DOCTORS' RESOURCE SPECIALISTS

Client Memo
July 2022

"Everything good, everything magical happens between the months of June and August."
-- Jenny Han

NEWS Update

Guidance Issued for Providers Forced to Share Patient Information

The HHS Office for Civil Rights issued privacy guidelines on June 29, 2022, to provide clarity on how to protect patient health information following the Supreme Court's ruling that ends the constitutional right to abortion, writes Samantha Liss in her article "HHS issues guidance on when Providers may be forced to share patient information' for the June 30, 2022, edition of *Healthcare Dive*.

> Healthcare providers are not permitted to disclose patient health information unless faced with a court order, the HHS said Wednesday, June 29th, in an attempt to provide clarity following the overturning of Roe v. Wade.
>
> In the absence of a court order, federal privacy rules about sharing health information — like whether a person obtained an abortion — is not a permitted disclosure, the HHS guidance says.
>
> The department also warned patients that data collected by third-party apps, such as period trackers, is not protected health information under federal rules and could be shared with other entities.

The guidance comes as providers and patients have expressed concerns about privacy and the release of patient health information that is protected under the Health Insurance Portability and Accountability Act, (HIPAA).

The HHS explained that disclosures without patient authorization are permitted only in narrow circumstances.

The health agency laid out examples for providers on when they may be compelled to turn over patient information.

If a person shows up to an emergency room with complications from a miscarriage at 10-weeks pregnant and a hospital worker suspects the person induced the miscarriage with a medication abortion, providers would not be forced to notify law enforcement if the state bans abortion after six weeks.

However, HHS seemed to indicate that providers may be forced to share that information in states that may require such reporting. "Where state law does not expressly require such reporting, the Privacy Rule would not permit a disclosure to law enforcement," HHS said.

In another example, HHS said that providers are not permitted to disclose information if law enforcement shows up at a clinic requesting abortion records; however, if a law enforcement officer had a court order, clinics may disclose only the information requested in the order. The federal privacy rule would permit this disclosure but does not require it, HHS said.

The guidance follows the Supreme Court's ruling last week that struck down the constitutional right to an abortion, ending nearly 50 years of protected access to the procedure in the U.S.

New Codes: Pfizer-BioNTech Vaccines for Children

On June 17, 2022, the FDA amended the Pfizer-BioNTech COVID-19 Vaccine Emergency Use Authorization to authorize use for all patients 6 months to 4 years old.

CMS issued new CPT codes effective June 17, 2022:

- Code **91308** for vaccine product: SARSCoV-2 vaccine, mRNALNP, spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use (SARSCOV2 VAC 3 MCG TRS-SUCR)

- Code **0081A** for vaccine administration, first dose
- Code: **0082A** for vaccine administration, second dose
- Code **0083A** for vaccine administration, third dose

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

New Codes for Vaccine Counseling

CMS released HCPCS codes for "stand-alone vaccine counseling" on May 12, 2022. The codes are to be used when a physician counsels a patient about receiving a recommended vaccine and the patient (or patient's parent or other health care agent) chooses not to have the vaccine administered that day.

CMS officials said physicians and other health care clinicians may use the codes to bill for "stand-alone vaccine counseling," including COVID-19 vaccine counseling provided to Medicaid and Children's Health Insurance Program (CHIP) beneficiaries who are eligible for coverage as required by the American Rescue Plan and the Medicaid EPSDT provisions.

CMS is allowing the codes to be used for vaccine counseling provided via telehealth as well as in person, but states can decide whether to cover these services via telehealth for Medicaid EPSDT.

"STAND-ALONE" COUNSELING ONLY MEANS THAT THE VACCINE DISCUSSED IS NOT ADMINISTERED AT THAT VISIT. THE CODES MAY BE USED FOR VISITS THAT INCLUDE OTHER SERVICES.

G0310 - Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service, 5-15 minutes.

G0311 - Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service, 16-30 minutes.

G0312 - Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21, 5-15 minutes.

G0313 - Immunization counseling by a physician or other qualified health care professional when the vaccine(s) is not administered on the same date of service for ages under 21, 16-30 minutes.

G0314 - Immunization counseling by a physician or other qualified health care professional for COVID-19, ages under 21, 16-30 minutes.

G0315 - Immunization counseling by a physician or other qualified health care professional for COVID-19, ages under 21, 5-15 minutes.

CMS officials noted that Medicaid beneficiaries have some of the lowest COVID-19 vaccination rates among patients for whom COVID shots are recommended and that vaccination rates for other shots have also fallen for Medicaid beneficiaries during the pandemic.

The agency wrote that the counseling represented by the new codes "has been shown to help address vaccine hesitancy by helping beneficiaries and their families learn about vaccines from trusted health care providers."

— Kent Moore, *AAFP,* June 13, 2022

HCC Coding Capture and Telehealth

As providers expand the use of telehealth, HHS will continue to include select telehealth and telephone-only services in its risk-adjustment programs. Hierarchical Condition Category (HCC) coding is a risk-adjustment model originally designed to estimate future healthcare costs for patients, explains Terry Fletcher, in her June 13, 2022, article for *ICD 10 Monitor*.

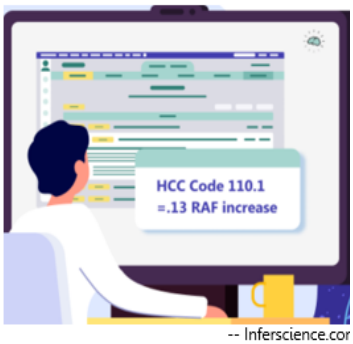
HCC coding relies on ICD-10-CM codes to assign risk scores to patients. Each HCC is mapped to an ICD-10-CM code. Along with demographic factors such as age and gender, insurance companies use HCC coding to assign patients a risk adjustment factor (RAF) score. Using algorithms, insurance companies can use a patient's RAF score to predict costs.

For example, a patient with few serious health conditions could be expected to have average medical costs for a given time. However, a patient with multiple chronic conditions would be expected to have higher healthcare utilization and costs.

There are some caveats of which to be aware, per CMS:

1. The e-visit CPT set (98970-98972, 99421-99423) and (98966- 98968, 99441-99443) is for use by physicians and non-physician qualified health professionals who may independently bill for E&M visits.

2. Like telehealth visits, telephone-only services are subject to the same requirements regarding provider type and diagnostic value and must be reimbursable under applicable state law. If states have taken audio-only encounters off of their payable services or have let their PHE (public health emergency) waivers end, they may not be considered for HCC reporting.
3. Many conditions cannot be diagnosed telephonically but will defer to applicable coding and diagnosis guidelines setting groups (e.g., the AMA) on what a permissible diagnosis telephonically may be.
4. HHS evaluates CPT/HCPCS codes for inclusion in risk adjustment on a quarterly basis, which allows for new codes to be evaluated and included regularly.



-- Inferscience.cor

It is also important to remember that the HHS Office of Inspector General is scrutinizing MA plans more than ever due to non-compliant coding. So, with telehealth services now allowed to be considered under the risk-adjustment model, it is imperative that providers are as accurate as possible when reporting HCC codes to avoid audit exposure and False Claim Act allegations.

Reminders for HCC Coding

- Risk adjustment scores reset every year. Practices need to report active diagnoses annually, even chronic conditions.
- HCCs are additive, so it is important to code all conditions that coexist at the time of the encounter or affect patient care or treatment.
- Conditions that were previously treated and no longer exist should not be coded. History codes may be used as secondary codes if the condition or family history impacts current care or influences treatment.
- Documentation must support the diagnoses reported. A good rule of thumb is to document to the MEAT principles: **a diagnosis should be monitored, evaluated, assessed, or treated**. *Diagnoses that are not supported by documentation will not be upheld in the event of an audit.*
- The medical record must contain a legible signature, with credentials.
- **Code to the highest level of specificity** and ensure that the diagnoses are properly sequenced on the claim. Some things to consider when selecting the appropriate diagnosis code:
  - Type and underlying cause (e.g., diabetes type 1 or 2, due to underlying condition, postprocedural circumstances, or due to genetic defects, etc.)
  - Control status
  - Severity
  - Site, location, or laterality
  - Associated co-morbid conditions
  - Substance use/exposure

With the ongoing pandemic still requiring providers to expand the use of telehealth and virtual care options, HHS will continue to include select telehealth and telephone-only services in its risk-adjustment program for qualified health plans in 2022.

How to Correctly Document and Bill for Patient E-visits

Renee Dowling reviews the required elements for patient e-visits in her June 7, 2022, article for *Medical Economics.* E-visits are utilized specifically for responding to patient-initiated health concerns and medical questions, and a provider's management of the patient's care utilizing communication through a patient portal.

While on-line communication is utilized more and more, e-visits should not be utilized for simply disseminating test results, processing medication requests, or scheduling an appointment. An E&M service needs to be performed in order to bill for the service.

In other words, the provider is making a clinical decision that typically would have been provided in the office (eg, medication dose adjustment, ordering of a test, or prescription of a new medication).

Below are some of the Dos and Don'ts of billing these types of visits:

Do bill an E-visit when ALL of the following are met:

- A provider is answering a patient-initiated message through the patient portal.
- Patient consents to the e-visit and understands that s/he might be billed.
- The patient is established to the provider.

- Time spent by the provider to respond is >5 minutes.
- The 2021 E/M guidelines for a visit are met.
- Clinician hasn't seen the patient within 7 days.
- Patient is not in a global period for the same or similar condition.
- Patient has a new/unrelated problem within seven days of a previous E/M visit when a different problem was addressed.
- Provider is making a clinical decision that typically would have been provided in the office (eg, medication dose adjustment, ordering of a test, or prescription of a new medication).
- The service period for online digital E/M services includes all related work within a 7-day period by the reporting individual and other qualified healthcare providers (QHPs) in the same group practice. *The 7-day period begins with the reporting provider's initial, personal review of the patient-generated inquiry.*

Don't bill an E-visit when:

- Within the 7-day period of the E-Visit, a separate face-to-face E/M service (either in person or via telehealth) occurs (included in the E/M).
- The provider bills for any other separately-reported services (such as care management, INR monitoring, remote monitoring, etc.) during the 7-day period.
- An E-visit for this patient was billed within past 7 days for the same or similar condition.
- The provider is simply disseminating test results, processing medication requests, or scheduling an appointment (an E/M service must be performed to bill).
- The time includes clinical staff time (only provider time can be included).
- The patient inquiry is related to a surgical procedure and occurs within the postoperative (global) period of the procedure

E-visit Codes to know

99421: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes

99422: 11-20 minutes

99423: 21 or more minutes

The complexity of the patient's issues would normally determine the time needed to respond.

2022 New Care Management Services Codes

There are new codes physicians need to know in the care management section of the Current Procedural Terminology codebook.

Principal Care Management Services

New CPT codes have been added in 2022 to describe "Principal Care Management Services." These codes are like chronic care management services in that the work involves the establishment, implementation, revision, and monitoring of a care plan for a patient.

Principal Care Management focuses on a single condition rather than two or more

99424 describes the first 30 minutes of a Principal Care Management service per calendar month provided by a physician or qualified healthcare professional.

99425 used to capture each additional 30 minutes of service in addition to 99424

CPT codes 99426 and 99427 also describe principal care management services, but for clinical staff time directed by a physician or qualified healthcare professional.

Starting this year, Medicare will accept CPT codes 99424, 99425, 99426 and 99427, and discontinue HCPCS codes G2064 and G2065.

Chronic Care Management Codes for 2022

A new CPT code 99437 was also created, effective January 1, 2022, to describe each additional 30 minutes of a chronic care management service performed by a physician or qualified healthcare professional.

99491 Chronic care management services provided by a physician or other qualified health care professional with the following required elements:

- Two or more chronic conditions expected to last at least 12 months, or until the death of the patient

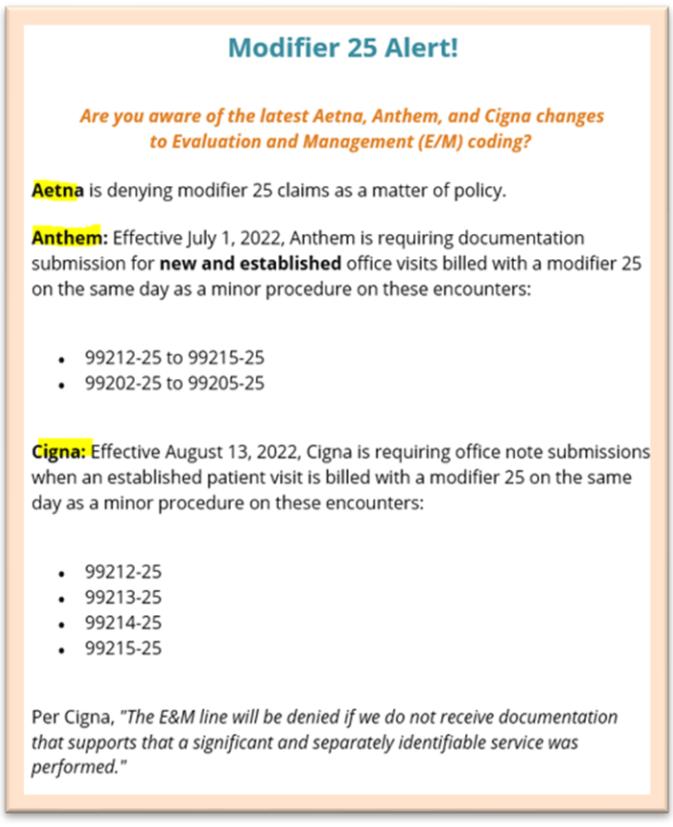
- Chronic conditions place the patient at significant risk of death, acute exacerbation or functional decline
- Comprehensive care plan established, implemented, revised, or monitored
- First 30 minutes of time per calendar month

99437 Each additional 30 minutes by a physician or other qualified health care professional, per calendar month

Beware: Modifier 25 Could be DOA

Modifier 25 is used to report an E&M service when another service was provided to the patient by the same physician or other qualified healthcare professional, reports Terry Fletcher, et al., in their June 17, 2022, broadcast for *Talk 10 Tuesdays.*

Recently, though, several payers, including Horizon Blue Cross in New Jersey, Horizon Medicare Advantage Plans, and Cigna Healthcare, to name a few, are now scheduled to cut provider payments when a Modifier 25 is used, creating burdensome paperwork to delay claims.



Modifier 25 Alert!

Are you aware of the latest Aetna, Anthem, and Cigna changes to Evaluation and Management (E/M) coding?

Aetna is denying modifier 25 claims as a matter of policy.

Anthem: Effective July 1, 2022, Anthem is requiring documentation submission for **new and established** office visits billed with a modifier 25 on the same day as a minor procedure on these encounters:

- 99212-25 to 99215-25
- 99202-25 to 99205-25

Cigna: Effective August 13, 2022, Cigna is requiring office note submissions when an established patient visit is billed with a modifier 25 on the same day as a minor procedure on these encounters:

- 99212-25
- 99213-25
- 99214-25
- 99215-25

Per Cigna, *"The E&M line will be denied if we do not receive documentation that supports that a significant and separately identifiable service was performed."*

MIPS Update

Updated HHS Security Risk Assessment (SRA) Tool

Version 3.3 of the HHS Security Risk Assessment (SRA) Tool includes a new SRA Tool Excel Workbook to replace the legacy paper version. The Office for Civil Rights (OCR) and the Office of the National Coordinator for Health Information Technology (ONC) released version 3.3 of the HHS Security Risk Assessment (SRA) Tool.

Objective:	Protect Patient Health Information
Measure:	Security Risk Analysis Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI data created or maintained by certified electronic health record technology (CEHRT) in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), implement security updates as necessary, and correct identified security deficiencies as part of the MIPS eligible clinician's risk management process.

The SRA Tool was developed to help HIPAA-covered entities navigate risk assessment requirements under the HIPAA Security Rule. The tool is a software application that organizations can download at no cost.

It is important to note that the use of the SRA Tool does not guarantee compliance with HIPAA, but it can help organizations conduct thorough risk assessments and evaluate technical, physical, and administrative safeguards.

MIPS Protect Patient Health Information Measure Added for 2022

To meet this measure, MIPS eligible clinicians must attest YES or NO to conducting an annual self-assessment of the High Priority Practices Guide of the SAFER Guides. Please go to the SAFER Guides website for more information:
https://www.healthit.gov/topic/safety/safer-guides

The SAFER Guides consist of nine guides organized into three broad groups. These guides enable healthcare organizations to address EHR safety in a variety of areas. Most organizations will want to start with the Foundational Guides, and proceed from there to address their areas of greatest interest or concern.

Objective:	Protect Patient Health Information
Measure:	High Priority Practices Guide of the Safety Assurance Factors for EHR Resilience (SAFER) Guides Conduct an annual assessment of the High Priority Practices Guide SAFER Guides beginning with the 2022 performance period.

Note: In order to earn a score greater than zero for the Promoting Interoperability performance category, MIPS eligible clinicians must:

- Complete the activities required by the Security Risk Analysis AND High Priority Practices SAFER Guide; submit their complete numerator and denominator or Yes/No data for all required measures; and attest to the actions to limit/ restrict compatibility/interoperability of CEHRT statement.
- Failure to report at least a "1" in all required measures with a numerator or reporting a "No" for a Yes/No response measure (except for the SAFER Guides measure) will result in a total score of 0 points for the Promoting Interoperability performance category

2021 Final Score Preview Now Available

CMS has opened the Final Score Preview period for MIPS. Authorized representatives of practices, virtual groups, and Alternative Payment Model (APM) Entities can now sign into the Quality Payment Program (QPP) website to preview 2021 MIPS final scores.

The MIPS Final Score Preview period is available until the final performance feedback, including payment adjustments, is released in August 2022.

The Final Score Preview period is a new phase of MIPS performance feedback that will provide clinicians with the opportunity to preview their final score prior to the release of payment adjustment information. As a reminder, your 2021 final score is what will determine your 2023 MIPS payment adjustment.

CMS encourages providers to sign in and preview final scores now and to contact the QPP Service Center with questions or concerns.

During the Final Score Preview, performance feedback will display data associated with the highest final score that could be attributed to the clinician, group or APM entity, and all the data required to calculate final scores, which includes:

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

The Final Score Preview period won't include payment adjustment information or patient-level reports. Final performance feedback, including MIPS payment adjustment information, will be available in August 2022. There will be a 60-day targeted review period during which clinicians can request a review of their MIPS payment adjustment calculation.

MEDICARE NEWS

Full Sequestration Cuts to Resume

Medicare payments will decrease as the full 2% sequestration cuts resume on July 1, 2022. A partial 1% cut occurred between April 1 through June 30, 2022.

Sequestration cuts will now revert back to the rate in effect prior to the PHE. The 2% reduction only applies to what Medicare pays you, the billing clinician.

The sequestration decrease will appear on Medicare remittance advices with claim adjustment code CO 253, "Sequestration – reduction in federal payment," as the reason.

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