AQREVA
Medical Billing & Consulting

Client Memo
September 2022

"Don't cry because it's over; smile because it happened." -- Dr. Seuss

NEWS Update

The COVID-19 Public Health Emergency is now set to end October 13, 2022

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

ICD-10 Codes to Know Before October

The CDC issued the 2023 ICD-10-CM code updates on June 9, 2022, which include 1,176 new, 28 revised, and 287 deleted codes to be used for patient encounters and discharges occurring from October 1, 2022 through September 30, 2023, writes Renee Dowling in her August 2, 2022, article for *Medical Economics*.

New Dementia Codes

The 2023 ICD-10 code set now includes nearly 100 new codes related to dementia. You're now able to report conditions like:

- vascular dementia (F01.5-F01.C4
- dementia in other diseases (F02.8-F02.C4) and
- unspecified dementia (F03.9-F03.C4).

The new guidelines for reporting dementia emphasize that providers must clearly document the severity of the patient's condition. The updated guidelines also instruct that if a patient with dementia is admitted to an inpatient facility and gets worse during their stay, the highest severity level should be reported during the stay.

In the CDC meeting, the Committee gave the following clarifications to help determine the dementia stage.

A few of the specific new dementia codes include:

- F02.811, dementia in other diseases classified elsewhere, unspecified severity, with agitation
- F02.A11, dementia in other diseases classified elsewhere, mild, with agitation
- F02.B11, dementia in other diseases classified elsewhere, moderate, with agitation

Endometriosis Code Expansions

There now are almost 400 new codes representing ob-gyn conditions. The American College of Obstetricians and Gynecologists proposed an expansion to the endometriosis section of the ICD-10-CM code set, and you will now see many of the new endometriosis codes with further specificity to detail whether the condition is superficial or deep. The definitions below will be critical in choosing the correct code:

Superficial endometriosis: Ectopic growth of endometrial-like tissue that extends 5mm or less below the peritoneal surface.

Deeply infiltrating endometriosis: Ectopic growth of endometrial-like tissue that extends greater than 5mm below the peritoneal surface. These lesions are commonly associated with deep fibrosis and adhesions.

For instance, you'll report superficial endometriosis of the right ovary with N80.111, and deep endometriosis of the right ovary will code to N80.121.

Loss of Consciousness Clarification

For concussion and brain injury codes, more than 100 new 2023 ICD-10-CM codes have been added in the S06 (Intracranial injury) range. According to the American Academy of Pediatrics, patients often present with injuries

that code to the S06 category without a clear history of loss of consciousness (LOC).

With the LOC addition, you will need to know whether a patient lost consciousness in order to select the correct diagnosis code. Here are some specific examples:

S06.0XAA, concussion with loss of consciousness status unknown, initial encounter
S06.0XAD, concussion with loss of consciousness status unknown, subsequent encounter
S06.0XAS concussion with loss of consciousness status unknown, sequela

Additional New Codes

In addition to the new 2023 ICD-10-CM codes outlined above, there are many code changes impacting nearly every specialty. Take some time to review the following:

ICD-10 Code Series	2023 Change
C84.4	Revisions to T-cell lymphoma codes
B37	New codes for candidiasis of vulva/vagina
D59.3	More specific codes for hemolytic-uremic syndrome
D68.0	Expansion of Von Wille brand disease codes
E34.3	New codes describing short stature
E87.2	Additional new acidosis codes
F10.9	New codes describing use of alcohol, opioids, cannabis, cocaine, and others
G71.03	Codes added to describe limb girdle muscular dystrophy
I25	Atherosclerosis category expansion
M62.5A	New codes describing muscle wasting of the back
M93.0	Additional codes describing slipped upper femoral epiphysis
P28	New code for newborn sleep disorders
V20-V29	Electric (assisted) bicycle injury codes
Z91.1	Patient noncompliance with provider's orders

New Meth Overdose Codes

You will find a new code category describing poisoning by methamphetamines, as well as codes for adverse effects relating to meth use

PFS Proposed Rule a Mixed Bag

Physicians can bank on payment cuts and decreased code valuations.

Physicians and other qualified healthcare providers can get a preview of what their revenue will look like next year by perusing the 2023 Physician Fee Schedule proposed rule, released by CMS on July 7, 2022, writes Lee Fifield in her article for *AAPC Knowledge Center*, July 28, 2022.

The proposed rule announces, among other things, Medicare policy changes to key physician services including E/M visits, telehealth, behavioral health, and chronic pain management.

Payments on the Decline

CMS proposes to cut the 2023 PFS conversion factor (CF) to $33.08. This represents a decrease of $1.53 from the 2022 CF of $34.61, reducing Medicare payment rates by 4.42 percent. This negative adjustment is largely a result of the expiration of a 3 percent increase in PFS payments for 2022, as required by the Protecting Medicare and American Farmers from Sequester Cuts Act. Also contributing to the drop in next year's rate is the budget neutrality adjustment to account for changes in relative value units (RVUs) and a 0 percent CF update.

New Guidelines for Other E/M Visits

CMS is proposing to "generally adopt" the CPT Editorial Panel's approved revised coding and updated guidelines for "Other E/M" visits, effective January 1, 2023. This means that the new and revised E/M guidelines already implemented for physician and outpatient visits will also apply to hospital inpatient, hospital observation, emergency department, nursing facility, home or residence services, and cognitive impairment assessment services.

More Telehealth Services Given Temporary Status

CMS will continue to recognize the services currently on the Medicare Telehealth Services List and is proposing to add more services (such as therapy services reported with CPT codes 97537, 97763, 90901, and 98960-98962) to the list on a Category 3 basis (temporary) through the end of 2023.

Coverage will extend 151 days following the end of the public health emergency. A delay for in-person visit requirements for mental health services furnished via telehealth would last until 152 days after the end of the PHE.

Telehealth claims will require the appropriate place of service (POS 02 or 10) indicator to be included on the claim, rather than modifier 95 after a period of 151 days following the end of the PHE and that modifier 93 be available to indicate that a Medicare telehealth service was furnished via audio-only technology, where appropriate.

Chronic Pain Management Services

CMS is proposing new HCPCS Level II codes and valuation for chronic pain management and treatment services for 2023 in an effort to facilitate payment for medically necessary services, prompt more practitioners to welcome Medicare beneficiaries with chronic pain into their practices, and encourage practitioners already treating Medicare beneficiaries who have pain to spend the time to help them manage their condition within a trusting, supportive, and ongoing care partnership.

For a full list of proposed changes, see the July 7th CMS Fact Sheet:
https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-proposed-rule

2023 E/M Code Changes

In 2021, the AMA made significant changes to the E/M criteria for office and outpatient visits for new and established patients. For 2023, similar revisions have been approved for the remainder of the E/M section, including services for hospital, nursing homes, and prolonged care. Here is a list of the categories that will undergo revisions in 2023:

Hospital – inpatient and observation services
Emergency department services
Domiciliary care services
Skilled nursing homes
Home visits
Consultations
Prolonged Services

The August 24, 2022, webinar 'Preparing for E/M Code Changes in 2023,' presented by Betsy Nicoletti for *Inbox Health*, outlines the changes that will begin January 2023.

CPT Extends the 2021 Guidelines

The basic framework established for office and outpatient services in 2021 is extended to hospital services, ED visits, consultations, nursing facility services and home visits

Visits to patients in domiciliary care, boarding homes, or rest homes will be billed with home visit codes

Excerpts from the presentation are outlined below for your review.

Changes to the MDM Elements

Use either:
- The level of MDM used for each service, or
- The total time for E/M services performed on the date of the encounter

Number and complexity of problems addressed
- Added to low: acute uncomplicated illness or injury requiring hospital inpatient or observation level of care
- Added to low: stable acute illness

Number and complexity of problems addressed: **nursing facility initial care only** of patient management
- Added to high: decision regarding hospitalization or escalation of hospital-level care. CPT notes that decision for hospitalization applies to the outpatient or nursing facility encounters while decision to escalate hospital level of care applies to the hospitalized or observation care patient.

Using time to select a code
- Time is not a descriptor for emergency department visits.
- If the physician or other qualified healthcare professional supervises a clinical staff member but does not see the patient, use 99211.
- Time is for the total time of the physician or other qualified healthcare professional on the date of the encounter.

Initial hospital or observational care

Only one initial hospital care code may be reported per stay, per specialty/ subspecialty
- Advanced practice nurses and physician assistants are considered as working in the same specialty as the physicians.
- For patients admitted and discharged from hospital inpatient or observation status **on the same date,** report 99234, 99235, 99236.
- 99217 - 99220 are deleted
- Use 99221 – 99223 for initial hospital inpatient or observation care
- Use 99231 - 99233 for subsequent hospital inpatient or observation care
- Use 99238, 99239 for hospital inpatient or observation discharge

Consultations
- Codes 99241 and 99251 are deleted
- 99242 - 99245 office or other outpatient consultation

- 99252 - 99254 inpatient or observation consultation

Nursing facility services

These codes are used in nursing facilities, skilled nursing facilities, psychiatric residential treatment centers, and immediate care facilities for individuals with intellectual disabilities.

- CPT notes these codes are for services performed by the principal physician, often referred to as the admitting physician, who oversees the patient's care
- May also be used by physicians or other qualified health care professionals in the role of a specialist
- 99304 – 99306 initial nursing facility care for the evaluation and management of a patient
- 99307 – 99309 subsequent nursing facility care for the evaluation and management of a patient
- 99315 nursing facility discharge management, 30 min; 99316 more than 30 minutes total time
- 99318 deleted

Domiciliary, rest home (e.g. boarding home), or custodial care services

This subsection is deleted from CPT 2023. All new and established patient codes in this category are deleted:

- 99324 - 99328, 99334 – 99337, 99339 and 99340, 99343 deleted
- Use revised new or established home visit codes to report these services
    - 99341 - 99345 home or residence visit for the evaluation and management of a new patient
    - 99347 – 99350 home or residence visit for the evaluation and management of an established patient
    - 99417 prolonged services 75 minutes or longer

Home or residence services

Level of service may be selected by medical decision making or time, but travel time may not be included

- New patient codes are 99341 - 99345
- Established patient visit codes are 99347 - 99350
- These codes are differentiated as new and established patient visits
- These codes are also used when the residence is in an assisted living facility, a group home that is not a licensed intermediate care facility, a custodial care facility, or a residential substance abuse treatment facility

Prolonged care codes

- Deleted codes: 99354, 99355, 99356, 99357
- 99358 Prolonged evaluation and management service **before and/or after** direct patient care; first hour
  +99359 each additional 30 minutes
- 99415 and 99416 Prolonged evaluation and management service provided by clinical staff in the office or outpatient setting
- +99417 Prolonged total time with or without direct patient contact
    - Use in conjunction with 99205, 99215, 99245, 99345, 99350, 99483
- +993X0 Prolonged inpatient or observation evaluation and management service with or without direct patient contact beyond the required time of the primary service, each 15 minutes of total time
    - Use in conjunction with 99223, 99233, 99236, 99255, 99306, 99310

Summary of deleted codes:

- Hospital observation services codes 99217 - 99220, 99224--99226
- Consultation codes 99241, 99251
- Nursing facility service 99318
- Domiciliary, rest home 99324 – 99328, 99334 – 99337, 99339 and 99340
- Home or Residential 99343
- Prolonged Care 99354 - 99357

Medical Necessity Denials

Medical necessity denials are a source of frustration for many practices nationwide, states Lisa Eramo in her article for the July 2020 issue of *Medical Economics.*

Listed below are suggestions on how to avoid medical necessity denials and ensure timely payment.

Sick visit on the same day as an annual wellness visit (AWV)

REASON FOR DENIAL: Lack of clear clinical documentation regarding why the physician had to go above and beyond what is normally addressed during an AWV.

HOW TO AVOID IT: write the note as if it were two separate visits: one for the problem and one for the well visit. The provider needs to spell out what makes the sick visit significant and separately identifiable from the well visit, advises Toni Elhoms, CCS, CPC, CPMA, CRC, the CEO of Florida-based Alpha Coding Experts. Providers also need to report the correct ICD10-CM code for the visit.

In-house labs and diagnostic testing

REASON FOR DENIAL: Testing too frequently. For example, a payer might deny a prostate screening when the patient had it done six months ago through a different physician. Or a payer might deny a hemoglobin A1C every four months because its policy states it only covers the test every six months.

HOW TO AVOID IT: For annual tests (eg, prostate screenings), patient communication and care coordination are critical. For other frequency-related denials, clinical documentation is paramount.

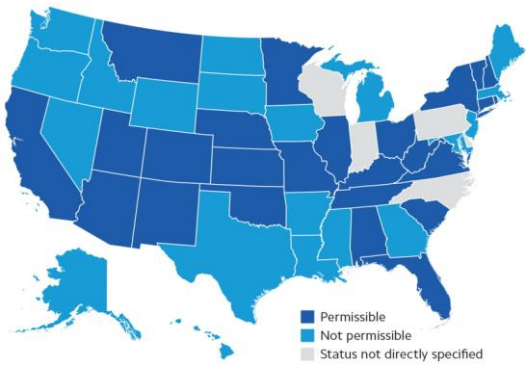
REASON FOR DENIAL: a common reason for denials is that physicians do not report the correct ICD-10-CM code to justify the test (eg, vitamin D), especially when ordered for an AWV.

HOW TO AVOID IT: First, link the correct diagnosis code with each lab or test. In other words, the principal diagnosis on the lab order should be the condition that is being screened or monitored.

Prescribing Controlled Substances for Patients Out of State

Physicians may be unsure about their ability to electronically send controlled substance prescriptions for patients who are away from home. For example, our clinic recently questioned whether we could prescribe stimulants for a patient away at college, writes Michael Campbell Jr., PharmD and Michael Grover, DO, in their article for *Family Practice Management,* July/August 2022

Our clinical pharmacist reviewed applicable U.S. Drug Enforcement Administration regulations and information from the National Association of Boards of Pharmacy to determine which states allow pharmacies to dispense controlled substances prescribed by doctors in other states. Our findings are summarized in the map below. ***The map is applicable only to physicians***. We did not review regulations for other types of prescribers, which may vary from state to state.



MIPS Update

October 3, 2022, begins the last 90-day period for reporting Promoting Interoperability performance measures for 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: • Immunization Registry Reporting • Electronic Case Reporting
	Report on any one of the following measures: • Public Health Registry Reporting OR • Clinical Data Registry Reporting OR • Syndromic Surveillance Reporting

Now Available: 2021 MIPS Performance Feedback, 2021 MIPS Final Score, and 2023 MIPS Payment Adjustment Information

CMS has released MIPS performance feedback and final scores for the 2021 performance year and associated MIPS payment adjustment information for the 2023 payment year.

You can view your 2021 MIPS performance feedback, including your final score and 2023 payment adjustment on the Quality Payment Program website. Sign in using your HCQIS Access Roles and Profile (HARP) system credentials; these are the same credentials that allowed you to submit your 2021 MIPS data

If you don't have a HARP account, please refer to the "Register for a HARP Account" section

Covid Flexibilities - CMS continued to implement flexibilities for the Quality Payment Program by leveraging existing policies in response to the COVID-19 pandemic for the 2021 performance year. The 2021 MIPS final scores available on the Quality Payment Program website reflect these COVID-19 flexibilities.

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

Now Available: 2021 MIPS Targeted Review

If you participated in MIPS in 2021, you can now review your performance feedback, including your MIPS final score and payment adjustment factor(s), on the Quality Payment Program website.

MIPS eligible clinicians, groups, virtual groups, and APM Entities (along with their designated support staff or authorized third party intermediary) may request that CMS review the calculation of their MIPS payment adjustment factor(s) through a process called targeted review. If you believe there's an error in the calculation of your MIPS payment adjustment factor(s), you can request a targeted review now until October 21, 2022.

MEDICARE NEWS

CMS Encourages States to Use Medicaid Payments to Nursing Homes

In support of President Biden's plan to improve the nation's nursing homes, CMS outlines actions for states to improve safety and quality of care for residents. CMS issued an informational bulletin detailing actions that states can take using existing Medicaid authorities to drive better health outcomes for nursing home residents and improve staff pay, training, and retention efforts.

Medicare Suspends Prior Authorization Requirements for Some DME – Lee Fifield, *AAPC Knowledge Center*, August 15, 2022

Prior authorization is no longer required for certain DME when it risks the health of the patient.

CMS has suspended the prior authorization requirements for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when waiting for prior authorization would delay healthcare and risk the life or health of the patient.

As of April 13, 2022, prior authorization is no longer required for specified orthoses items that previously required prior authorization as a condition of payment under certain circumstances when reported with certain modifiers:

- Claims for HCPCS Level II codes L0648, L0650, L1832, L1833, and L1851 that are billed with modifier ST indicate that the item was furnished urgently.
- Claims for HCPCS Level II codes L0648, L0650, L1833, and L1851 billed with modifiers KV, J5, or J4, by suppliers furnishing these items under a competitive bidding program exception (as described in 42 CFR 414.404(b)), to convey that the DMEPOS item is needed immediately either because it is being furnished by a physician or treating practitioner during an office visit where the physician or treating practitioner determines that the brace is needed immediately due to medical necessity or because it is being furnished by an occupational therapist or physical therapist who determines that the brace needs to be furnished as part of a therapy session(s).

Prior authorization will continue to be needed for orthoses items L0648, L0650, L1832, L1833, and L1851 when furnished under circumstances not covered in this update, as well as all other items on the Required Prior Authorization List

CORRECTION: Monkeypox & Smallpox Vaccines: Include Product Code on Claims

The CMS August 11th edition of *MLN Connects* instructed to only bill for vaccine administration when the vaccine was obtained at no cost from the government. The correct instructions are to include these 3 elements on your claim, even if you get the vaccine from the government for free:

1. product code 90611 (smallpox and monkeypox vaccine) or 90622 (vaccinia smallpox virus)
2. applicable ICD-10-CM diagnosis code
3. administration code

The no cost government vaccine product payment adjustments will be addressed during claims processing and will show on the remittance advise.

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