55-80 years old, must not be too debilitated to have major lung surgery, and the scan cannot be repeated within the past 12 months.

Asking for a contrast study often results in denials of CT scans of the chest. Contrast material in a CT scan should not be used to screen for lung cancer, follow a solitary pulmonary nodule for change in size, or evaluate or monitor interstitial lung disease. All other reasons for a chest CT scan would support using contrast.

Most Denied Request #4: Choosing Diagnostic Tests for Coronary Artery Disease

The fourth most common denial for primary care physicians and the number one denial for cardiologists are diagnostic tests for CAD.

For previously undiagnosed chronic or intermittent chest pain, there is a choice of three diagnostic tests, depending upon the clinical presentation: a non-imaging exercise treadmill test (ETT), stress echo, or sestamibi MPI.

Although ETT does not require prior authorization, sestamibi MPI almost always requires prior authorization, and stress echo requires approval for some insurance companies but not all.

Patients can skip the ETT and go directly to an imaging scan if they are older than 40 years and have chest pain plus diabetes, or if they have a coronary artery calcium score over 100. Other criteria and exceptions may be found in RBM guidelines for CAD imaging.

Most imaging study denials for diagnosing CAD involve patients with low or intermediate PTP, and the denial reason will specify that an ETT should be performed before an advanced imaging study.

Most Denied Request #5: MRI of the Shoulder or Knee

Denials of an MRI of the shoulder or knee usually have to do with lack of a recent x-ray or not completing 6 weeks of unsuccessful conservative treatment directed by a qualified provider.

Virtually all requests must be accompanied by the results of a standard x-ray taken since the injury. If the MRI is requested for chronic pain, the x-ray must be made in the past 3 months.

As in several other guidelines, this guideline first requires 6 weeks of conservative treatments that have not been successful, including:

- Physical therapy;
- Analgesic agents, such as NSAIDs, injections, or stronger pain medications;
- Chiropractic treatment;
- A provider-directed home exercise program; or
- Use of medical devices, such as splints, crutches, and braces

Although RBM guidelines are substantially shorter than the original medical society guidelines, they still contain many nuances and must be reviewed carefully to be fully understood.

Safeguard Your NPI Number

Your NPI is easy to steal; here's how to prevent that, writes James F. Sweeney in his September 10, 2019, article "Safeguard Your NPI Number" for *Medscape Medical News*

Anyone can enter a doctor's name into a public CMS registry and get not only the physician's NPI, but other data as well, such as the NPI enumeration date and type, NPI status, whether the practice is a sole proprietorship, mailing and practice addresses, phone numbers, Medicaid ID, and state license number.

Criminals use NPIs and other information in a variety of scams, such as medical device companies placing fraudulent orders with Medicare or a nurse or coder stealing a prescription pad and setting up a false mailing address to which opioids are delivered.

Is There Any Way to Protect Your NPI?

There are steps doctors can take to keep it as private as possible.

First, they should be aware of how their practice uses doctor NPIs and with whom they're shared. In many cases, its use is required, but the practice should stop using it on documents or during transactions where it's not necessary.

That "need to know" policy should apply within the practice as well, she said. NPIs should be shared only with those who need them to do their jobs, such as coders and billers.
NPIs follow physicians throughout their career, regardless of where they practice. Doctors who leave a practice should make sure that their former employer is not still using their number, whether out of habit or deliberately. Physicians who stop practicing can notify CMS so that their NPIs are flagged as no longer valid for future transactions.

Practices should have policies in place to detect fraud and misuse. The most important of these is routinely checking Medicare and Medicaid statements for errors or suspicious activity and following up on discrepancies.

Having these policies in place might not prevent misuse, but they are helpful in tracking down where and how it occurred and are a valuable part of a practice's defense against any charges of fraud.

Although it's impossible for physicians and clinicians to completely keep their NPI out of the public realm, there are still ways you can be aware and stay on top of activity regarding your NPI that may put you in jeopardy. The key is to recognize this area as a potential threat, and pay attention to it as you would to any other possible threat.

Ironically, the NPI was created to fight fraud.

Quality Payment Program Update

Security Risk Assessment Tool

As part of the MIPS Promoting Interoperability Performance Category, a Security Risk Assessment must be completed by all providers for the performance year in order to fulfill the Protect Patient Health Information measure.

The Office of the National Coordinator for Health Information Technology (ONC) recognizes that conducting a risk assessment can be a challenging task.

Objective:	**Protect Patient Health Information**
Measure:	**Security Risk Analysis** Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI data created or maintained by certified electronic health record technology (CEHRT) in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), implement security updates as necessary, and correct identified security deficiencies as part of the MIPS eligible clinician's risk management process.

That's why ONC, in collaboration with the HHS Office for Civil Rights (OCR) and the HHS Office of the General Counsel (OGC), developed a downloadable SRA Tool [.exe - 91.3 MB] to help guide you through the process. This tool is not required by the HIPAA Security Rule, but is meant to assist providers and professionals as they perform a risk assessment.

The SRA Tool is a self-contained operating system (OS) independent application that can be run on various environments including Windows OS's for desktop and laptop computers and Apple's iOS for iPad only.

The SRA Tool takes you through each HIPAA requirement by presenting a question about your organization's activities. Your "yes" or "no" answer will show you if you need to take corrective action for that particular item. There are a total of 156 questions.

Resources are included with each question to help you:

- Understand the context of the question;
- Consider the potential impacts to your PHI if the requirement is not met; and
- See the actual safeguard language of the HIPAA Security Rule.

You can document your answers, comments, and risk remediation plans directly into the SRA Tool. **The tool serves as your local repository for the information and does not send your data anywhere else.**

For details on how to use the tool, download the SRA Tool User Guide [PDF - 4.5 MB]. or copy the link below and go to:
https://www.healthit.gov/sites/default/files/attachmenta-security_risk_assessment_tool_user_guide_v6.pdf

October 3rd: Last Day to Begin MIPS Promoting Interoperability & Improvement Activities 90-Day Performance Period

MIPS requires eligible clinicians to report measure data for the Promoting Interoperability (PI) and Improvement Activities (IA) performance categories for 90 continuous days or more during 2019.

Keep in mind that October 3, 2019 is the last day to begin collecting data collection in order to meet this 90-continuous day requirement for the 2019 performance period.

Medicare News

New Medicare Beneficiary Identifier (MBI)

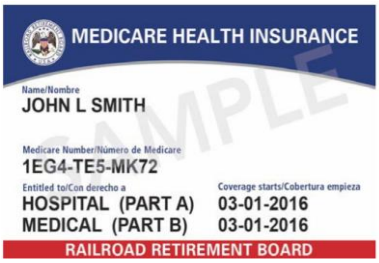
Starting January 1, 2020, even for services provided before this date, providers must use MBIs regardless of the date of service.

Office staff should ask Medicare patients for their new Medicare cards as they come in for appointments. MBIs can also be obtained via the MBI look-up tool on the Medicare portal. The MBI look-up tool can be used even after the end of the transition period.

To use the look-up too, providers must have the patient's SSN for the search. It may differ from the HICN, which uses the SSN of the primary wage earner. If the Medicare patient doesn't want to give his or her SSN, tell the patient to log into mymedicare.gov to get the MBI.

The new MBIs apply to both Medicare and Railroad Medicare patients.

Don't use hyphens or spaces with the MBI to avoid rejection of your claim.



With a few exceptions, ***Medicare will reject claims submitted with Health Insurance Claim Numbers (HICNs.) Medicare will also reject all eligibility transactions submitted with HICNs.***

PDPM Bulletin

SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1

On October 1, the new PDPM is replacing the Resource Utilization Group, Version IV (RUG-IV) for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS). PDPM improves the accuracy and appropriateness of payments by classifying patients into payment groups based on specific, data-driven patient characteristics, while simultaneously reducing administrative burden.

Use the Health Insurance Prospective Payment System (HIPPS) code generated from assessments with an assessment reference date on or after October 1, 2019, to bill under the PDPM.

Under the PDPM, clinically relevant factors and patient characteristics are used to assign patients into case-mix groups across the payment components to derive payment. Additionally, the PDPM adjusts per diem payments to reflect varying costs throughout the stay.

For more information please click or copy and paste the ink below:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/PDPM-101_Final.pdf

Microsoft will no longer Support Windows 7 on January 14, 2020

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