2020 3rd Quarter Newsletter

active MANAGEMENT
Practice Management, Medical Billing & Consulting
Maximizing Your Office Potential

E&M Changes for 2021

This includes many revised E/M codes and 99201 is deleted.

99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

E&M Changes for 2021

99354	Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service; first hour (List separately in addition to code for outpatient Evaluation and Management or psychotherapy service, except with office or other outpatient services [99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215])
99355	Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)
99356	Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient or observation Evaluation and Management service)
99415	Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service)
99416	Prolonged clinical staff service (the service beyond the highest time in the range of total time of the service) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (List separately in addition to code for prolonged service)

99487	Complex chronic care management services with the following required elements: multiple (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/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; first 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.
99489	Complex chronic care management services with the following required elements: multiple (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/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored, moderate or high complexity medical decision making; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
99490	Chronic care management services with the following required elements: multiple (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/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

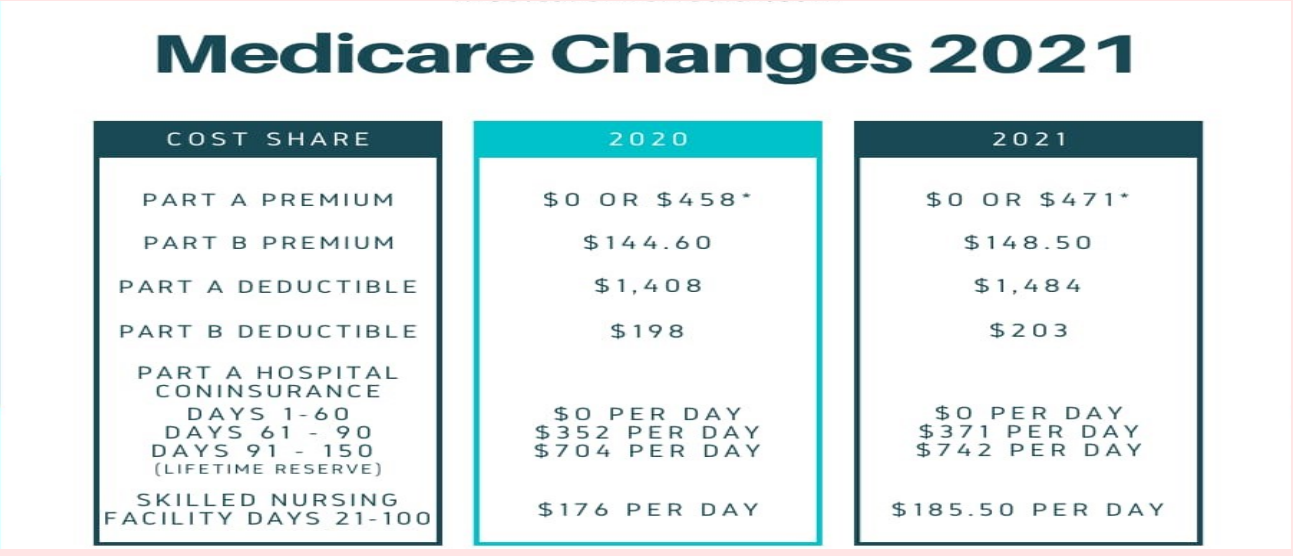
CMS Announces the 2021 Medicare Part B Deductible

On November 6, 2020 the Centers for Medicare & Medicaid Services (CMS) released the 2020 premiums, deductibles, and coinsurance amounts for the Medicare Part A and Part B programs.

Medicare Part B Deductible

For 2021, the annual deductible for all Medicare Part B beneficiaries is **$203**, an increase of $5 from the annual deductible of $198 in 2020.

The increase in the Part B premiums and deductible is largely due to rising spending on physician-administered drugs. These higher costs have a ripple effect and result in higher Part B premiums and deductible.



Public Health Emergency

Health and Human Services Secretary Alex Azar has once again renewed the public health emergency (PHE) for the coronavirus pandemic (COVID-19). Originally set to have expired Oct. 23, the PHE is now set to expire Jan. 21, 2021 — one year after declaring a PHE for COVID-19 in the United States.

The renewal has many implications, including the effect on healthcare coverage. AAPC recently reported that many insurance companies had already stopped gratuitous coverage for services nonrelated to COVID-19, and were gearing up to end coverage of expanded telehealth services on either Oct. 25 or Dec. 31.

With the PHE now extended another 90 days, payers will likely follow suit and update their coverage policies accordingly. (Please check with individual payers)

Implication of PHE on Telehealth Waiver

Section 1135 waivers are set to continue for however long the PHE for COVID-19 lasts. These freedoms permitted the Centers for Medicare & Medicaid Services (CMS) to, among other things, expand the types of healthcare professionals who can furnish distant site telehealth services and to add coverage for audio-only telehealth for certain services.

RFC Denials-Bundling

Podiatrists in the New York Area have been seeing more denials from MCR Advantage and Commercial payors for the 1105X and 117XX

CMS says you can bill CPT code 1105X with code 117XX as long as the two procedures are performed on different toes and/or different parts of the foot. The two codes are bundled, but you can use modifier 59 as evidence of the distinct procedure.

This means that if you are paring a callus on the right great toe near the nail area (1105X), you can report 117XX with a modifier 59 if you are debriding the right second and third toes. But if you are paring a corn/callus of the right great toe near the nail area and also debriding that great toe nail, you can only report the column-one code [1105X].

The claim must be appealed with documentation proving the validity of the 59 modifier. It is crucial that your notes clearly document the toes debrided and the location of corns and callouses.

From a coding perspective:

⇒ Providers are correctly linking diagnosis codes to substantiate separate payment, along with use of modifier -59 or the -X[EPSU] modifiers

⇒ Blue Cross is only reimbursing one of the two procedures under routine circumstances, with no resolution/adjustment for the denial when contacting customer service

⇒ In addition, if an E&M code (office, home, assisted living facility, etc) is billed along with the routine foot care procedures, that code may be denied as bundled as well, even with a distinct CC/diagnosis unrelated to RFC and use of modifier -25

⇒ Appeals, even if they have documentation that clearly substantiate that services are not mutually exclusive in one way or another, are largely unsuccessful and denials are being upheld

RFC Denials-Bundling-Cont'd

⇒ Medical policies from Empire do not specify any special processing rules, coding requirements, or other unique circumstances, so it could be reasonably inferred that the carrier is following Medicare guidelines, which reimburse these services with no issues

This has not only been an issue limited to Empire Blue Cross, but has been a problem with other Medicare Advantage plans, such as Amerigroup (owned by Anthem BC/BS), Humana, United Healthcare, and other Blue Cross carriers outside of the downstate New York region, such as Excellus BC/BS.

The NYSPMA insurance committee, and legal department and billing and coding advisor are working together to have this addressed and resolved.

Emblem Health/GHI Update

See references below:

As of July 1st, 2020 GHI members who are current or retired employees of the city of New York were issued new ID cards with an updated ID format.

Traditionally, ID cards were nine digits (starting with 930, 931 or 932), or the patient's social security number. All claims on or after this date will have to be submitted with the new "K-ID" number in order to be processed correctly. The new format will be the letter "K", following eight digits- if the patient has a covered spouse or dependent on their policy, there will also be a relationship suffix of -01, -02, -03, etc.

If a patient does not have their current ID card at the time of service, benefits can be verified on the Emblem Health website or automated system to obtain the current ID for billing.

For your reference, see link below:

(https://www.emblemhealth.com/providers/resources/provider-articles/New-ID-Numbers-and-Cards-for-GHI-PPO-City-of-NY-Members-Coming-in-July)

EmblemHealth-New Claims Payment & Remittance

On Aug. 19, 2020, implemented a new claims payment and remittance (CPR) service powered by ECHO Health, Inc. (ECHO) for:

⇒ Group Health Incorporated (GHI)

⇒ Health Insurance Plan of Greater New York (HIP)

⇒ HIP Insurance Company of New York (HIPIC) followed on Sept. 2, 2020

This service will expand the EmblemHealth claims payment and remittance delivery options available to you

⇒ If you were receiving ERAs/EFTs through PNC remittance advantage, your payment preferences would be migrated to Echo Health

⇒ If you were receiving paper checks, they have been replaced by virtual credit cards

⇒ Providers can enroll with Echo Health and update their payment and EOB preferences at any time if they were not previously enrolled with PNC remittance advantage

⇒ There is no fee for using Echo Health for EFTs and ERAs from Emblem Health- the third party does offer additional services for providers, but are not required in order to get payment information from the insurance

See links below for FAQ sheet and Provider letter that was sent out:

Nov 4 2020 Lecture\49539 How Do I_ECHO_FAQS_AfterJILL_Abbreviated for Newsletter_8-20-2020.pdf

Nov 4 2020 Lecture\49539 PNC Echo Provider Letter_FINAL_7-3-2020.pdf

EmblemHealth-Secondary Plan

Many Medicare beneficiaries in the New York Metro area are retired public employees that have Emblem Health secondary to cover their Medicare co-insurance at 100% with no patient responsibility.

When Medicare claims were processed, they were incorrectly auto-crossed to Empire Blue Cross (which handles the hospital benefits for retired NYC employees).

Blue Cross denied secondary claims as non-covered services, which may have led to some patients being balance billed incorrectly because providers thought the denials were coming from Emblem Health, or leaving secondary balances aging on a practice's A/R.

To be reimbursed for the outstanding co-insurance, secondary claims simply need to be resubmitted to Emblem Health with the Medicare EOB.

Keep in mind, if a claim needs to be resubmitted and the DOS is on or after July 1st, the secondary claim needs to be submitted with the updated "K-ID".

NYSHIP-Orthotics Coverage

- ⇒ Prostheses and Orthotic Devices – Covered for one prosthesis and/or orthotic device per affected body part meeting an individual's functional needs
- ⇒ No copayment for the prosthesis and/or orthotic device when using a participating provider
- ⇒ Replacements, when functionally necessary, are also covered
- ⇒ An orthotic device used to support, align, prevent or correct deformities or to improve the function of the foot is covered only when it is medically necessary and custom made

CPT 99072

CPT code 99072 is a new practice expense code that describes the additional supplies and clinical staff time providers are using to stop the spread of the novel coronavirus while still providing safe in-person visits. The code should only be used during a declared public health emergency and is different from code 99070, which is typically reported for supplies and materials that may be provided to patients during a normal office visit.

CPT code 99072 should be reported only once per in-person visits per provider identification number (PIN), regardless of the number of services performed during the visit.

AMA also noted that it has submitted recommendations to CMS to "inform payment" of the new CPT code.

What Insurers Are Covering the 99072?

Documentation requirements for 99072 will vary among insurers, so be sure to check with your top payers for their specific policy. Your documentation must include information that supports the requirements for 99072. Include a statement that notes "Due to COVID-19 …" and then document what steps you took or supplies you used.

Since this code is so new, it's tough to predict its prospects for payment. First, you'll have to manually upload the new CPT code to your system — and it may take payers some time to update their own systems and policies. To avoid claim denials, it's always wise to confirm with your payers if they are accepting 99072 yet, and if not, when you can expect it.

Some third-party payers have and will reimburse providers for this new CPT code, others won't. CMS announced on October 27 it has assigned CPT 99072 procedure status "B." Status "B" means:

CPT 99072-Cont'd

- ⇒ there are no RVUs for this code;
- ⇒ CMS considers it to be bundled with whatever service was provided that day;
- ⇒ CMS' contractors will not pay for this service;
- ⇒ providers may not bill the beneficiary for this service; and
- ⇒ issuing an Advanced Beneficiary Notice related to this service is not an option
- ⇒ some payers are bundling the charge with other covered services that are billed (Blue Cross, The Empire Plan, Oxford, UnitedHealthcare)

CMS ISSUES ABN UPDATE

A new Fee-for-Service Advanced Beneficiary Notification of Non-coverage (ABN) form is now effective, with an expiration date of June 30, 2023. The use of the old ABN (version 03/2020) will be considered **invalid after Aug. 31, 2020.**

What's Changed in the ABN?

⇒ Guidelines for dual eligible beneficiaries (patients with both Medicare and Medicaid coverage) have been added to the ABN form instructions.

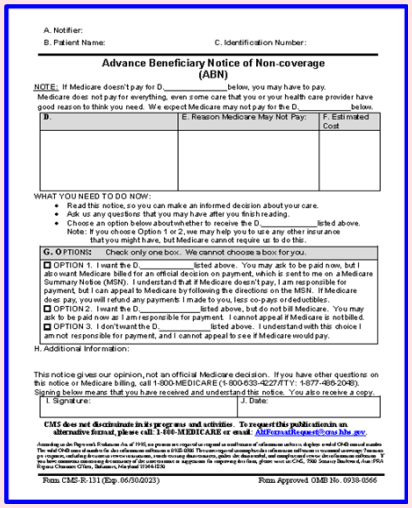
⇒ The changes were necessary to comply with billing prohibitions for patients in a Qualified Medicare Beneficiary (QMB) program.

⇒ The QMB program helps pay Part A, Part B, or both program premiums, deductibles, coinsurance, and copayments.

See links below for English and Spanish versions:

Nov 4 2020 Lecture\ABN English 2023.pdf

Nov 4 2020 Lecture\ABN Spanish 2023.pdf



A. Notifier:
B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D._____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D._____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D._____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ OPTION 1. I want the D._____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐ OPTION 2. I want the D._____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
☐ OPTION 3. I don't want the D._____ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call 1-800-MEDICARE or email ABNoticeRequest@cms.hhs.gov.

Form CMS-R-131 (Exp. 06/30/2023) Form Approved OMB No. 0938-0566

Stay Tuned For More Updates……