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Medical Billing & Consulting

Client Memo
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"The joy of brightening other lives becomes for us the magic of the holidays." – W.C. Jones

NEWS Update

CMS Issues Final Rules

On November 1, 2022, CMS issued final rules concerning the 2023 Hospital Outpatient Prospective Payment System (OPPS) payment rates and 2023 Medicare Physician Fee Schedule (PFS), reports the staff at Robinson & Cole LLP in their November 4, 2022, article "CMS Issues Final Rules Concerning the 2023 Outpatient Prospective Payment System Rates and Physician Fee Schedule" for *The National Law Review*.

These final rules implement various updates and policy changes for Medicare payments under the PFS and OPPS, and made significant updates to the Medicare Shared Savings Program (MSSP), which go into effect on or after January 1, 2023.

Key changes are summarized below:

Physician Fee Schedule (PFS)

- **Payment Rates -** The final 2023 PFS conversion factor is updated to $33.06, which is a decrease of $1.55 to the 2022 PFS conversion factor of $34.61. E/M visit codes and related coding guidelines have also been updated.
- **Split E/M Visits -** CMS has finalized a year-long delay to its policy regarding which provider should bill for a shared visit, which will now go into effect in 2024. Under the policy, a professional that provides the "substantive portion" of the service should bill. The new policy defines a "substantive portion" as more than half of the total time. Beginning in 2024 total time must be used.
- **MSSP -** The changes to the MSSP address certain issues faced by ACOs, including, but not limited to, changes to quality reporting and quality performance requirements, eliminating the requirement to submit marketing materials to CMS, and changes to the skilled nursing facility three-day rule waiver.
- **Telehealth Services -** CMS is extending telehealth expansions originally intended to address the COVID PHE *through 2023 or the end of the year in which the PHE ends, whichever is later*. Using the modifier "95," physicians and practitioners will be able to continue to bill with the place-of-service indicator that would have been reported had the services been provided in-person**.**
- **Behavioral Health -** CMS has finalized an exception to the direct-supervision requirements for behavioral health practitioners. The exception will allow behavioral health services to be provided under general supervision by a physician or non-physician practitioner (NPP), rather than under direct supervision, when the services are furnished by auxiliary personnel incident to the services of a physician or NPP.
- **Clinical Laboratory Fee Schedule (CLFS) -** CMS implemented various changes to the CLFS, including: updating data reporting and payment requirements, increasing the nominal fee for specimen collection, codifying and clarifying various laboratory specimen collection fee policies, and modifying the Medicare CLFS travel allowance policies.
- **Chronic Pain Management and Treatment Services -** New codes and valuations for chronic pain management and treatment have been finalized.
- **Colorectal Cancer Screening -** Medicare will now cover as a preventive service a follow-on screening colonoscopy after a non-invasive stool-based test returns a positive result.
- **Preventive Vaccine Administration Services -** CMS has refined the payment amount for preventive vaccine administration under the Medicare Part B vaccine benefit, which includes the influenza, pneumococcal, hepatitis B, and COVID-19 vaccines.

Physician Pay Cuts Threaten Access to Care

In an excerpt from her November 2, 2022, article, "CMS Settles on Physician Fee Schedule Conversion Factor Cut of $1.55," for *RevCycle Intelligence*, Jacqueline LaPointe writes that leading physician advocacy groups are saying that physicians treating Medicare beneficiaries are up against more than the PFS conversion factor cut, and that combined, the payment cuts will threaten access to care.

"The Medicare payment schedule released today puts Congress on notice that a nearly 4.5 percent across-the-board reduction in payment rates is an ominous reality unless lawmakers act before January 1, 2023. The rate cuts would create immediate financial instability in the Medicare physician payment system and threaten patient access to Medicare-participating physicians," Jack Resneck Jr., MD, president of the AMA said in a statement.

Physicians are also facing the end of the 4 percent Pay-As-You-Go (PAYGO) sequestration by the year's end. Like the temporary boost in PFS payments, Congress also paused PAYGO cuts in Medicare to support healthcare providers during the COVID-19 pandemic.

Combined, the looming cuts are expected to reduce physician payment by nearly 8.5 percent, Resneck reported. With significant physician payment cuts looming, physician advocacy groups worry about the future of patient care access and are calling on Congress to step in.

"Ninety percent of medical practices reported that the projected reduction to 2023 Medicare payment would reduce access to care," reported Anders Gilberg, senior vice president of government affairs at the Medical Group Management Association (MGMA).

Groups like the Surgical Care Coalition are putting their support behind H.R. 8800, the Supporting Medicare Providers Act of 2022. The Act would extend certain increases in physician payments through 2023 to provide continued support.

The Supporting Medicare Providers Act of 2022 would extend certain increases in physician payments through 2023.

"At a bare minimum, Congress must pass H.R. 8800 to prevent these cuts whose effects would be to harm Americans most in need of care," said Patricia L. Turner, MD, MBA, FACS, executive director and CEO of the American College of Surgeons. If allowed to go into effect, these reductions will be yet another blow to an already stressed healthcare system, she added.

While physician advocacy groups have focused on PFS payment cuts, the National Association of ACOs is praising CMS for the positive alterations to the Medicare Shared Savings Program finalized in the new rule.

The ACO association commended CMS for giving ACOs more to time assume two-sided financial risk, which for some new ACOs will be up to seven years and making the Enhanced Track optional. The association also supports giving advance payments to some ACOs, adding a health equity quality adjustment, and modifying financial benchmarks by accounting for prior shared savings, which will help to stop ACO benchmarks from dropping over time.

However, the association expressed concerns with CMS's use of a prospectively projected administrative growth factor for determining ACO financial benchmarks.

2023 PFS Final Rule and MIPS – *CMS Quality Payment Program Bulletin,* November 1, 2022

The 2023 Medicare Physician Fee Schedule Final Rule also includes policy changes for the Quality Payment Program (QPP) for the 2023 performance year and beyond. The following are some of the key QPP policies that CMS finalized for the 2023 performance year and beyond:

MVPs

MIPS Value Pathways (MVPs) are a new reporting option available for MIPS eligible clinicians, in addition to traditional MIPS and the Alternative Payment Model (APM). Beginning with the 2023 performance year:

- 5 new MVPs will be introduced and 7 previously established MVPs will be revised for 2023 reporting.
- The initial 12-month segment of the 24-month MIPS determination period will be used to determine the eligibility of clinicians intending to participate and register as a subgroup.

MIPS (General)

- The performance threshold for the 2023 performance year/2025 payment year remains at 75 points. This means clinicians and groups must reach 75 MIPS points again in 2023 to avoid a negative payment adjustment for 2025.
- The data completeness threshold will be increased from 70% for 2023 to 75% for the 2024 and 2025 performance years.

- Updating MIPS quality measures and the improvement activities inventory by:
  - Expanding the definition of "high priority measure" to include health equity-related quality measures.
  - Reducing the inventory of quality measures from 200 to 198, including the addition of 9 quality measures and the removal of 11 quality measures.
  - Making substantive changes to 76 existing quality measures, adding and removing measures for specific specialty sets, and partially removing 2 measures from the MIPS quality measure inventory (2 measures finalized for removal in traditional MIPS and finalized for retention in MVPs).
- Adding 4 new improvement activities, modifying 5 existing improvement activities, and removing 6 existing improvement activities.
- Updating the measure reporting requirements for the Promoting Interoperability performance category, including making the Query of Prescription Drug Monitoring Program measure a requirement beginning with the 2023 performance period; adding a third option, Participation in the Trusted Exchange Framework and Common Agreement, for satisfying the Health Information Exchange objective; and allowing APM Entities to report Promoting Interoperability at the APM Entity level.
- Establishing a maximum cost improvement score of 1 percentage point out of 100 percentage points for the cost performance category.

Small Practices

There are no major changes to the Quality Payment Program for small practices (15 or fewer clinicians billing under the practice's TIN) participating in MIPS for 2023.

- Clinicians in small practices can continue submitting quality measures for individual or group participation through Medicare Part B claims.
- 6 bonus points will continue to be added to the quality performance category score for clinicians in small practices who submit at least one measure, either individually or as a group or virtual group.
- For the 2023 performance year, small practices will be awarded 3 points for submitting:
  - Quality measures without an available benchmark (historical or performance period)
  - Quality measures that don't meet the case minimum or data completeness requirements.
- Small practices will continue to receive automatic reweighting of the Promoting Interoperability performance category to 0%, regardless of whether they choose to participate as an individual, group, or virtual group.
  - Small practices no longer need to submit a MIPS Promoting Interoperability Performance Category Hardship Exception application to request reweighting in this performance category.
  - Small practices still can choose to submit Promoting Interoperability data, which would void reweighting of the performance category. Any data that's submitted will be scored.

Advanced APMs

- Removing the 2024 expiration of the 8% minimum on the Generally Applicable Nominal Risk standard for Advanced APMs and making the 8% minimum permanent.

What the Eventual End of the PHE will mean for Nursing Home Operators

Despite the federal government's likely decision to keep the public health emergency (PHE) in place past January, the nursing home industry continues to prepare for operations without the safety net of certain waivers, reports Amy Stulick, in her November 14, 2022, article for *Skilled Nursing News*.

Leaders say any continuation of PHE waivers – temporary or permanent – should be dependent on cost and patient quality evaluations. The trouble is, while such evaluations of the waivers and Covid-related programs exist, that information hasn't been made publicly available by CMS, according to former CMS Administrator Seema Verma. The only exception being surveys tied to the temporary nurse aide (TNA) program, she told *Skilled Nursing News.*

In the meantime, operators would benefit from investing in ways to continue using certain waivers. Verma used the three-day stay waiver as an example, which is still allowed beyond the PHE through value-based care programs.

The Department of Health & Human Services (HHS) is expected to keep the PHE in place past the January expiration date, according to a Reuters report, as concerns of a tripledemic looms over all health care settings during winter months.

Waivers that CMS sunset in May include:

- restricting in-person resident groups
- physician delegation of tasks to other clinical positions
- physician visits made by other clinical positions
- suspending quality assurance and performance improvement (QAPI) efforts
- waiving utilization of certain resources to help residents choose a post-acute care provider
- suspending the requirement to provide residents with a copy of their records within two working days

Waivers that ended June 7th include:

- allowing non-certified nurse aides to work for longer than four months as they prepare for their exams (with the exception of approved extensions per state)
- using non-SNF-certified buildings or rooms for isolation purposes
- waiving maintenance of dialysis machines and ancillary dialysis equipment

The only waiver that had any sort of evaluation made publicly available, according to Verma, was the TNA program. Associations appear to be split on the TNA program.

CMS originally announced back in April that it had planned to phase out the waiver, among others tied to the PHE. Anyone hired prior to June 7 would have until Oct. 7 to meet testing requirements, CMS had said.

But in August CMS issued updated guidance that provided opportunities for individual facility and statewide or county waivers to get additional time to certify TNAs when testing and training barriers were apparent.

Telehealth allowances, with parameters

While CMS officials will likely want to put parameters in place to deter overbilling and ensure utilization is appropriate, Verma said a continuation of telehealth waivers will help operators increase quality and access to care in the years ahead.

Telemedicine visits in a nursing home need to have additional equipment available to monitor different parts of the body – meaning remote patient monitoring will need to become more normalized in facilities and at the core of a SNF telehealth visit definition.

Physician visits tied to care transitions should revert back to in-person appointments, she added, while behavioral health assessments or visits with specialists could still be a telehealth visit moving ahead.

States replace PHE safety net

Looking ahead, some states have baked aspects of the PHE waivers into their budgets moving forward, mostly through making temporary Federal Medical Assistance Percentage (FMAP) funding permanent. Illinois, for one, approved a $700 million increase to nursing home funding in the state as of July 1st.

Florida's rate increase included $293 million for nursing center care, or $419,000 per care center, and requires all nursing home employees be paid at least $15 per hour as a condition of the additional funding. Pennsylvania's Medicaid reimbursement rate increase was 17.5% higher for nursing homes in 2023, an increase of $35 per resident per day.

A big priority for AHCA in 2023 will be to get all 50 states to revisit and ultimately adjust their Medicaid rates, with rate increases tied to staff pay, minimum staffing ratios and other measures tied to care quality.

The federal government could also step in and issue a Medicaid adequacy rule, AHCA President and CEO Mark Parkinson said in an October interview. Such a rule would require states to pay an adequate amount of Medicaid to not just nursing homes but all government providers.

A data-informed future

From the day CMS waivers were implemented, and every quarter thereafter, CMS has been running parallel evaluations and updating the possibility of more permanent solutions, according to Verma.

These should be data-driven decisions," Verma told *Skilled Nursing News*. She hopes CMS uses that data, along with dialoguing between the agency and industry leaders, to figure out what's needed moving forward. At the same time, she recognizes that the extension of some of these waivers is not a permanent solution to larger nursing home issues.

New CPT Codes for 2023: This Year's Need-to-Know Updates

The AMA has officially released the 2023 Current CPT® code set. The 2023 updates include 102 new codes, 68 deleted codes, and 87 codes with revised long descriptions writes Mikki Fazzio, RHIT, CCS, in her October 25, 2022, article for *Health-Catalyst.com.*

The updates are effective beginning January 1, 2023, and include the following changes:

EVALUATION AND MANAGEMENT -- The E/M section has one addition, 26 deletions, and 50 revisions for 2023.

- A new add-on code (99418) describes prolonged inpatient or observation E/M services.
- Many observation codes are deleted due to the consolidation of inpatient and observation E/M codes in 2023.
- The other deleted codes include domiciliary or rest home and prolonged service codes.

The revisions include the following:

- Clarifying hospital E/M codes to include "inpatient or observation" care due to the consolidation of inpatient and observation codes.
- Replacing the wording describing a detailed or comprehensive history and examination with a "medically appropriate history and/or examination."
- Changes to the total time to meet when using time for code selection.
- On hospital discharge day management codes, the words "on the date of the encounter" have been added for clarification.
- Office consultation codes have been revised to include "other outpatient" consultation services.
- An emergency department E/M code has been revised to include services that may not require the presence of a physician or other qualified healthcare professional.
- Home visit codes have been revised to include "residence" as a place of service.

SURGERY -- Coding updates in the surgery section include the following systems: integumentary, musculoskeletal, respiratory, cardiovascular, digestive, urinary, male genital, and nervous, a few of which are outlined below.

Integumentary System: There are three new codes in the integumentary system section, plus one deletion and one revision:

- Code 15778 describes the implantation of absorbable mesh or another prosthesis for delayed closure defects.
- Codes 15853 and 15854 describe the removal of sutures or staples not requiring anesthesia.
- Code 15850, describing the removal of sutures under anesthesia, has been deleted.
- Code 15851 has been revised to include the removal of staples.

Musculoskeletal System: One new add-on code (22860) in the musculoskeletal system section describes a total disc arthroplasty and discectomy to prepare an interspace.

Respiratory System: One new respiratory system code (30469) describes repairing a nasal valve collapse using temperature-controlled remodeling.

MEDICINE – 10 new codes have been added to the medicine section:

- Three new codes (93569 and 93573–93575) are add-on codes describing injection procedures for angiographies during cardiac catheterizations.
- New codes 96202 and 96203 are for multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis.
- Additional new codes describe the respiratory syncytial vaccine (90678), orthoptic training (92066), quantitative pupillometry (95919), and remote therapeutic monitoring for cognitive behavioral therapy (98978).

The Coding Corner

Code to the Highest Level of Specificity for Fewer Claim Denials – Staff, *Coding Tips, United Audit Systems, Inc.*, March 16, 2022

Each year, CMS releases updates to the ICD-10-CM diagnosis codes that are effective on October 1st. An important official guideline change, that was effective October 1, 2021, may have gone unnoticed. The ICD-10-CM General Coding Guideline I.B.2. Level of Detail in Coding, was updated as follows: ***"Diagnosis codes are to be used and reported at their highest number of characters available and to the highest level of specificity documented in the medical record."***

More recently, CMS has twice proposed to remove all unspecified diagnosis codes from the CC/MCC lists for DRG grouper assignment. They have yet to implement that, but the hand-writing is on the wall.

Healthcare Training Leader

Medicare and other plans are increasingly denying claims for inappropriate use of unspecified diagnosis codes.

On April 1, 2022, the Medicare Code Editor (MCE) was updated to apply a new edit for unspecified laterality.

ICD-10 Coding Alerts – Staff, MedData Service Bureau, *2023 ICD 10 Updates Newsletter*

The 2023 ICD-10-CM codes are to be used for services and encounters occurring from October 1, 2022, through September 30, 2023.

2023 brings massive changes for ICD-10. With so many new and deleted codes, providers need to pay special attention to code descriptions and guidance. Some of the often 'missed' or 'misused' guidance include:

Unspecified Codes – unspecified codes should only be used when neither the diagnostic statement nor the documentation provides enough information to assign a more specific code. **Providers need to avoid un-specified diagnosis codes.** With over 1100 new codes, providers should code to the highest level of specificity, i.e., the most specific code available to describe what occurred, location, etc.

Laterality – several codes have been enhanced with laterality in the description. Providers need to pay special attention when adding modifiers such as LT/RT to confirm the diagnosis selection and documentation corresponds to the modifiers affixed to the charge to avoid denials.

Code First/Use Additional/Code Also – Additional cod-ing notations are included throughout the ICD-10 book. These indicators are used to alert providers that additional codes are required to be reported together and in some case in a specific order.

Some codes are not allowed to be the primary diagnosis while other codes are considered 'manifestation' codes, others must be reported with another code, and others are required to be the last diagnosis code listed.

- **BMI and Obesity** – one example of codes that should be reported together and in a specific order. BMI codes (Z68.xx) should be reported as a secondary diagnosis code to obesity (E66.xx).

2022 MIPS Update

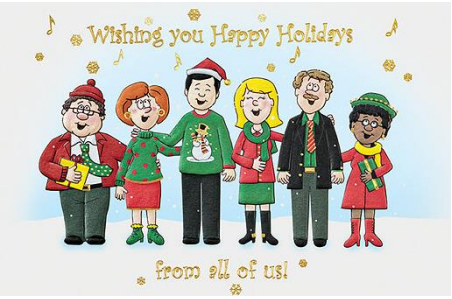
2022 MIPS Extreme & Uncontrollable Circum-stances Exception and MIPS Promoting Inter-operability Performance Category Hardship Exception

The MIPS Extreme and Uncontrollable Circumstances Exception and MIPS Promoting Interoperability Performance Category Hardship Exception applications are open for the 2022 performance year. **Applications can be submitted until 8 p.m. ET on January 3, 2022, and can be found on the Quality Payment Program website:** https://qpp.cms.gov

MEDICARE NEWS

Medicare Part B pays for physician services based on the Medicare Physician Fee Schedule (MPFS), which lists the more than 7,400 unique covered services and their payment rates. Physicians' services include office visits, surgical procedures, anesthesia services and a range of other diagnostic and therapeutic services. The 2023 Physician Fee Schedule can be reviewed on the MPFS website at:
https://med.noridianmedicare.com/web/jfb/fees-news/fee-schedules/mpfs

Happy Holidays from your Team at AQREVA
A word of gratitude for your continued trust and partnership with our team.
A sincere thank you for referring AQREVA to your colleagues and friends - the Best compliment you can give is a referral!
Warmest wishes this Holiday Season and continued success in the new year!



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