AQREVA Medical Billing & Consulting

Client Memo October 2021

"Some people are always grumbling because roses have thorns; I am thankful that thorns have roses." -- Alphonse Karr

NEWS Update

Grace Period for Provider Relief Fund Reporting Period 1 Announced

The September 30, 2021, Reporting Period 1 deadline was not changed; however, in response to challenges providers were facing given the Covid surges and natural disasters around the country, a 60-day Grace Period between **October 1 through November 30, 2021**, was announced. This will allow providers to come into compliance with their PRF reporting requirements if they failed to meet the September 30, 2021, deadline.

U09.9 Post COVID-19 Condition

Implementation of this new code U09.9, which was created by the World Health Organization for sequelae after recovery from COVID-19, begins October 1st. It should be used if there is a description of a sequela of COVID-19, a residual condition following COVID-19, or a post-COVID-19 condition, writes Susan Gatehouse in her August 13, 2021, article "Quantifying the Sequelae Following Acute COVID-19," for *ICD-10 Monitor*.

This code is not to be used in cases that still are presenting as COVID-19 and should be used in place of code B94.8 (sequelae of other specified infectious and parasitic diseases). It is also referred to as 'long haul COVID.'

Review What's New for ICD-10 – Stacy Chaplain, MD, CPC, *AAPC Knowledge Center*, July 2, 2021

Stay on top of the latest in diagnosis coding by reviewing highlights from Dr. Chaplain's chapter-by-chapter summary of the changes, effective October 1, 2021.

CHAPTER 1: Certain Infectious and Parasitic Diseases (A00-B99) -- 1 new code

- A79.82 *Anaplasmosis [A. phagocytophilum]*.

CHAPTER 3: Diseases of the Blood and Blood-Forming Organs and Certain Disorders Involving the Immune Mechanism (D50-D89) – 5 new codes

- D55.21 *Anemia due to pyruvate kinase deficiency*
- D55.29 *Anemia due to other disorders of glycolytic enzymes*.
- D75.838 *Other thrombocytosis*
- D75.839 *Thrombocytosis, unspecified*
- D89.44 *Hereditary alpha tryptasemia*.

CHAPTER 5: Mental, Behavioral and Neurodevelopmental Disorders (F01-F99) – 1 new code & 2 additions

- F32.A *Depression, unspecified* under revised category F32 *Depressive episode*.
- F78.A1 *SYNGAP1-related intellectual disability*
- F78.A9 *Other genetic related intellectual disability* under new subcategory F78.A- *Other genetic related intellectual disabilities*.

CHAPTER 6: Diseases of the Nervous System (G00-G99) – 10 new codes:

- G04.82 Acute flaccid myelitis
- G44.86 Cervicogenic headache
- Added under new code for *Immune effector cell-associated neurotoxicity syndrome* (G92.0) are six codes to classify immune effector cell-associated neurotoxicity syndrome by grade.
- Two codes to distinguish other and unspecified toxic encephalopathy:
  - G92.8 *Other toxic encephalopathy*
  - G92.9 *Unspecified toxic encephalopathy*

CHAPTER 11: Diseases of the Digestive System (K00-K95) – 3 new codes

- K22.81 Esophageal polyp
- K22.82 Esophagogastric junction polyp
- K22.89 Other specified disease of esophagus (hemorrhage of the esophagus NOS)

Another notable change in this chapter is new subcategory K31.A- *Gastric intestinal metaplasia* and ten codes to capture gastric intestinal metaplasia.

CHAPTER 12: Diseases of the Skin and Subcutaneous Tissue (L00-L99) – 8 new codes, 2 new subcategories

- Under L24.A- *Irritant contact dermatitis due to friction or contact with body fluids*, the 2022 code set adds four new codes to identify the type of fluid.
- Under L24.B- *Irritant contact dermatitis related to stoma or fistula*, the addition of four new codes enables specification of the type of stoma or fistula (e.g., digestive, respiratory, fecal/urinary).

CHAPTER 13: Diseases of the Musculoskeletal System and Connective Tissue (M00-M99) -- The numerous changes in Chapter 13 relate primarily to new codes in these areas:

- Three codes added under subcategory M31.1- to allow reporting hematopoietic stem cell transplant-associated thrombotic microangiopathy. The code set adds a Use Additional note after code M31.11, instructing you to also code for the specific organ dysfunction.
- Several codes under the revised subcategory for *Sjögren's syndrome* (M35.0) are also revised, and seven codes are added for identification of associated diseases or conditions.
- New subcategory *Non-radiographic axial spondyloarthritis* (M45.A) and ten codes for nonradiographic axial spondyloarthritis, which allow for classification based on the affected region of the spine.
- Expansion of M54.5 *Low back pain*, with the addition of three codes:
  M54.50 *Low back pain, unspecified*
  M54.51 *Vertebrogenic low back pain*
  M54.59 *Other low back pain*.

CHAPTER 18: Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (R00-R99) -- 14 new codes

R05 is no longer a reportable code in the 2022 code set. Instead, use one of the six new codes, which provide added specificity to cough.

- R05.1 (Acute cough)
- R05.2 (Subacute cough)
- R05.3 (Chronic cough)
- R05.4 (Cough syncope)
- R05.8 (Other specified cough)
- R05.9 (Cough, unspecified)

2 new codes added for polyuria:

- R35.81 Nocturnal polyuria
- R35.89 Polyuria not otherwise specified (NOS)

Other additions include:

- R45.88 *Non-suicidal self-harm*
- R79.83 *Abnormal findings of blood amino acid levels*

Another noteworthy change is the addition of the following four codes:

- R63.30 Feeding difficulties, unspecified
- R63.31 Pediatric feeding disorder, acute
- R63.32 Pediatric feeding disorder, chronic
- R63.39 Other feeding difficulties (i.e., feeding problem elderly, infant, NOS, picky eater)

CHAPTER 19: Injury, Poisoning, and Certain Other Consequences of External Causes (S00-T88) -- longest list of changes

- The addition of 6 codes to differentiate traumatic brain compression with or without herniation under new subcategory S06.A- *Traumatic brain compression and herniation*.
- Under new subcategories T40.71 *Cannabis (derivatives)* & T40.72 *Synthetic cannabinoids* are 36 new codes to classify poisoning adverse effect, and underdosing of cannabis and synthetic cannabinoids.
- Adds three codes specifying initial, subsequent, and sequela for complication of immune effector cellular therapy. Keep in mind that each code in T80.82- requires a 7th character (A, D, or S), so the five-character addition in the addenda translates to three new seven-character codes.

CHAPTER 21: Factors Influencing Health Status and Contact with Health Services (Z00-Z99) - 19 new codes

- Several updates relating to social determinants of health:
  - Z55.5 *Less than High School Diploma*
  - Z58.6 *Inadequate drinking-water supply*
  - Z59.0- *Homelessness*, sheltered or unsheltered
  - Z59.41 *Food insecurity*
  - Z59.48 *Other specified lack of adequate food*
  - Z59.81 *Housing instability, housed*
  - Z59.89 *Other problems related to housing and economic circumstances* to account for foreclosure on loan, isolated dwelling, and problems with creditors
- Z71.85 *Encounter for immunization safety counseling*
- Z91.014 *Allergy to mammalian meats*
- Two codes to differentiate between history of suicidal behavior and non-suicidal self-harm are added under Z91.5 *Personal history of self-harm.*

- Under Z92.8 *Personal history of other medical treatment*, the 2022 code set adds four codes: Three under new subcategory Z92.85 *Personal history of cellular therapy*, including chimeric antigen receptor T-Cell Therapy (CAR-T); and Z92.86 *Personal history of gene therapy*.

CHAPTER 22: Special Purposes (U00-U85) - 1 new code

- U09.9 *Post COVID-19 condition, unspecified*. Also added is a Code First note, which instructs you to list the code for the specific condition related to COVID-19, if known, first.

Remember, this is just an overview of the 2022 ICD-10-CM code updates. The 2022 code descriptions in tabular order, addendum, and code tables and index are available for download on the CMS website:
https://www.cms.gov/medicare/icd-10/2022-icd-10-cm

NEW COVID-19 Provider Funding -- Prepare to Apply

The Department of Health and Human Services (HHS), through the Health Resources and Services Administration has announced a new application cycle for $25.5 billion in COVID-19 provider funding.

Applicants will be able to apply for both Provider Relief Fund (PRF) Phase 4 and American Rescue Plan (ARP) Rural payments during the application process.

PRF Phase 4 is open to a broad range of providers with changes in operating revenues and expenses. ARP Rural is open to providers who serve rural patients covered by Medicare, Medicaid, or the Children's Health Insurance Program (CHIP).

A detailed list of eligible providers is on the HRSA website:
https://www.hrsa.gov/provider-relief/future-payments

Get Ready to Apply!

The application period began on **September 29, 2021** and will close on **October 26, 2021 at 11:59 p.m. ET**. Providers who have previously created an account in the *Provider Relief Fund Application and Attestation Portal* and have not logged in for more than 90 days will need to first reset their password before starting a new application at:
https://cares.linkhealth.com/#/

In order to streamline the application process and minimize administrative burdens, providers will apply for both programs in a single application.

What Is Considered Rural?

ARP Rural payments will be determined based on the location of the patients, not the provider. Simply select whether your organization (including any included subsidiaries) would like to be considered for ARP Rural payments during the application process.

HRSA will base payments on data already available to us on the amount and type of Medicare, Medicaid, and CHIP services provided to rural patients.

What Documentation Will I Need?

Supporting documentation and information needed to complete an application will include:

- Applicant Tax ID (TIN) and TINs for any subsidiaries included in the application.
- Financial statements that substantiate operating revenues and expenses from patient care in 2019 Q1, Q3, and Q4; 2020 Q3 and Q4; and 2021 Q1.
- Federal income tax return, audited financial statements, or internally generated financial statements submitted in their entirety.

The 99211 Checklist

Renee Dowling's article for the August 2021 issue of *Medical Economics* goes over the proper use of 99211.

99211: *An office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician*

99211 doesn't have any specific guidelines like the rest of the office visit codes. Can you give us some insight about what to document for these visits?

When considering whether to assign 99211 for a service, remember these important points for proper reporting.

- Check for a documented evaluation of the patient along with management of the patient's care. For example, if a nurse only refills the patient's medications and no other E/M service takes place, you should not report 99211.

- Do ensure the patient is an established patient. Based on the CPT code description, you should report 99211 for an established patient, seen by the rendering provider (or provider of same group and specialty/subspecialty) within the past 3 years, in any setting.

The established-patient rule also is important because Medicare applies the concept of incident-to services for 99211, meaning a provider previously furnished a direct, personal, professional service to initiate a course of treatment, and the 99211 service being performed is an incidental part of that care plan.

- Do be certain that the supervising provider is in the office suite.

- Do prove that the visit is medically necessary.

MIPS UPDATE

Promoting Interoperability for 2021 Performance Year – 25% of final score

October 3, 2021, marks the beginning of the last 90-day reporting period for the 2021 MIPS Promoting Interoperability category.

As a reminder, the following requirements must be met:

- Must use an EHR that meets the 2015 Edition certification criteria.
- Must submit collected data for certain measures from each of the 4 objectives measures (unless an exclusion is claimed) for the same 90 continuous days (or more) during 2021.

The 2021 Promoting Interoperability performance category focuses on 4 objectives:
- e-Prescribing
- Health Information Exchange (HIE)
- Provider to Patient Exchange
- Public Health and Clinical Data Exchange

Do not forget to perform or review a Security Risk Analysis

You must conduct or review a security risk analysis on your 2015 Edition CEHRT functionality on an annual basis, within the calendar year of the performance period.

Additional guidance on conducting a security risk analysis is available at: https://www.hhs.gov/hipaa/forprofessionals/security/guidance/guidance-risk-analysis/index.html?language=es

Hardship Exception Application for 2021

You may submit a MIPS Promoting Interoperability Performance Category Hardship Exception Application, citing one of the following reasons for review and approval:

- MIPS eligible clinician in a small practice
- MIPS eligible clinician using decertified EHR technology
- Insufficient Internet connectivity
- Extreme and uncontrollable circumstances
- Lack of control over the availability of CEHRT

If your hardship exception is approved, the Promoting Interoperability performance category will receive a weight of 0% when calculating your final score and the 25% will be redistributed to another performance category (or categories) unless you submit data for this performance category.

Some clinicians will be automatically reweighted based on special status (for example, hospital-based clinicians) or their clinician type (for example, a physical therapist, occupational therapist, or clinical psychologist). These clinicians will not need to submit a Promoting Interoperability Hardship Exception Application.

MIPS Facility-Based Scoring Is Not Available for Performance Year 2021

In response to the impact of the ongoing COVID-19 public health emergency, CMS finalized a special scoring policy for fiscal year (FY) 2022 that will not calculate a total performance score for any hospital for FY 2022.

CMS Updates 2020 MIPS Performance Feedback and 2022 MIPS Payment Adjustments

Recently, CMS released performance feedback for clinicians included in the MIPS 2020 performance year. The requests received through the 2020 targeted review process caused CMS to identify 2 issues that needed to be corrected, resulting in changes to the 2020 MIPS final scores and 2022 MIPS payment adjustments.

1) Complex Patient Bonus Correction for Medicare Shared Savings Program ACOs -- the complex patient bonus wasn't added to the final scores of the Medicare Shared Savings Program Accountable Care Organizations (ACOs). In their updated

performance feedback, Shared Savings Program ACOs will see up to 10 complex patient bonus points reflected in their performance feedback and added to their final scores, if applicable.

2) Patient-Reported Outcome Measure Correction - patient-reported outcome measures were not recognized as outcome measures. The scoring logic was corrected, which resulted in 2 potential changes to quality performance category scoring for approximately 30,000 MIPS eligible clinicians, the majority of which will see a modest increase in their quality performance category score and MIPS final score.

As a result of changes to MIPS final scores from these corrections, CMS reassessed the associated MIPS payment adjustments to maintain budget neutrality. Some clinicians that weren't affected by the issues identified will see slight changes in their payment adjustment due to the reapplication of budget neutrality. More clinicians moved into the exceptional performance pool, causing a slight decrease in the exceptional performance adjustment.

Sign-In to View Updated Feedback

The 2020 final scores and 2022 MIPS Payment Adjustment revisions were made to the performance feedback on the Quality Payment Program (QPP) website on September 27, 2021. **Please sign-in to the Quality Payment Program website as soon as possible to review your performance feedback**. If you believe an error still exists with your 2022 MIPS payment adjustment calculation, the targeted review process is available to you.

Targeted Review Extension

To offer additional time for clinicians, groups, virtual groups and APM entities and their participants to access and review their performance feedback, CMS has extended the targeted review deadline to November 29, 2021, at 8:00pm (ET). You can submit a targeted review by signing into the Quality Payment Program website at: https://qpp.cms.gov

2020 Performance Category Reweighting Requests due to COVID-19 will be accepted through 11/29/2021

With the COVID-19 pandemic continuing to impact all clinicians across the United States and territories, CMS recognizes that not everyone may have been able to submit an Extreme and Uncontrollable Circumstances (EUC) Exception Application for performance year 2020 before the March 31, 2021, deadline.

The deadline has now been extended through November 29, 2021, at 8 p.m. ET. *There will also be a different process for submitting these requests*.

Due to technical limitations, CMS is unable to reopen the 2020 EUC Exception Application form. Stakeholders are allowed to submit 2020 EUC reweighting requests through the Targeted Review form, which can be found on the QPP website: https://qpp.cms.gov.

What does this mean for MIPS reporting?

Facility-based clinicians and groups will need to submit data on MIPS quality measures to receive a score other than zero for the quality performance category.

- Facility-based clinicians and groups without available and applicable measures can request performance category reweighting by submitting an Extreme and Uncontrollable Circumstances (EUC) application.
- Please be sure to **cite "COVID-19"** as the triggering event, as the decision to suppress measures in the Hospital Value-Based Purchasing (VBP) Program was in response to the COVID-19 PHE.

Cost Performance Category Reweighted to 0%

CMS is reweighting the cost performance category from 15% to 0% for the 2020 performance period for all MIPS eligible clinicians regardless of participation as an individual, group, virtual group or APM Entity.

The 15% cost performance category weight will be redistributed to other performance categories.

Based on CMS's analysis of the 2020 performance year data, CMS did not believe it could reliably calculate scores for the cost measures that would adequately capture and reflect the performance of MIPS eligible clinicians.

Clinicians who aren't covered by the automatic extreme and uncontrollable circumstances policy or who didn't apply to request reweighting will still have their cost performance category weighted to 0%.

Internet Explorer 11 Browser & QPP Website

Microsoft is ending support for the Internet Explorer (IE) 11 browser in June 2022. As a result, this browser will not be up to date with the latest security updates. Due to these security concerns, ***as of October 13, 2021***, users will not be able to access the QPP website, (https://qpp.cms.gov) using the IE 11 browser.

By discontinuing support, CMS will be able to improve security and the user experience for the 98% of users who access the website through other browsers. The QPP website will continue to support modern browsers such as Google Chrome and Microsoft Edge.

MEDICARE NEWS

Medicare announces influenza vaccine payment rates for 2021-2022 – Kent Moore, *FPM Journal,* September 20, 2021

CMS announced the Medicare Part B payment allowances for various influenza vaccines for the 2021-2022 flu season. Effective dates vary somewhat by vaccine but are generally from August 2021 through July 2022.

The Medicare Part B payment allowances for flu shots represent 95% of the average wholesale price, except for vaccines given in a:

- Hospital outpatient department
- Rural Health Clinic
- Federally Qualified Health Center

Medicare bases payment on reasonable cost for the above 3 locations

Note that Medicare administrative contractors (MACs) will reprocess paid claims for the current flu season (which began August 1st) if they used payment allowances other than those on the CMS pricing webpage.

Code	Labeler Name	Vaccine Name	Pymt Allowance
90686	GlaxoSmithKline, Sanofi, Pasteur Seqirus	Fluarix, Flulaval, Fluzone Afluria	$20.526
90687	Sanofi, Pasteur, Seqirus	Fluzone.25m Afluria .25ml	$9.953
90688	Sanofi Pasteur Seqirus	Fluzone Afluria	$19.906
90694	Seqirus	Fluad	$66.426
90756	Seqirus	Flucelvax	$28.370

Please refer to the CMS pricing webpage for additional vaccines and payment allowances: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing

CMS Will Pay for COVID-19 Booster Shots, Eligible Consumers Can Receive at No Cost

Coverage without cost-sharing is available for eligible people with Medicare, Medicaid, CHIP, and Most commercial health insurance coverage.

Following the FDA's recent action that authorized a booster dose of the Pfizer COVID-19 vaccine for certain high-risk populations and a recommendation from the CDC, CMS will continue to provide coverage for this critical protection from the virus, including booster doses, without cost sharing.

COVID-19 vaccines and their administration, including boosters, will also be covered without cost-sharing for eligible consumers of most issuers of health insurance in the commercial market. People can visit vaccines.gov (English) or vacunas.gov (Spanish) to search for vaccines nearby.

We are working hard to keep you on the edge of healthcare. Help us fulfill our strong commitment to maintain our level of service excellence by providing us with your feedback. Please feel free to contact your Account Representative or call 1.800.568.4311.

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