DOCTORS' RESOURCE SPECIALISTS

Client Memo
June 2022

"I was thinking that we all learn by experience, but some of us have to go to summer school."
-- Paul De Vries

NEWS Update

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Public Health Emergency Expected to be Extended

HHS had a deadline of May 16, 2022, to notify the public that the Public Health Emergency would end in 60 days. Because the deadline has come and gone with no word, it is expected that the PHE will be extended past the current July 16 end date, but how far is unknown, writes Todd Shryock in his May 19, 2022, article for *Physician's Practice.*

The American Medical Association in conjunction with the American Nurses Association and the American Hospital Association wrote to Department of Health and Human Services Secretary Xavier Becerra, lobbying for another renewal.

Becerra told health care leaders after the first extension that he would give them a 60-day warning if it will not be renewed.

The PHE removed many barriers to telehealth, allowing Medicare reimbursement and elimination of various site and security requirements, giving doctors and patients the ability to use whatever technology they had access to. While the Biden administration has pushed to make some of these changes permanent, congressional action is required.

While much of the country has moved on as if the pandemic was over, the CDC shows a rising number of cases in recent weeks, with a rise in hospitalizations, as well. These rising numbers concern the professional medical groups, who point out that new variants may emerge that strain hospital and health systems.

HHS Extended the Public Health Emergency for another 90 Days until mid-July 2022. States to be given a 60-day notice before the PHE expires.

ICD-10 Diagnosis Codes – Vaccine Status

Effective April 1, 2022, CMS implemented new diagnosis codes for reporting COVID-19 vaccination status:

Diagnosis Code	Description
Z28.310	Unvaccinated for COVID-19
Z28.311	Partially vaccinated for COVID-19
Z28.39	Other under-immunization status

Prepare for More Diagnosis Codes -- Laurie M. Johnson, MS, Approved ICD-10-CM/PCS Trainer, *ICD-10 Monitor*, May 8, 2022

The Proposed Rule for the Inpatient Prospective Payment System (IPPS) was released on April 18, 2022. The tentative list of new diagnosis codes was also released, including three diagnosis codes that were effective for discharges and visits occurring on and after April 1. The tentative list includes 1,176 new diagnosis codes.

The final list is expected to be published in mid-June.

The most significant changes appear in chapters 3, 5, 9, 13, 14, 15, 19, 20, and 21.

Summarized below are some of the changes by chapter:

Chapter 3 (Diseases of the Blood and Blood Forming Organs and Certain Disorders Involving the Immune Mechanism) -- the code set has expanded von Willebrand disease and hemolytic-uremic syndrome.

Chapter 5 (Mental, Behavioral, and Neurodevelopmental Disorders) – additional codes added for various forms of drug use, in remission, and expansion of several types of dementia with manifestations.

Chapter 9 (Diseases of the Circulatory System) -- codes regarding aortic aneurysms added, as well as additions including refractory angina and changes to ventricular tachycardia.

Chapter 13 (Diseases of the Musculoskeletal System and Connective Tissue) -- codes for acute, chronic, or acute-on-chronic slipped femoral epiphysis added.

Chapter	Letters	Mnemonics	# New Codes
1	A-B	Advancing Bugs	2
2	C-D49	Cancer/Death	0
3	D50-D89	Dracula	20
4	E	Endocrine	11
5	F	Freud	83
6	G	"Gittery"	14
7	H-H59	Hyphema	0
8	H60-H95	Hearing	0
9	I	Infarction	43
10	J	Just Gasping	1
11	K	Knot in Stomach	1
12	L	Lipoma	0
13	M	Musculoskeletal	35
14	N	Nocturia	139
15	O	Obstetrics	175
16	P	Perinatal	10
17	Q	Quirky	16
18	R	Relative Symptoms	0
19	S-T	Simply Traumatic	101
20	V,W,X,Y	Vehicles, Woops, eXposure,whY	477
21	Z	Zero Problems	48
22	U	Unusual	0

Chapter 14 (Diseases of the Genitourinary System) -- changes include expanding the sites of endometriosis.

Chapter 15 (Pregnancy, Childbirth, and Puerperium) – codes added for central nervous system malformations, chromosomal abnormalities, and facial, cardiac, gastrointestinal, genitourinary, and extremity anomalies.

Chapter 19 (Injury, Poisoning, and Certain Other Consequences of External Cause) – codes expanded for several types of brain injuries and codes added for poisoning by methamphetamines.

Chapter 20 (External Causes of Morbidity) -- includes the electric bicycle (driver and passenger) and caught, crushed, or pinched between moving and stationary objects. This chapter has also expanded on accidents of the motorcycle driver and passengers.

Chapter 21 (Factors Influencing Healthcare Status and Contact with Health Services) – codes expanded for non-compliance, to include patients and caregivers.

Chapter 17 (Congenital Malformations, Deformations, and Chromosomal Abnormalities), -- code for PTEN Hamartoma Tumor Syndrome, appears in the tentative list as Q85.81.

Coding Clarification for Wound Care

Many family physicians provide wound care for their nursing facility patients. Coding and billing correctly for such wound care is important to assure appropriate payment and avoid potential allegations of fraud or abuse.

One of the challenges in this regard is understanding when to report chemical cauterization of granulation tissue versus debridement, especially as it pertains to Medicare patients.

Coding Chemical Cauterization of Granulation Tissue

According to Medicare claims data, CPT code **17250** for chemical cauterization of granulation tissue (i.e., proud flesh) is a service increasingly reported by family physicians in the nursing facility setting.

CPT code 17250 is specific to the application of chemicals such as silver nitrate to excessive healing tissue known as proud flesh or granulation tissue and may include the removal of loose granulation tissue and subsequent hemostasis.

As noted in the parentheticals below the CPT code, 17250 is NOT intended to be reported in the following situations:

- With removal or excision codes for the same lesion,
- When chemical cauterization is used to achieve wound hemostasis,
- In conjunction with active wound care management codes 97597, 97598, or 97602 for the same lesion.

Coding for debridement -- Codes 97597, 97598, and 97602 describe a more extensive service than described by code 17250, as follows:

97597 Debridement (e.g., high-pressure waterjet with or without suction, sharp selective debridement with scissors, scalpel, and forceps), open wound (e.g., devitalized epidermis and/or dermis, exudate, debris), including topical application(s), wound assessment, use of

a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less

97598 each additional 20 sq cm, or part thereof (list separately in addition to code for primary procedure)

Active wound care procedures are performed to remove devitalized and/or necrotic tissue and promote healing.

- 97597 involves cleansing the wound thoroughly with copious irrigation, then removing proteinaceous slough, fibrin, and debris covering the wound bed with curette, scalpel, and forceps or scissors until healthy tissue is visualized.
- 97598 involves the same service done over an additional surface area.
- Chemical cauterization (code 17250) to achieve wound hemostasis is included in these procedures and should not be reported separately for the same lesion.

97602 Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion, larval therapy), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session.

Medicare Payment for Wound Care Services

Correctly coding wound care services in the nursing facility setting is important, given the different ways Medicare pays for such services. Medicare beneficiaries can either be in a Part A covered skilled nursing facility (SNF) stay, which includes medical services as well as room and board, or they can be in a Part B non-covered SNF stay in which Part A benefits are exhausted but certain medical services are still covered, although room and board are not.

Under the Balanced Budget Act of 1997, Congress mandated that payment for most services provided to beneficiaries in a Medicare covered Part A SNF stay be included in a bundled prospective payment to the SNF.

The SNF is required to bill these bundled services in a consolidated bill to the Part A Medicare administrative contractor. The bundled services cannot be billed separately.

There are a limited number of services specifically excluded from consolidated billing and, therefore, separately payable. Currently, CPT code 17250 is among those excluded from the consolidated billing rule and, therefore, separately reportable.

In contrast, CPT codes 97597 and 97598 are subject to the SNF consolidation billing. Reporting 17250 rather than 97597/97598 to avoid consolidated billing would be inappropriate.

When reporting services, clinicians should use the code that accurately identifies the service performed, per CPT guidelines. It is not appropriate to select a code that approximates the service or to report a code solely for reimbursement purposes. Further, CPT code selection should always be supported by the clinical documentation in the medical record.
— posted May 11, 2022, by Kent Moore, AAFP, and Emily Hill, PA-C, president of Hill & Associates, a Wilmington, N.C., consulting firm, for *Getting Paid, FPM Journal Blog.*

Do Not Bill Pulse Oximetry with E&M Services

Billing a pulse oximetry is not allowed with any other service(s) performed on the same day. Pulse oximeters are considered incidental to office visits or procedures and separate reimbursement is not provided for incidental procedures.

Pulse oximetry represents a fundamental component of the assessment services provided to a patient during a procedure and therefore is not separately reimbursable.

Health plans that have adopted this payment policy will deny pulse oximetry when billed with an evaluation and management service when billed on the same date by the same provider.

Per CMS NCCI Policy Manual (2022), *many procedures require cardiopulmonary monitoring either by the physician performing the procedure or an anesthesia practitioner. Since these services are integral to the procedure, they are not separately reportable (page I-11).*

CMS assigns CPT codes 94760 and 94761 to a status indicator of "T." Status T procedures are only paid if there are no other services paid under the physician's fee schedule billed on the same date by the same provider.

CPT	Descriptor
94760	Noninvasive ear or pulse oximetry for oxygen saturation; single determination
94761	Noninvasive ear or pulse oximetry for oxygen saturation; multiple determinations (e.g., during exercise)

Preventing Coding and Billing Errors

For primary care practices, earning enough revenue to meet overhead expenses and provide quality care has always been a challenge. But practices often make the challenge even greater through sloppy coding and billing, leading to delayed or incorrect reimbursements from payers, states longtime coding consultant Nancy Enos, FACMPE,CPC, CPMA, in her May 2022 article for *Medical Economics*.

Fortunately, there are steps doctors and practice administrators can take to ensure they receive all they are owed in a timely fashion. But it requires forethought, training, and commitment from everyone in the practice, Ms. Enos adds.

Solutions & Takeaways

- Front office staff can help minimize claim denials by verifying patient insurance coverage and eligibility before the appointment.
- Clinician notes should be as detailed and specific as possible to obtain the correct billing code(s).
- Billing and coding errors should be corrected immediately with feedback provided to the source of the error.
- Practices should conduct periodic internal audits of their billing and coding and share the results with clinicians and staff members.
- Don't treat internal audits as an onerous task but rather as a method of self-protection and a tool to prevent under-coding

Common front office-related reasons for denials include the following:

- Lack of coordination of patient benefits;
- Expired insurance coverage;
- Expenses not covered by a patient's insurance;
- Expenses incurred prior to the patient's coverage date;
- Lack of required precertification/authorization for an expense.

The front office is where the revenue cycle begins. This means staff members need to verify eligibility up front, so patients know their financial responsibilities and agree to meet them.

Clinicians can minimize claim denials by making sure their notes are concise, detailed, and specific**. Diagnoses lacking specificity is one of the biggest reasons for denials.** Putting in the clinical details such as the problem's severity and whether it's chronic or acute will get you to the most specific diagnosis code and get your claim paid faster.

Other problems frequently seen in clinical notes include:

- The date of service doesn't meet frequency limits.
- Time spent with the patient for time-based services is not documented.
- The note is not signed.
- The billing provider's and service provider's names don't match.
- The note doesn't support the CPT codes reported for it.

Behavioral Health: To Screen or not To Screen?

Behavioral health screenings aim to detect mental health symptoms in many seemingly healthy people. The goal is to apply these screening methods uniformly to patients with potentially undiagnosed mental health problems, writes Christine Hall in her May 23, 2022, article for *ICD 10 Monitor.*

CPT® code 96127 -- Brief emotional/behavioral evaluation (e.g., depression inventory, attention-deficit/hyperactivity disorder scale), with scoring and documentation, following standardized instrument) is the code to use when indications or symptoms prompt a provider to supply a patient with a brief emotional/ behavioral assessment. The standard screening tool is the Patient Health Questionnaire-9 (PHQ-9).

Payer guidance varies from payer to payer, especially reporting depression screenings. For example, some payers recommend postpartum depression screenings should be reported with code 96127 while others recommend reporting codes **96160** or **9616**1 (see table).

Most commercial payers may process their behavioral health claims separately by utilizing a third-party payer. The claim should be processed by the physical medicine side if the mental health tests were utilized to assess whether the patient's mental health was influencing his or her physical health.

PHYSICAL MEDICINE ICD-10-CM CODES RATHER THAN MENTAL HEALTH DIAGNOSIS CODES MAY HELP AVOID THE DIFFICULTIES THAT COME WITH BEHAVIORAL HEALTH COVERAGE.

Medicare refers to HCPCS code **G0444** for Medicare patients who are undergoing a depression screening without symptoms.

Alternatively, testing is used to evaluate the existence or absence of a mental health disorder when the possibility of one has been proven by screening or the presence of a comorbid illness. Test administration needs "medical necessity" for billing purposes, which must be supported by an ICD-10-CM code.

Test assessment services are intended to cover the time spent by a physician or other qualified healthcare professional assessing the findings of a patient's mental health test(s) and formulating a treatment plan.

Many screenings and assessments are recommended during preventive services, and some may be considered in performance measures and incentive payments.

Although payments for screening and assessments are minimal, they can build up to a substantial amount of revenue throughout a patient-specific course of care.

Some of the codes used are:

CPT	Description
96127 screening	Brief emotional/behavioral assessment with scoring and documentation, per standardized instrument
96130	Psychological testing evaluation services, including integration of patient data, interpretation of test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member or caregiver, first hour
96131	Same as above, each additional hour
96136 admin	Psychological or neuropsychological test administration and scoring by physician or NPP, 2 or more tests, any method, first 30 minutes
96137	Same as above, each additional 30 minutes
96138	Psychological or neuropsychological test administration and scoring by a technician, 2 or more tests, any method, first 30 minutes
96139	Same as above, each additional 30 minutes
96160	Administration of patient-focused health risk assessment instrument (e.g. health hazard appraisal) with scoring and documentation, per standardized instrument
96161	Administration of caregiver-focused health risk assessment instrument (e.g. depression inventtory) for the benefit of the patient, with scoring and documentation standardized instrument

Fees Related to Receiving Electronic Payments

Health plans cannot force physicians to incur fees for receiving electronic payments, writes Kent Moore, senior strategist for AAFP Physician Payments, in his March 31, 2022, blog for *FPM Journal.*

CMS released new guidance March 22, 2022, in response to concerns raised by the AAFP (American Academy of Family Physicians) and other groups about health plans and their vendors charging fees for electronic payments to physicians.

The guidance states that HIPAA electronic funds transfer (EFT) and electronic remittance advice (ERA) standards permit health plans to pay claims by virtual credit card (VCC), which may include fees that aren't subject to Health and Human Services' regulations.

However, the guidance also affirms that health plans cannot force physicians to receive claims payment by VCC and accept the associated fees. If physicians or other health care providers request electronic claims payment via other (fee-free) means, the plan must comply.

The guidance also says health plans may not require physicians to deal with a specific vendor to receive electronic payments. While the CMS guidance does not specifically address the appropriateness of fees levied by some health plan vendors, it does show that practices may be able to avoid interacting with vendors that charge fees. The agency advises physicians to be aware of any agreements they have with health plans related to claims payment terms.

If you believe a health plan has failed to comply with any of the adopted standards or operating rules, you may file a complaint with CMS through the Administrative Simplification Enforcement Testing Tool located at: https://asett.cms.gov/ASETT_HomePage

Questions about this latest guidance or other topics related to EFT or ERA standards and operating rules should be sent to: AdministrativeSimplification@cms.hhs.gov with the subject line: EFT ERA Guidance Question.

For more information, please visit the CMS Administrative Simplification website. https://www.cms.gov/regulations-guidance/administrative-simplification

MIPS Update

CMS Now Accepting 2022 MIPS Extreme and Uncontrollable Circumstances Exception and MIPS Promoting Interoperability Performance Category Hardship Exception Applications

The MIPS Extreme and Uncontrollable Circumstances Exception and MIPS Promoting Interoperability Performance Category Hardship Exception applications are now open for the 2022 performance year. Applications can be submitted until 8 p.m. ET December 31, 2022.

Extreme and Uncontrollable Circumstances

MIPS eligible clinicians, groups, and virtual groups may apply to reweight any or all MIPS performance categories if they've been affected by extreme and uncontrollable circumstances.

NOTE: CMS continues to use its extreme and uncontrollable circumstances policy to allow clinicians, groups, virtual groups, and APM Entities to submit an application requesting reweighting of performance categories for the 2022 performance year due to the COVID-19 public health emergency.

Promoting Interoperability Applications

MIPS eligible clinicians, groups, and virtual groups may apply to reweight the Promoting Interoperability performance category to 0% if they:

- have decertified EHR technology;
- have insufficient Internet connectivity;
- face extreme and uncontrollable circumstances such as disaster, practice closure, severe financial distress, or vendor issues; or
- lack control over the availability of certified EHR technology (CEHRT); simply lacking the required CEHRT doesn't qualify you for reweighting.

NOTE: You don't need to apply for this application if you qualify for automatic reweighting of the Promoting Interoperability performance category based on your clinician type or special status (e.g., Hospitalists).

REMINDERS:

- As a reminder, small practices qualify for automatic reweighting beginning with the 2022 performance year.
- Must have a HCQIS Access Roles and Profile (HARP) account to complete and submit an exception application on behalf of yourself, or another MIPS eligible clinician, group, virtual group or APM Entity.

MEDICARE NEWS

Medicare Cards Without Full Names

Please share with staff: due to a character limit, some Medicare cards don't display patients' full names. According to section 10.2 of the Medicare Claims Processing Manual, Chapter 26, you should, "Enter the patient's last name, first name, and middle initial, if any, as shown on the patient's Medicare card."

Your claims will still process using the name displayed on the patient's Medicare card, even if it isn't their full name.

DRS New Address:

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Phoenix, AZ 85029
602.439.6780

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