AQREVA Medical Billing & Consulting

Client Memo August 2022

"We live in a rainbow of chaos."

-- Paul Cezanne

NEWS Update

U.S. Renews Public Health Emergency

On July 15, 2022, Department of Health and Human Services Secretary Xavier Becerra again renewed the declaration of a Public Health Emergency (PHE) under the Public Health Service Act, averting a July 15, 2022, expiration and extending the declaration through October 13, 2022.

As expected, the COVID-19 PHE has been extended another 90-days, effective July 15, 2022. This means that most waivers under the 1135 CARES Act of 2020 will continue to stay in effect through October 12, 2022, while others are winding down, writes Terry Fletcher in her July 18, 2022, article for *ICD 10 Monitor.*

The good news is that access to certain services, primarily telehealth coverage, continues not only through October 12th under the waiver 1135 flexibilities, but 151 days after the PHE ends under the Consolidated Appropriations Act of 2022 congressional extension.

Telehealth, in which patients are using their home as the originating site, will continue to be allowed for office visits when an audio and video connection exists. Audio-only visits, when billed with telephone CPT codes, will continue for another 90 days as well. Behavioral health services will need certain modifiers to reflect audio only in 2022.

Extending Telehealth Flexibilities to the End of 2024

The passing of HR 4040 by the US House of Representatives has resulted in a two-year extension of telehealth flexibilities enacted during the COVID-19 pandemic, announces Mark Melchionna in his July 28, 2022, article "House Passes Billing Extending Telehealth Flexibilities to the End of 2024" for *mHealth Intelligence.*

In March 2020, Congress enacted legislation that expanded telehealth access for Medicare beneficiaries, leading to a rapid uptake of the virtual care modality that changed perspectives on care delivery.

In March 2022, the omnibus spending bill, which included several provisions to extend telehealth flexibilities, became law. But it only extended the flexibilities for five months after the public health emergency officially expired.

Congresswoman Liz Cheney (R-WY) and Congresswoman Debbie Dingell (D-MI) composed HR 4040 to ensure these flexibilities remain in place for an additional two years, allowing patients and providers to sustain the use of remote care through December 31, 2024.

Specifically, the bill seeks to continue flexibilities that increased the number of geographic locations from where Medicare beneficiaries can receive telehealth services; increased the number of virtual care services that can be offered by physician assistants, nurse practitioners, clinical nurse specialists, and others; extended Medicare reimbursement for telehealth services provided by federally qualified health centers and rural health centers; and allowed virtual mental health services for up to six months without an in-person visit.

After a 416-12 vote, the House passed HR 4040. It has been sent to the US Senate.

-- Adobe Stock

It also aims to extend flexibilities related to the coverage of audio only telehealth.

Several healthcare stakeholders, including the American Telemedicine Association (ATA) and the AMA, applauded the bill's passage.

Changes to Medicare Telehealth

CMS has finalized that certain services added to the Medicare telehealth services list will remain on the list through December 31, 2023. CMS will extend the inclusion of certain services added temporarily to the telehealth services list that would have been removed at the end of the COVID-19 PHE or December 31, 2023.

Some of these changes include:

- extending the inclusion of certain cardiac and intensive cardiac rehabilitation codes through the end of CY 2023;
    - G0422 and G0423, intensive cardiac rehabilitation
    - 93797 and 93798, Cardiac Rehabilitation
- adopting a separate code G2252 and paying for a longer virtual check-in service on a permanent basis;
- removing geographic restrictions and adding the home of the beneficiary as a permissible originating site for telehealth services furnished for the purposes of diagnosis, evaluation or treatment of a mental health disorder;
    - CMS will continue to recognize POS 2 as the location where health services are provided or received through telecommunication
- requiring the use of a new modifier for services furnished using audio-only communications, which would serve to verify that the practitioner, used audio-only technology due to beneficiary choice or limitations;
    - Modifier 93 – Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System
- clarifying that mental health services can include services for treatment of substance use disorders (SUDs).

CMS has also proposed substantial changes for 2023 as outlined by Rachel Goodman, Nathaniel Lacktman, and Thomas Ferrante with Foley & Lardner LLP in their July 14, 2022, article "Medicare Telehealth Services for 2023" for *Health Care Law Today*.

On July 7, 2022, CMS released its proposed 2023 Medicare Physician Fee Schedule (PFS) rule. The rule, if enacted as proposed, will include:

1. Three new permanent telehealth codes for prolonged E/M services;
2. Discontinue reimbursement of telephone (audio-only) E/M services;
3. Discontinue the use of virtual direct supervision;
4. Postpone the effective date of the telemental health six-month rule until 151 days after the PHE ends;
5. Extend coverage of the temporary telehealth codes until 151 days after the PHE ends.

Reading between the lines, the nature of CMS' comments and the changes it proposed (and refused to propose) suggest that CMS rulemakers anticipate the Public Health Emergency (PHE), and associated PHE waivers, will expire no later than the first half of 2023.

Three new telehealth codes for prolonged E/M services were added:

- GXXX1 Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service; each additional 15 minutes (list separately in addition to CPT codes 99223, 99233, and 99236 for hospital inpatient or observation care evaluation and management services).
- GXXX2 Prolonged nursing facility evaluation and management service(s) beyond the total time for the primary service using time on the date of the primary service; each additional 15 minutes (list separately in addition to CPT codes 99306, 99310 for nursing facility evaluation and management services).
- GXXX3 Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service; each additional 15 minutes (list separately in addition to CPT codes 99345, 99350 for home or residence evaluation and management services).

AMA Releases 2023 E&M Updates -- Terry Fletcher, *ICD 10 Monitor*, July 11, 2022

In 2021, the AMA CPT® Editorial Panel approved and published new documentation guidelines for Office and Other Outpatient Evaluation and Management (E&M) CPT® codes (99202-99215, deleting 99201) and their code descriptors and documentation standards.

As part of the ongoing updates to E&M visits and related coding guidelines, the AMA CPT® Editorial Panel approved revised coding and updated guidelines for Other E&M visits, which includes hospital inpatient, hospital observation, emergency department, nursing facility, home or residence services, and cognitive impairment assessment, effective January 1, 2023.

CMS also published its version of the new updates in its recently published July 7, 2022, press release.

The following is a summary of some "key" revisions to the E&M code descriptors and guidelines for 2023:

- Expect deletion of observation CPT® codes (99217-99220, 99224-99226) and merged into the existing hospital care CPT codes (99221-99223, 99221-99233, 99238-99239), with updated code descriptors.
- Consultations will get a facelift, with the deletion of some confusing guidelines, including the definition of "transfer of care" and in keeping with the level one deletions as MDM duplication. Expect to see the deletion of the lowest level office (99241) and inpatient (99251) consultation codes to align with four levels of MDM.
- Nursing facility services, along with home and residence services will also see revisions in line with similar documentation rules as the 2021 office visit revisions.

Updated Medicare Payment Policies for SNFs for 2023

On July 29, 2022, CMS issued a final rule that updates Medicare payment policies and rates for skilled nursing facilities under the Skilled Nursing Facility Prospective Payment System (SNF PPS) for 2023. In addition, the final rule includes updates for the SNF Quality Reporting Program (QRP) and the SNF Value-Based Purchasing (VBP) Program for FY 2023 and future years.

Listed below is a summary of key provisions, effective October 1, 2022.

- 2.7% net payment rate increase for skilled nursing facilities
- Patient Driven Payment Model parity adjustment recalibration (use the FY 2023 proposed rule calculator to learn more) and changes in ICD-10 code mappings
- Permanent 5% cap on annual wage index decreases
- SNF Quality Reporting Program: compliance date revisions for certain requirements, new influenza vaccination coverage for health care personnel measure, and regulation text revisions
- SNF Value Based Purchasing: not apply the SNF 30-Day All Cause Readmission Measure for the FY 2023 program year and add 3 new measures for FY 2026 & 2027 program expansion years

CMS is also finalizing a two-year phase-in of an adjustment to the SNF payment rates due to the transition to the Patient Driven Payment Model (PDPM), a SNF payment classification model.

New Provider Type Established

According to Stanley Nachimson's article "New Final Payment Rules From CMS Signal More to Come" in the July 11, 2022, edition of *ICD 10 Monitor*, CMS has published a proposed rule to establish a new provider type: Rural Emergency Hospitals (REHs).

This is a new provider type established by the Consolidated Appropriations Act of 2021 to address the growing concern over closures of rural hospitals. The REH designation provides an opportunity for Critical Access Hospitals (CAHs) and certain rural hospitals to avert potential closures and continue to provide essential services for the communities they serve.

Conversion to an REH allows for the provision of emergency services, observation care, and additional medical and health outpatient services, if elected by the REH, that do not exceed an annual per patient average of 24 hours. The rule provides an opportunity for CAHs in rural areas to better serve patients.

New Vaccine Codes

COVID-19: Novavax Vaccine, Adjuvanted — New Codes

On July 13, 2022, the FDA authorized emergency use of the Novavax COVID-19 vaccine, Adjuvanted for the prevention of COVID-19 disease in patients 18 years and older.

CMS issued 3 new CPT codes effective July 13, 2022:

Code 91304 for the vaccine product.
Code 0041A for vaccine administration, first dose
Code 0042A second dose.

Visit the COVID-19 Vaccine Provider Toolkit for more information, and get the most current list of billing codes, payment allowances, and effective dates. The toolkit can be found at: https://www.cms.gov/covidvax-provider

Codes for Smallpox and Monkeypox vaccines

The AMA has announced an update to CPT® that includes a new laboratory test code for the orthopoxvirus and two codes for the vaccines being utilized to prevent monkeypox infection.

These new CPT codes are effective for immediate use.

87593 -- new laboratory test that detects the nucleic signature of an orthopoxvirus, including the monkeypox virus.

The two new vaccine codes are designed to describe the two smallpox and monkeypox virus products currently available:

1. 90622 describes the existing FDA-approved ACAM2000 vaccine manufactured by Sanofi Pastuer Biologics Co. for active immunization against smallpox disease for persons determined to be at high risk for smallpox infection.
2. 90611 describes the FDA-approved JYNNEOS vaccine manufactured by Bavarian Nordic for prevention of smallpox and monkeypox disease in adults 18 years of age and older at high risk for smallpox or monkeypox infection.

Claim Denial Rates as High as 80% for Some Marketplace Payers

A new analysis shows that claim denial rates for in-network services among Healthcare.gov marketplace payers varied significantly, with some as high as 80%, according to analysis from Kaiser Family Foundation, writes Jacqueline LaPointe in her July 6, 2022, article for *RevCycle Intelligence.*

Marketplace payers must report claims denial data under the Affordable Care Act. The Kaiser Family Foundation analysis tapped into the data from 2020 to uncover current claim denial rates based on more than 230 million claims submitted to 144 payers selling marketplace coverage that year.

The analysis found that, overall, nearly one out of every five claims submitted for in-network services in 2020 was denied by marketplace payers. However, depending on the payer, average claim denial rates ranged from just 1 percent to 80 percent.

Claim denial rates also varied significantly by location, the analysis showed. For example, the average claim denial rates were highest in states such as Indiana (29 percent) and Mississippi (29 percent), while rates were just 6 percent in South Dakota and 7 percent in Oregon.

However, researchers reported that the three payers with the largest market share by enrollees had denial rates of 10.5 percent (Florida Blue Cross Blue Shield), 11.1 percent (Health Options), and 27.9 percent (Celtic Insurance).

Marketplace payers with higher overall claim denial rates for in-network services in 2020 included Celtic in five states (Arizona, Indiana, Missouri, Tennessee, and Texas), Molina in six states (Missouri, Mississippi, Ohio, South Carolina, Utah, and Wisconsin), QualChoice in Arkansas, Ambetter in North Carolina, Oscar in seven states (Arizona, Florida, Mississippi, Missouri, Tennessee, Texas, and Virginia), and Meridian in Michigan.

Marketplace payers denied claims for various reasons in 2020, the analysis found. Among denials for in-network services, about 10 percent of denials were for services that lacked prior authorization or referrals, 16 percent were for excluded services, and 2 percent were for medical necessity reasons. The majority of claim denials for in-network services—72 percent—were for "other" reasons.

Claim denial rates have been on the rise for providers. A 2020 survey found that the healthcare industry saw a 20 percent increase in claim denial rates over the previous five years.

Critical Access Hospital Payment Rule

– Victoria Bailey, *RevCycle Intelligence*, July 26, 2022

Reinstating the 96-hour payment rule for critical access hospitals would require the facilities to discharge or transfer patients after 96 hours to receive reimbursement.

A bipartisan group of 25 House members has asked HHS to clarify its plans regarding the enforcement of Medicare's 96-hour payment rule for critical access hospitals (CAHs) following the end of the COVID-19 public health emergency (PHE).

CAHs are an essential source of care in many rural communities. Reinstating the 96-hour payment rule could reduce access to care and impact physicians' ability to make decisions about patient care.

The representatives raised concern that HHS will begin prioritizing the enforcement of the 96-hour rule again once the PHE ends.

UnitedHealthcare News

Starting Sept. 23 — say goodbye to printed overpayment letters

Beginning Sept. 23, 2022, overpayment notification letters sent directly by UnitedHealthcare for most commercial and UnitedHealthcare® Medicare Advantage plans to network health care professionals (primary and ancillary) and facilities are going paperless including:

- Overpayment identified – Notifying you that UnitedHealthcare paid too much on a processed claim
- Overpayment reconsideration requests – Acknowledging United Healthcare received your request to review our overpayment determination
- Overpayment reconsideration decision – Providing the outcome of the reconsideration review and outlining what happens next

Please note: This change includes letters sent by Optum for payment accuracy reviews they perform on behalf of UnitedHealthcare. It does not include overpayment letters sent by any other vendor. Those letters will continue to be mailed.

View overpayment letters 1 of 3 ways

1. Document Library: View overpayment letters using Document Library on the UnitedHealthcare Provider Portal
   a) Go to UHCprovider.com and select "Sign In" in the upper right corner, then sign in with your One Healthcare ID and password
   b) If you don't have a One Healthcare ID, visit UHCprovider.com/access to get started
   c) In the menu, select Documents & Reporting > Document Library > Overpayment documents
2. API: Consider API if you have significant claims volume and prefer an option other than looking up individual items in Document Library. Data can be pulled into your practice management system, portal or any application you prefer. API requires technical programming between your organization and UnitedHealthcare.
3. Enroll in Direct Connect: Use this free portal tool to review and resolve overpaid claims quickly, and reduce letters and calls from United Healthcare and third-party vendors.

Looking ahead to 2023, contracted health care professionals and facilities will be required to submit most claims, claim attachments, reconsideration requests and appeal requests electronically. We'll also begin to introduce digital member ID cards for commercial plans.

All transitions will be announced in Network News at least 90 days prior to the change.

Bind is changing its name to Surest

Bind, a UnitedHealthcare company, is changing its name and logo to Surest™. This change will begin to take effect on September 1, 2022.

The name is changing. The health plan is not.

What you need to know:

- You can begin using the name Surest now and update your systems
- Group and member IDs won't change
- The payer ID for Surest won't change
- For digital claims, use 25463
- For paper claims, mail to P.O. Box 211758, Eagan, MN 55121
- To access member eligibility, benefits and claims, continue using the UnitedHealthcare Shared Services (UHSS) Provider Portal or call UHSS Provider Services at 844-368-6661

Arizona, Missouri and Washington, D.C.: Get ready for paperless Medicaid prior authorization and clinical decision letters

Beginning September 9, 2022, UnitedHealthcare will no longer print and mail prior authorization and clinical decision letters for most UnitedHealthcare Community Plans to network health care professionals and facilities in Arizona, Missouri and Washington, D.C.

Instead, you'll be able to view them 24/7 through either the UnitedHealthcare Provider Portal or an Application Programming Interface (API) system-to-system data feed.

Letter types going paperless:

- Pre-service/prior authorization decision letters
- Inpatient review letters, including concurrent, retrospective, length of stay and level of care
- Peer-to-peer decision letters
- Extension for lack of clinical information letters
- Complex care management and OrthoNet letters available in Document Library

Later this year, UnitedHealthcare will begin to introduce digital member ID cards and the ability to submit claim attachments online through an EDI 275 transaction.

CIGNA 3rd Quarter 2022 Update

Virtual care services should now be billed with POS code 02

Effective July 1, 2022, CIGNA recommends that providers bill all virtual care services using POS code 02. CIGNA recently updated its systems to ensure providers receive 100 percent of the face-to-face reimbursement rate using this code. When you bill POS code 02, patients may also

pay a lower cost share for the virtual services they receive due to a recent change in some plan benefits.

Additional Virtual Care services now permanently reimbursable

Through a virtual care service utilization review spanning two years of the COVID-19 pandemic and by garnering direct feedback from providers, Cigna learned that certain virtual care services continue to play a pivotal role in helping ensure patients have access to the care they need.

As a result, Cigna has made the following services and codes permanently reimbursable as part of their Virtual Care Reimbursement Policy.

- Quick 5-10 minute telephone conversation between a provider and patient – **G2012**
- eConsults: **99446-99449, 99451** and **99452**
- Virtual home health services**: G0151-G0153, G0155, G0157-G0158, G0299-G0300, G0493, S9123, S9128-S9129** and **S9131**

Cigna Revises Modifier 25 Policy

A California Medical Association (CMA) blog issued June 6, 2022, announced that Cigna will begin requiring the submission of medical records with all E/M claims (99212-99215) and modifier 25 when a minor procedure is billed. Failure to submit the required medical records will result in a denial of the E&M service.

Julie Kyles also reports in her June 17th article for *Decision Health Part B News,* that, effective August 13, 2022, Cigna will deny claims for 99212-99215 that are submitted with modifier 25 unless documentation for the claim supports medical necessity.

CMA and the AMA are reaching out to Cigna regarding their concerns.

The policy also instructs practices to send the documentation to a dedicated fax line and continue to submit claims electronically. The notes should also be sent with "a cover sheet indicating the office note supports the use of modifier 25 appended to the E/M code."

There remains a chance that Cigna will withdraw the policy.

Practices with questions regarding this policy update can contact Cigna Customer Service at (800) 88Cigna (882-4462).

MIPS Update

REMINDER: MIPS final scores are now available for preview. Scores are available for those who reported through traditional MIPS or the APM Performance Pathway. The preview will show data used to calculate the highest final score that could be attributed to a clinician, group, or APM entity, including:

- Performance category-level scores and weights
- Bonus points
- Measure-level performance data and scores
- Activity-level scores

The preview will not include information about payment adjustments or patient-level reports. The targeted review period opens when CMS releases final performance feedback and payment adjustment information. The agency anticipates doing this in August.

What to do if you haven't received your 2022 APM incentive payment

CMS has published 2022 APM incentive payment details on the Quality Payment Program (QPP) website. Eligible clinicians can now log in to the QPP website using their HARP credentials to see the payment amounts for them individually (based on their 10-digit National Provider Identifier) and for their organizations.

The QPP website can be found at https://qpp.cms.gov.

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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