AQREVA Medical Billing & Consulting

# Client Memo October 2022

"Autumn is a second spring when every leaf is a flower." -- Albert Camus

***NEWS Update***



## HHS Plans to Extend Covid-19 PHE

State and local public health officials, having not heard differently, are expecting the Biden administration to extend the Covid-19 public health emergency for another 90 days in mid-October, writes David Lim in his August 17, 2022, article for *POLITICO.*

**"The COVID-19 Public Health Emergency remains in effect and as HHS committed to earlier, we will provide a 60-day notice to states before any possible termination or expiration," an HHS spokesperson told *POLITICO.***

The administration has not notified groups, including the Association of State and Territorial Health Officials, Federation of American Hospitals and the American Public Health Association, that the PHE would end, a courtesy HHS has said it would issue 60 days before the Covid-19 declaration is terminated. The 60-day notice would have been issued the week of August 15, 2022, under that pledge.

"Silence from the administration means that the public health emergency will almost certainly be extended into January 2023," said Larry Levitt, executive vice president for health policy at the Kaiser Family Foundation.

**End Dates by Payers for Relaxed Telehealth Visit Rules**

| INSURANCE PLAN | PROPOSED END DATE |
|---|---|
| Aetna | Until further notice |
| BCBS No Dakota | until end of COVID-19 emergency |
| BCBS So Dakota | until further notice |
| BCBS Oklahoma | until end of COVID-19 emergency |
| BCBS Federal Plan | until end of COVID-19 emergency |
| Cigna | New 2021 Virtual Care Policy |
| GEHA | until further notice |
| Humana | until end of COVID-19 emergency |
| Medicare | until end of COVID-19 emergency |
| Tricare | until end of COVID-19 emergency |
| UnitedHealthcare Medicare Advantage | until end of COVID-19 emergency |
| UnitedHealthcare | New 2021 telehealth Reimbursement Policy |

-- Updated 8/312022

## CMS Maps Out End of PHE – Lee Fifield, *AAPC Knowledge Center*, September 8, 2022

After two-plus years of working under the flexibilities granted to the healthcare industry during the COVID-19 PHE in the United States, CMS has released a roadmap for the eventual end of the PHE.

The first PHE was declared by the U.S. Department of Health & Human Services (HHS) in January 2020 and has been renewed every 90 days since. The latest renewal is scheduled to expire in mid-October.

Whether one last 90-day extension is in the cards or not, CMS is encouraging healthcare providers to prepare for the end of the PHE flexibilities they have been operating under as soon as possible. It is essential that healthcare organizations have a plan of action and begin re-establishing previous health and safety standards and billing practices as soon as they are ready.

Some services are already set to continue once the PHE ends. Other waivers will continue to apply for a short length of time and may be under consideration to become permanent policy.

**The COVID-19 reporting requirements for staff and patients in nursing homes will continue through December 2024**.

Under the Consolidated Appropriations Act of 2022, the following telehealth flexibilities will continue to apply for 151 days following the end of the federal PHE:

- Medicare beneficiaries can receive telehealth services from any geographic location, including their home.
- Telehealth visits can be delivered via smartphone in lieu of equipment with both audio and video capability.
- Medicare will cover most audio-only telehealth services that do not expressly require the use of interactive audio/visual equipment.

- Certain telemedicine services will continue. They can be found on the Medicare Telehealth Services List and are marked as extending through Dec. 31, 2023. These services will be evaluated as to whether they should be added permanently to the list.
- Federally qualified health centers (FQHCs) and rural health clinics (RHCs) can provide telehealth services to Medicare patients.
- Physical therapists, occupational therapists, speech language pathologists, and qualified audiologists can provide telehealth services to Medicare beneficiaries.
- In-person requirements for certain mental health services will continue to be waived.

Most waivers and flexibilities, however, are set to expire when the federal PHE ends. Create a plan to transition back to normal standards, coding, and billing if you have not already, and start putting your plan into action before the end of the PHE to ease the transition, Ms. Fifield advises.

Congress is currently considering several bills which seek to extend or make permanent key telehealth reimbursement flexibilities. The Ensuring Telehealth Expansion Act of 2021, which seeks to make permanent several telehealth flexibilities, has been introduced but has not yet been voted on by the House or Senate for approval.

The House recently passed the Advancing Telehealth Beyond COVID-19 Act that would extend key telehealth reimbursement flexibilities through the end of 2024, but the act has yet to progress through the Senate.

Lawmakers, healthcare advocates, and providers alike have expressed hope that any extensions to the current PHE waivers will provide time for the depleted healthcare workforce to recover, limited disruptions to patient care, and lessened impact on communities that have been disproportionately impacted by the pandemic.

## Annual ICD-10 CM Update

Each October, the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) gets an update. This update includes additions, deletions, and revisions.

Since incorrect diagnosis coding sometimes affects payment as much as incorrect procedure coding, it's important to look at the update, especially as it relates to the codes your practice uses most often, writes Kent Moore for *FPM Journal,* September 26, 2022.

A sample of some of the changes that may be relevant to family medicine includes the following.

**B37.3**, "Candidiasis of vulva and vagina," is being subdivided into two new codes:
- acute cases (B37.31)
- chronic cases (B37.32).

**D75.82**-, "Heparin-induced thrombocytopenia (HIT)," is being subdivided into four new codes, ranging from D75.821 for non-immune HIT through D75.829 for HIT unspecified; you'll need to use an additional code, if applicable, for adverse effect of heparin (T45.515-).

**E34.3**, "Short stature due to endocrine disorder," is being subdivided into seven new codes, ranging from E34.30, "Short stature due to endocrine disorder, unspecified," to E34.39, "Other short stature due to endocrine disorder."

**F01.5-,** "Vascular dementia," is being relabeled as "Vascular dementia, unspecified severity." This will distinguish it from a long series of codes starting with F01.A- that describe specific levels of severity:
- F01.A- Vascular dementia, mild,
- F01.B- Vascular dementia, moderate,
- F01.C- Vascular dementia, severe.

In the **F02.- and F03**.- code families, similar revisions are being made:
- F02.8- will become "Dementia in other diseases classified elsewhere, unspecified severity" with the addition of F02.A- through F02.C- that describe specific levels of severity,
- F03.9- will become "Unspecified dementia, unspecified severity" with the addition of F03.A- through F03.C- that describe specific levels of severity.

**F43.8**, "Other reactions to severe stress," is being subdivided into two new codes:
- prolonged grief disorder (F43.81)
- other reaction to severe stress (F43.89)

**S06.0XA**, is a new code being added for "Concussion with loss of consciousness status unknown."

Under **T43.65-,** a new set of codes is being added for "Poisoning by, adverse effect of, and underdosing of methamphetamines."

The growing popularity of electric bicycles has found its way into Chapter 20 of ICD-10-CM, which addresses external causes of morbidity. For example, new code **V20.01** describes "Electric (assisted) bicycle driver injured in collision with pedestrian or animal in nontraffic accident."

In Chapter 20, there is also a new code**, W23.2,** for being "Caught, crushed, jammed or pinched between a moving and stationary object."

Lastly, there are multiple additions among the "Z" codes, which describe factors influencing health status and contact with health services. Among them are the following:

- **Z03.83**, "Encounter for observation for suspected conditions related to home physiologic monitoring device ruled out."
- Three new codes under **Z59.8**-, "Other problems related to housing and economic circumstances":
  - Z59.82 Transportation insecurity
  - Z59.86 Financial insecurity
  - Z59.87 Material insecurity
- A new family of codes, **Z79.6-,** for "Long term (current) use of immunomodulators and immunosuppressants" and a new code, **Z79.85**, for "Long-term (current) use of injectable non-insulin antidiabetic drugs."
- Subdivision of **Z91-**, personal risk factors, into two codes describing patient noncompliance:
  - Z91.11- Patient's noncompliance with dietary regimen
  - Z91.19- Patient's noncompliance with other medical treatment and regimen."

As noted, this is just a sample of the changes taking effect on October 1, 2022. Full information is available on the CMS website at:
https://www.cms.gov/medicare/icd-10/2023-icd-10-cm

## Physicians Slam Fee Schedule Cuts

Physician advocacy groups say the proposed fee schedule updates will harm patient access to care and cripple practices financially unless Congress passes Medicare payment reform, writes Jacqueline Lapointe in her article for *Revcycle Intelligence*, September 7, 2022

The AMA and other physician advocacy groups are calling on CMS to reverse proposed Medicare Physician Fee Schedule updates, which would slash Medicare payment for physicians next year.

CMS proposed in July to decrease the Fee Schedule conversion factor by $1.53 to $33.08 in 2023. The proposed decrease would account for the expiration of the 3 percent increase in Physician Fee Schedule reimbursements in 2022 as required by the Protecting Medicare and American Farmers From Sequester Cuts Act, as well as CMS's statutory obligation to implement a 0 percent conversion factor in 2023.

If finalized, however, the Fee Schedule cut would harm patient access to care, according to the AMA.

Physician practices continue to feel the economic impact of the ongoing COVID-19 pandemic, the Medical Group Management Association (MGMA) also told CMS.

MGMA said in a comment letter on the proposed Medicare Physician Fee Schedule rule for 2023 that group practices have yet to return to a "new normal" as staffing shortages and increased demand for care make it difficult for practices to deliver timely, appropriate care.

Physicians are also staring down additional Medicare payment reductions if Congress does not act to prevent cuts scheduled for 2023, including the 1.5 percent budget neutrality reduction, the statutory annual freeze, and the 4 percent PAYGO sequester.

The American Medical Group Association (AMGA) also expressed concerns about telehealth reimbursement rates in the proposed Medicare Physician Fee Schedule rule. CMS had reimbursed Medicare physicians for telehealth visits at the same rate as an office-based visit during the COVID-19 public health emergency. The proposed rule, however, would reduce the rate of telehealth visits.

Physician advocacy groups, including the AMA, have recognized the importance of expanding telehealth coverage and reimbursement after the COVID-19 public health emergency ends.

As medical groups expect to see Medicare payment cuts in 2023, practices are considering limiting the number of new Medicare patients and reducing clinical staff to ensure financial stability, according to the MGMA, adds Victoria Bailey in her September 28, 2022, article "Medical Groups May Reduce Staff, Patients Amid Medicare Payment Cuts," for *Revcycle Intelligence.*

The report reflects responses from 517 group practices across 45 states that shared how they plan to respond to the proposed Medicare payment reductions.

The 4.5 percent decrease in the Medicare conversion factor included in the 2023 Physician Fee Schedule (PFS) proposed rule coupled with the 4 percent Pay-As-You-Go (PAYGO) sequester will reduce 2023 Medicare payments by at least 8.5 percent.

The majority of practices (92 percent) said that 2022 Medicare reimbursement rates already do not adequately cover the cost of care provided.

## 2022-2023 Influenza Vaccine Pricing

Annual Influenza Vaccine season starts on August 1 and ends on July 31 of the following year.

**Payment Allowances 2022-2023 Flu Season**

| Code | Labeler Name | Vaccine Name | Payment Allowance |
|---|---|---|---|
| 90662 | Sanofi Pasteur | Fluzone High-Dose Quadrivalent (2022/2023) | $ 69.941 |
| 90672 | MedImmune | FluMist Quadrivalent (2022/2023) | $ 26.876 |
| 90674 | Seqirus | Flucelvax Quadrivalent (2022/2023) (Preservative Free) | $ 32.278 |
| 90682 | Sanofi Pasteur | Flublok Quadrivalent (2022/2023) (Preservative Free) | $ 69.941 |
| 90686 | GlaxoSmithKline<br>Sanofi Pasteur<br>Seqirus | Fluarix Quadrivalent (2022/2023) (Preservative Free)<br>Flulaval Quadrivalent (2022/2023) (Preservative Free)<br>Fluzone Quadrivalent (2022/2023) (Preservative Free)<br>Afluria Quadrivalent (2022/2023) (Preservative Free) | $ 21.518 |
| 90687 | Sanofi Pasteur<br>Seqirus | Fluzone Quadrivalent 0.25ml (2022/2023)<br>Afluria Quadrivalent 0.25ml (2022/2023) | $ 10.241 |
| 90688 | Sanofi Pasteur<br>Seqirus | Fluzone Quadrivalent (2022/2023)<br>Afluria Quadrivalent (2022/2023) | $ 20.482 |
| 90694 | Seqirus | Fluad Quadrivalent (2022/2023) (Preservative Free) | $ 71.682 |
| 90756 | Seqirus | Flucelvax Quadrivalent (2022/2023) | $ 30.581 |

Annual Part B deductible and coinsurance amounts do not apply for the influenza virus vaccinations. All physicians, non-physician practitioners, and suppliers who administer these vaccinations must take assignment on the claim for the vaccine.

## Revisions to Consultation Services

The AMA announced major revisions to E&M Services for Jan 1, 2023. The E&M categories that will undergo revision in 2023 include inpatient and observation care services, emergency department services, consultations, nursing facility services, home and residence services, and prolonged services.

Revisions to the E&M category for consultations include updates within two subcategories: office or other outpatient consultations and inpatient consultations with both subcategories currently divided into five levels of service.

As defined in the AMA's CPT® codebook, a consultation is a type of E&M service provided at the request of another physician, other qualified health care professional, or appropriate source to recommend care for a specific condition or problem.

The biggest revision to the consultation E&M category, as with all the categories undergoing revision for 2023, is that the three key components, history, exam, and medical decision making are no longer required for reporting these services.

For both subcategories, a level one E&M, 99241 for office or outpatient services and 99251 for inpatient or observation consultation, has been deleted. Additionally, similar to the combining of inpatient and observation care services into one E&M category, the inpatient consultation subcategory title has been revised to include consultations performed on observation patients.

## Sloppy Coding Means Lost Revenue

Despite your best efforts to follow billing guidelines, payers still deny your claims. Or in some cases, they pay you and then take the money back, writes Lisa Eramo in her August 2022 article, "The 2022 Coding Guide," for *Medical Economics.*

Experts say you can't ever eliminate denials and post-payment recoupments entirely, but you can reduce them by focusing on coding and documentation compliance. Listed below are eight of the most common reasons, for denials and how to avoid them.

**Incorrect Patient Status** (i.e., new versus established) -- A patient who is new to you is not necessarily a new patient per official definitions. For example, did the patient have an audio-visual telehealth appointment

within the past three years? If so, they are considered an established patient even if they've never been seen in person, according to Victoria Moll, CPC, owner and founder of Contempo Coding, LLC, in

**Incorrect application of prolonged services codes** with office visit E/M codes. In 2021, Medicare and current CPT rules and codes changed:

- G2212 – prolonged service code for Medicare
- 99417 – prolonged service code non-Medicare
- Physicians can only report G2212 or 99417 with 99205 or 99215 when the physician selects the E/M code based on total time (not medical decision-making). Also be sure to append modifier -25 to the base E/M code.

**Invalid Medical Codes** -- Stay abreast of annual coding changes. Physicians who do not stay on top of coding changes also run the risk of reporting invalid procedure codes.

**Unspecified Diagnosis Codes** -- Avoid unspecified diagnosis codes when possible, as they are on most payers' non-covered lists.

**Coordination of Benefits** -- educate front desk staff on verification of benefits, policy language, and pre-certification so they help avoid denials on the front end of the billing process.

Well-educated front desk staff can sort out whether Medicare should be primary or secondary, for example. Front desk staff can also help determine whether the reason for the visit pertains to an injury that worker's compensation or auto insurance might cover as primary.

**High Utilization of Incident-to-Billing** -- Common incident-to billing errors that could result in a denial are:

- Billing incident-to when the payer does not permit it under any circumstances
- Billing incident-to services for a new patient
- Billing incident-to for an established patient when a change to the plan of care occurs
- Billing incident-to for an established patient when the supervising physician is not present in the office suite and immediately available to provide assistance and direction

Payers know primary care physicians typically see around 20 patients a day. If your practice has a utilization rate of 70 encounters per day, the payer will flag this and potentially start denying claims on a pre-payment basis, states Toni Elhoms, CCS, CPC, chief executive officer of Alpha Coding Experts, LLC.

**Billing for a related E/M service within 7 days** of a virtual service (i.e., virtual check-in or e-visit) -- If the physician does not provide a related E/M service within seven days of providing the virtual service, practices can bill the virtual service. If the physician does provide a related E/M service within seven days, practices can only bill one or the other — not both.

## Blue Cross Blue Shield of ND News

**Payment Integrity Retrospective Claims Accuracy (RCA) Implementation** – *Healthcare News*, September 30, 2022

Blue Cross Blue Shield of North Dakota (BCBSND) has implemented the next phase of our enhanced payment integrity program, Retrospective Claims Accuracy (RCA) for Fully Insured, BlueCard and Medicaid Expansion.

Initial RCA reviews include a nine-month lookback period based on paid date. Providers will start receiving Overpayment Notice letters over the next week. These letters come directly from Cotiviti; but are co-branded with the BCBSND and Cotiviti logos.

Providers must respond to the Overpayment Notice within 45 days of the letter date.
If you have any specific questions to the program, please contact BCBSND Provider services at 800-363-2312. If you have questions on RCA, please contact Cotiviti at 203-529-4199.

## MIPS UPDATES

**Last 90-day period for reporting MIPS Promoting Interoperability measures for 2022 is October 3, 2022.**

| Objective | Measure |
|---|---|
| Electronic Prescribing | e-Prescribing |
| | *Bonus*: Query of PDMP |
| Health Information Exchange -OR- | Support Electronic Referral Loops by Sending Health Information |
| | Support Electronic Referral Loops by Receiving and Reconciling Health Information |
| Health Information Exchange (alternative) | Health Information Exchange Bi-Directional Exchange |
| Provider to Patient Exchange | Provide Patients Electronic Access to Their Health Information |
| Public Health and Clinical Data Exchange | Report the following 2 measures:<br>• Immunization Registry Reporting<br>• Electronic Case Reporting |
| | Report on any one of the following measures:<br>• Public Health Registry Reporting OR<br>• Clinical Data Registry Reporting OR<br>• Syndromic Surveillance Reporting |

## 2022 Promoting Interoperability Reminders

A new required (but unscored) attestation was added called the Safety Assurance Factors for EHR Resilience Guides (SAFER Guides). This measure requires clinicians to attest to conducting an annual assessment of the SAFER Guides beginning with the 2022 performance period.
Certain clinician types will have PI automatically re-weighted to 0% and will not have to submit a PI hardship exception application. These include:

| | |
|---|---|
| clinical social workers | physician assistants |
| nurse practitioners | clinical nurse specialists |
| nurse anesthetists | physical therapists |

Clinicians and groups with "special status" designations also qualify for automatic reweighting and will not have to submit a PI hardship exception application. They include: small practices (15 or fewer clinicians), ambulatory Surgical Center (ASC)-based individual clinicians who furnish 75% or more of their covered professional services in an ASC, hospital-based individual clinicians who furnish 75% or more of their covered professional services in a hospital or groups when more than 75% of the MIPS eligible clinicians in the group meet the definition of hospital-based as individuals.

### Hardship Exceptions

If a clinician or group does not qualify for PI to be automatically reweighted, they can apply to CMS to obtain an exemption from the PI category due to a "significant hardship." The deadline to submit applications to CMS is December 31, 2022.

Please visit the QPP website for more detailed information https://qpp.cms.gov.

### MIPS dates and deadlines for October 2022

- MIPS eligibility for the 2022 performance year will be updated based on the June 30 Alternative Payment Model (APM) snapshot data. Note: Qualifying APM Participant (QP) determinations and MIPS APM participation information will be available on the QPP Participation Status Tool.
- 2023 virtual group election period opens, allowing solo practitioners and groups interested in participating in MIPS through this option an opportunity to submit, revise, or retract an election for the 2023 performance period. Note: Log in to your Quality Payment Program (QPP) account to begin the election process.
- Last day to begin data collection for a continuous 90-day performance period for the improvement activities and Promoting Interoperability performance categories in the 2022 performance period is October 3, 2022.
- Final day to request a **MIPS targeted review** for your 2021 performance year feedback, including your MIPS final score and payment adjustment factor(s) is **October 21, 2022.**

## MEDICARE NEWS

**Medicare Premiums & Deductibles Decrease for 2023**

Each year the Medicare Part B premium, deductible, and coinsurance rates are determined according to the Social Security Act. The standard monthly premium for Medicare Part B enrollees will be $164.90 for 2023, a decrease of $5.20 from $170.10 in 2022. The annual deductible for all Medicare Part B beneficiaries is $226 in 2023, a decrease of $7 from the annual deductible of $233 in 2022.

Beginning in 2023, certain Medicare enrollees who are 36 months post kidney transplant, and therefore are no longer eligible for full Medicare coverage, can elect to continue Part B coverage of immunosuppressive drugs by paying a premium. For 2023, the immunosuppressive drug premium is $97.10.

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