September 28, 2020 | Volume 34, Issue 37

Part B News
partbnews.com

COLLECT EVERY DOLLAR
YOUR PRACTICE DESERVES

In this issue

DecisionHealth
a Simplify Compliance brand

Practice management

Flu season plus COVID-19 'twindemic' could get rough; push shots early and hard

COVID-19 complicates your flu season immunization picture, but experts say it may become an opening that not only gets more patients interested in having their shots, but also gets them to receive other needed care.

The CDC considers fall and winter to be flu season, though the agency recommends getting a flu vaccination in September or October. Americans have in recent years been getting better about receiving flu shots. In its most recent "Early-Season Flu Vaccination Coverage" report from November 2018, the CDC says that "flu vaccination coverage among adults aged ≥18 years was 44.9%, an increase of 6.4 percentage points compared with the same time period last flu season."

In a Sept. 16 press release, CMS outlined "new resources" for providers, referring to its Flu Vaccine Partner Toolkit. HHS has noted, though, the increased role of non-traditional providers in delivering the shots; in an August amendment to its COVID-19 extensions of pharmacists' authority to administer immunizations, CMS noted that pharmacists "already play a significant role in annual influenza vaccination. In the early 2018-19 season, they administered the influenza vaccine to nearly a third of all adults who received the vaccine."

A run on shots?

The COVID-19 public health emergency has some experts worried that patients, spooked by general uncertainty about the safety of doctors' offices, might react to the flu season in ways that could stress your practice. For example, the emergence of COVID-19 will have patients who are experiencing

even modest respiratory symptoms more on edge than usual and eager to get to the doctor.

"We face a double whammy of two viral pathogens circulating at the same time that can both mimic each other's symptoms and intensify each other's morbidity and mortality," says Richard Parker, M.D., chief medical officer of Arcadia, a medical software company in Burlington, Mass. "Physicians are preparing for the onslaught of calls from patients with fever, cough and body aches who are unsure whether they have the flu, COVID-19, both or some other circulating virus. This anticipated surge of flu-like illness is likely to severely strain already fatigued health care workers and their facilities."

The situation might also encourage people who may have been lax about immunizations in the past to come forward, says Edmond Baker, M.D., medical director for complex care at Equality Health, a whole health delivery system in Phoenix, Ariz.

"There's a group of patients who are used to [getting shots] — those with chronic illnesses, the older population," Baker says. "It's the other group of patients that have always been difficult — the younger, never-been-sick crowd."

But with COVID-19, "it seems everyone knows somebody who's had it," Baker adds. "Even if they got better, they know how serious it could be. So some of these patients are even coming to us asking for the flu shot."

You have to prepare for higher-than-normal demand, says Julita Mir, M.D., chief medical officer of Community Care Cooperative (C3), an accountable care organization (ACO) created by federally qualified health centers (FQHC) serving low-income communities in the greater Boston area. "We hear in the communities we serve that individuals really want to get the flu shot this year, and they want to get it earlier," Mir says.

Let them in

Given the potential for a run on vaccinations and related care, and with pharmacies and urgent care centers doing more shots, some practices may consider soft-pedaling their flu shot practice and letting other providers pick up the slack. But experts think a potential "twindemic" of flu and COVID-19 demands an all-hands-on-deck approach from providers.

"To layer a bad flu season on top of the pandemic, which many experts expect could worsen this winter, would be catastrophic in some communities," says Lisa Doggett, M.D., senior medical director at HGS/AxisPoint Health, a population health management company in Westminster, Colo.

Also, this is an opportunity for you to meet patients who have been avoiding medical treatment and bring them into the continuum of care. "You're not going to make money off this, but you will be able to engage patients, talk to them, take their history and find out what's really going on with them," Baker says.

Simplify Compliance
Learn, Comply, Succeed

SUBSCRIBER INFORMATION

Have questions on a story? Call or email us.

***PART B NEWS* TEAM**

Maria Tsigas, x6023
Product Director, Information, Print Subscription Products and Services
mtsigas@decisionhealth.com

Marci Geipe, x6022
Senior Manager, Product and Content
mgeipe@simplifycompliance.com

Steven Andrews, x3171
Managing Editor, Coding
sandrews@hcpro.com

Richard Scott, 267-758-2404
Associate Content Manager
rscott@decisionhealth.com

Roy Edroso, x6031
Editor
redroso@decisionhealth.com

Medical Practice & Hospital community!
www.facebook.com/DecisionHealthPAC
www.twitter.com/DH_MedPractice
www.linkedin.com/groups/12003710

SUBSCRIPTIONS
Direct questions about newsletter delivery and account status, toll free, to 1-855-CALL-DH1 or email: customer@decisionhealth.com

DECISIONHEALTH PLEDGE OF INDEPENDENCE:
Part B News works for only you, the provider. We are not affiliated with any special interest groups, nor owned by any entity with a conflicting stake in the health care industry. For nearly three decades, we've been independently watching out for the financial health of health care providers and we'll be there for you and your peers for decades to come.

CONNECT WITH US
Visit us online at: www.partbnews.com.

CEUS
Direct questions about newsletter delivery and account status, toll free, to 1-855-CALL-DH1 or email customer@decisionhealth.com.

ADVERTISING
To inquire about advertising in *Part B News*, call 1-855-CALL-DH1.

Part B News® is a registered trademark of DecisionHealth. Part B News is published 48 times/year by DecisionHealth, 100 Winners Circle, Suite 300, Brentwood, TN 37027. ISSN 0893-8121. pbncustomer@decisionhealth.com Price: $647/year.

DecisionHealth
a Simplify Compliance brand

5 flu shot promo ideas

- **Curb service.** Some providers have opted for new kinds of outreach to get patients in the door — or at least to the parking lot. WSYR-TV in western New York reports that a Wegman's in Liverpool, N.Y., taking a page from curbside COVID-19 testing, is offering patients a "flu shot from the comfort of your car from 10 a.m. until 3 p.m." Baylor, Scott & White Pediatrics in San Antonio, Texas is doing something similar, according to news reports.
- **Education as outreach.** Adding the immunization message to your other medical discussions can help, too, Baker advises. As part of his COVID-19 intervention in the African-American community, Baker has been doing webinars such as the recent "Surviving the Pandemic" series in association with the Black AZ COVID-19 Task Force. He said this has gotten people interested in other health interventions, including flu shots.

"We had large group of people that watched [the webinars] and became engaged through that fashion," Baker says. When viewers got in touch with Baker or the clinic afterward, they began talking about their other concerns, including the flu. The entry to the subject can come from anywhere. For example, Baker recalls a recent encounter involving a discussion of colon cancer. "I approached it from the vantage point of screening," he says. "In that screening talk, I also talked about flu shots — all those other things which help improve overall population health."

Baker says the message gets through by repetition in a variety of forums. "The more they see it, the more they understand," he says. "It's like advertising on TV. You see enough of hamburgers on TV, pretty soon vegans are going to want a hamburger, too."

- **360-degree advertising.** Speaking of advertising, Mir's C3 uses every available medium — social media, Facebook pages, websites, patient portals — to advertise the importance of flu shots, with emphasis on reaching the high-risk patients that especially need it, such as pregnant and immunocompromised persons. The focus is on the shots, not necessarily on C3. "We're saying, 'Come and get it done with us, but if it's easier for you to go to your local pharmacy, go ahead and use that facility,'" Mir says. "Whatever is most convenient for them."
- **Intake protocol.** Doggett suggests pitching shots to every patient who approaches the practice. "While contacting patients to remind them of the importance of flu vaccination will not be feasible for many practices, messaging can be added to the practice's phone greeting, website and appropriate social media to remind patients to get vaccinated," she says. "Staff, including those answering the phones, can be trained as well to take every opportunity to promote vaccination."
- **Lean on telehealth.** You don't want a flood of coughing, sneezing patients in your waiting room, and neither do your visitors. COVID-19 has increased practices' and patients' social distancing awareness and made telehealth interventions more common and accepted. Rakhee Langer, Healow business lead at eClinicalWorks in Westborough, Mass., suggests text triage that gets patients to affirm that they're asymptomatic not only at the time of appointment, but also in the days before, to make sure their status hasn't changed. If the patient evinces any symptoms, Langer adds, it's a time-out and telehealth appointment to discuss next steps.

— Roy Edroso (redroso@decisionhealth.com) ■

RESOURCES

- Flu Vaccine Partner Toolkit: https://www.cms.gov/outreach-education/partner-resources/flu-vaccine-partner-toolkit
- Third Amendment to Declaration Under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID–19: www.hhs.gov/sites/default/files/third-amendment-declaration.pdf
- Early-Season Flu Vaccination Coverage–United States, November 2018: www.cdc.gov/flu/fluvaxview/nifs-estimates-nov2018.htm

Correct Coding Initiative

Next NCCI edit update will revive thousands of code pairs, reset MUEs

Prepare your practice: CMS will roll back many of the National Correct Coding Initiative (NCCI) edits that it temporarily extended during the COVID-19 public health emergency (PHE) and add a few hundred more. But the latest quarterly update, effective Oct. 1, it doesn't spell the end of all health emergency-related flexibilities.

The next procedure-to-procedure (PTP) update contains 291,274 added edit pairs. The off-schedule NCCI update released April 7, which was retroactive to Jan. 1, contained 291,903 edits, which indicates that some of the edits are still on hold. The medically unlikely edit (MUE) update contains 218 revised edits, including changes that were suspended in April and restored with higher than normal values in July.

CCI version 26.3 scorecard

Changes effective Oct. 1, 2020. (For more on CCI version 26.3 edits, see related story, p. 3.)

Code range	CCI code pairs added	CCI code pairs deleted	MUEs added	MUEs deleted	MUEs revised
0001T — 0999T	4,784	0	0	0	0
00000 — 09999	20,747	0	0	0	0
10000 — 19999	14,983	0	0	0	0
20000 — 29999	65,398	1	0	0	0
30000 — 39999	40,789	10	0	0	1
40000 — 49999	33,667	0	0	0	0
50000 — 59999	29,811	1	0	0	0
60000 — 69999	34,507	0	0	0	0
70000 — 79999	6,080	1	0	0	1
80000 — 89999	0	0	1	0	4
90000 — 99999	34,454	0	0	0	169
A0000 — V9999	6,054	703	6	5	41
Totals	291,274	716	7	5	216

Note: Code range is based on the comprehensive code of the edit.
Source: Part B News *analysis of CCI version 26.3 changes.*

"We all knew the day of reckoning was coming," says Devona Slater, president, Auditing for Compliance and Education, Overland Park, Kan.

Based on *Part B News* analysis, here are the highlights that will affect practices:

- **More than 20,000 anesthesia edits are back.** The PTP edits that bundle a wide range of E/M visits into anesthesia services performed on the same patient and the same day will return. The E/M visits will include office visits (**99201-99215**), initial inpatient hospital visits (**99221-99223**) and emergency department services (**99281-99285**), as well as telehealth consults for initial encounters (**G0425-G0427**), follow-up encounters (**G0406-G0408**) and critical care encounters (**G0508-G0509**). The edits will still have a modifier indicator of '0,' which means the edits cannot be broken with a modifier.
- **Procedures re-incorporate E/M visits.** Modifier **25** (Significant, separately identifiable E/M by the same physician or other qualified health care professional on the same day of the procedure or other service) will be back on your radar thanks to the return of thousands of edits that bundle E/M codes in to procedure codes. Many of the edits have a modifier indicator of '1,' which will allow you to break the pair by appending modifier 25 to the E/M code when appropriate.
- **Online E/M edits turned on.** Edit pairs that bundle office and other E/M visits into online E/M services (**99421-99423**) are back in the NCCI code set with a modifier indicator of 0. Previously, the pairs had a not applicable/deleted modifier indicator of '9.'

MUEs back at full strength

The Oct. 1 update will reset the MUEs for most E/M services to pre-PHE levels. You will no longer be able to report multiple units of the same service including office visits for the same patient on the same day and the restoration of a modifier adjudication indicator of 2 will make it impossible to appeal denials.

- **Telephone E/M exception.** Telephone codes **99441-99443** will have an MUE of 1 under the new update. Prior to the health emergency exceptions, the codes had an MUE of 0. If your clinicians have gotten into the habit of holding multiple calls with a patient on a single day, remind them they will be limited to one unit of the time-based code per day.

What to tell your staff

Emphasize that the NCCI changes do not spell the end of other PHE waivers that CMS and other agencies have put in place. However, they should be prepared for changes if the PHE is not renewed at the end of October.

(*continued on p. 6*)

Benchmark of the week

Flu vaccine code 90662 leads pack; watch specs on your codes to avoid denials

Both utilization and denial rates fluctuate wildly among different flu vaccines paid for by Medicare, and the differences remain stark even among places of service.

Not much has changed in recent years when it comes to vaccine administration rates among Medicare Part B beneficiaries. As measured by use of **G0008** (Administration of influenza virus), overall rates were at normal levels in 2018, after a slightly dip in 2017, according to the latest available Medicare claims data (*PBN 2/20/20*). But this still means only 45% of the Medicare population was getting vaccinated.

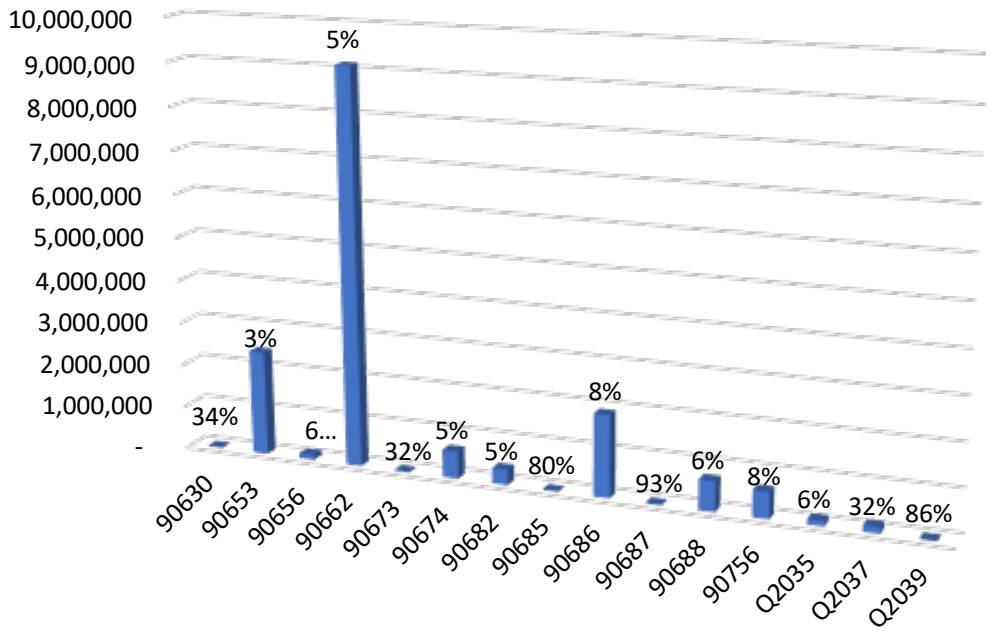
Denials sometimes result from inappropriate use of a specific vaccine. In the past, providers have seen claims denied because they were put in for dates on which a vaccine was not yet authorized for payment or because they were only to be used for children but were billed for adults (*PBN 10/31/16*).

In 2018, Fluzone High-Dose Quadrivalent, billed with **90662**, was by far the most used flu vaccine under Part B, and denials were rare. According to the CDC, the 90662 vaccine is licensed only for patients over 65. On the other hand, Fluzone Quadrivalent, billed in 2017-2018 with **90687** and massively denied, was specified for patients 6 months through 35 months old.

The only two places of service (POS) billed with these vaccine codes that had significant numbers in 2018 are office (11) and mass immunization center (60), billed roughly 8 million and 7.8 million times, respectively. It's a long drop from there to the third-highest POS, state or local public health clinic (71), with 103,890 claims. Surprisingly, given trends in drugstore immunization, urgent care centers (20) barely registered.

Year-on-year price changes on vaccine tend to be modest, around a buck and change (*PBN 9/28/15*). Note, however, the new payment allowance for Fluzone High-Dose Quadrivalent is $60.98; the year before it was $56.01. The only new code in the list is **90694** (Fluad quadrivalent). – *Roy Edroso* (*redroso@decisionhealth.com*)

Flu vaccine code claims, 2018, with denial rates



Source: Part B News *analysis of Medicare claims data*

(*continued from p. 4*)

For example, CMS intends to keep its COVID-19 flexibilities in place until the end of the year if the emergency declaration expires in October, according to the proposed 2021 Medicare physician fee schedule. But the HHS Office for Civil Rights (OCR) will have to decide if it will maintain the HIPAA flexibilities that allow practices to use internet platforms such as Skype, FaceTime or Google Hangouts to perform telehealth services. — *Julia Kyles, CPC (jkyles@decisionhealth.com)* ■

2021 E/M changes

E/M coding scenario: Work out new MDM rules for a 99214 encounter

For the first time in more than two decades, the E/M office visit code set (**99202-99215**) is subject to a coding and documentation overhaul. Starting Jan. 1, 2021, you'll find that previously vital components of code level selection — namely, the history and exam components — no longer factor into your level of decision-making. Instead, determining a level of service will come down to one of two components: Medical decision-making (MDM) or time.

The following coding scenario, adapted from the *2021 E/M Office Visit Reference Guide*, a DecisionHealth publication, provides a closer look at the new MDM guidelines that will dictate code choice in 2021. This scenario portrays a patient encounter that would lead to a 99214 visit next year.

Scenario

Multiple stable chronic illnesses follow up

Provider documentation

Visit Type:

Established

Chief Complaint:

Patient presents today for follow up of DM, COPD and HTN

History of Present Illness:

54-year-old female who has been compliant with her medication and diet for several years for DM, COPD and HTN. She comes in for her six-month checkup and medication management. She continues to follow Weight Watchers' diet, walks every morning, and feels great.

Her recent lab work was reviewed and her cardiac profile and hemoglobin A1c are in acceptable ranges.

Review of Systems:

- Constitutional: Denies: Fever
- Eyes: Denies: Blurred vision
- Ears, nose, mouth, throat: Denies: Hearing loss
- Cardiovascular: Denies: Chest pain
- Respiratory: Denies: Cough, Shortness of breath
- Gastrointestinal: Denies: Abdominal pain
- Genitourinary (male): Denies: Dysuria
- Musculoskeletal: Denies: Back pain
- Integumentary (male): Denies: Rash
- Neurologic: Denies: Headache
- All Other Systems: Reviewed and negative

Past Medical History:

Hypothyroidism, CAD

Family History:

Noncontributory

Social History:

Patient has never smoked. She lives alone.

Exam:

- Vital signs: Temperature 98.5, Height 63 in Weight 152 lb, BP 128/72
- Constitutional: Appears stated age, this is a woman in moderate distress.
- Eyes: conjunctivae clear, eyelids normal and palpebral fissures equal.
- ENMT: Lips appear normal and healthy. Gums, normal. Palate, normal in appearance. Oro- pharynx: normal. Oral mucosa, normal with no thrush. Tongue is normal.
- Respiratory: wheezing, rales noted. Weak respiratory effort.
- Skin: dry, no lesions noted. Slightly dehydrated.

Assessment:

- DM, stable. Continue insulin, metformin and diet.
- COPD, asymptomatic, continue current medications.
- Hypertension: Metoprolol, cardiovascular exercise.

Time spent:

15 minutes

Coding

Number and complexity of problems addressed:

3 chronic, stable conditions: Moderate

Amount and/or complexity of data to be reviewed and analyzed:

2 laboratory tests: Limited

Risk of complications and/or morbidity or mortality of patient management:

Prescription management: Moderate

Level of MDM based on 2 out of 3 elements of MDM:

Moderate

Code:

99214

Rationale:

Level of service is based on MDM.

Bonus Tip:

The E/M service level is chosen either by the level of MDM performed or by the total time spent performing the service on the day of the encounter, whichever is more advantageous to the provider. In this visit, the time statement of 15 minutes supports 99212, and the complexity of MDM supports 99214. ■

Editor's note: You'll find dozens of scenarios and in-depth details of the coming code changes in the *2021 E/M Office Visit Reference Guide*. Learn more: www.codingbooks.com/products/coding-books/procedural-coding-cpt/2021-em-office-visit.

Telehealth

High-profile taskforce urges CMS to retain telehealth changes, add HIPAA enforcement

In a show of unity by major telehealth advocates, a Taskforce on Telehealth Policy released a series of advocacy proposals Sept. 15 that call for the retention of the major telehealth flexibilities that providers have enjoyed since the start of the COVID-19 public health emergency (PHE) in March.

The Taskforce, convened by the National Committee for Quality Assurance (NCQA), the Alliance for Connected Care and the American Telemedicine Association (ATA), reports that, under the PHE flexibilities, the "virtually unfettered availability of telehealth has not resulted in excess cost or utilization increases, even as supply and demand for in-person care has rebounded."

The advocacy group, which includes input from health policy luminaries such as former CMS chief medical officer Kate Goodrich, M.D., further reported that the PHE flexibilities have reduced broken appointments, increased use of transitional care management services, and helped skilled nursing facilities in situations that would otherwise require "costly ambulance trips to hospitals and emergency departments."

Further, they found no significant negative effects patient safety and program integrity, and improvements in data flow and care coordination. However, the Taskforce found that there was an uptake in mental

health utilization, possibly owing to a "lessening of social stigmas," that might have added to costs.

For these reasons the Taskforce calls on HHS to keep its major PHE flexibilities, including those regarding geographic restrictions, originating sites, provider eligibility, waivers of prior in-person encounter requirements and restrictions on telehealth across state lines. They also call for HHS to "fully reinstate enforcement" of HIPAA, which has been largely suspended under the PHE, and they offer "strong, but not unanimous, support for permanently lifting all controlled substance prescribing restrictions in telehealth."

The Taskforce also recommends that CMS set "clear data sharing standards and guidelines" that would "encourage integration of telehealth-related data and care records with all other patient information"; "pilot a patient experience survey linked to telehealth encounters"; allow audio-only telehealth "where evidence demonstrates it to be effective, safe and appropriate"; and expand use of remote patient monitoring (RPM). The Taskforce also called for funding for further studies of telehealth generally, and exploration of telehealth-based value-driven care models or "virtual medical homes."

In addition to Goodrich, the Taskforce includes former U.S. surgeon general Regina Benjamin, M.D.; director of CMS' Quality Measurement & Value Based Incentives Group Michelle Schreiber, M.D.; and officers of several health systems, insurers and industry groups, including AARP, Humana and America's Health Insurance Plans (AHIP). They also took recommendations from telehealth stakeholders in writing and via a virtual townhall. — *Roy Edroso (redroso@decisionhealth.com)* ■

RESOURCE

- Taskforce on Telehealth Policy: www.ncqa.org/programs/data-and-information-technology/telehealth/taskforce-on-telehealth-policy/

Coding

New set of COVID-19 ICD-10-CM codes proposed for Jan. 1 launch

Practices may have at least five new COVID-related diagnosis codes to use starting in January 2021, according to updates announced Sept. 9. The new codes would be in addition to the ICD-10-CM code and guideline changes set to take effect Oct. 1 this year.

In response to "multiple requests for related codes," the ICD-10 Coordination and Maintenance Committee announced that it was is considering adding three new Z codes to the code set:

- **Z11.52** (Encounter for screening for COVID-19), reported for people who are asymptomatic.
- **Z20.822** (Contact with and [suspected] exposure to COVID-19).
- **Z86.16** (Personal history of COVID-19).

A new J code would allow providers to report COVID-caused pneumonia with one code instead of two:

- **J12.82** (Pneumonia due to coronavirus disease 2019), which includes the inclusion terms, "Pneumonia due to COVID-19" and "Pneumonia due to 2019 novel coronavirus (SARS-CoV-2)."

The committee proposed the new combined coronavirus pneumonia code to "improve coding specificity for pneumonia due to coronavirus disease," the agency stated.

Existing coding guidance for COVID-related pneumonia instructs coders to report two diagnosis codes for the condition: **U07.1** (COVID-19) and **J20.89** (Other viral pneumonia).

However, the committee said it needed to draft the combined code J12.82 after an investigation of CMS data showed that using two codes "may substantially under-record pneumonia-related COVID-19, with more than 50% of recorded COVID-19 cases having had 'other viral pneumonia' recorded."

A new M code would report multisystem inflammatory syndrome that has been associated with COVID-19, particularly in children:

- **M35.81** (Multisystem inflammatory syndrome).

Comments on the proposed changes are due Oct. 9.

Payer representatives who attended the virtual committee meeting, including those from America's Health Insurance Plans (AHIP) and Humana, welcomed the changes and said they would be ready to implement them Jan. 1.

David Berglund, M.D., a staff member on the ICD-10 Coordination and Maintenance Committee said the panel is committed to launching the codes sometime in January, and is shooting for a Jan. 1 implementation date. — *Laura Evans, CPC (levans@decisionhealth.com)* ■

RESOURCE

- ICD-10 Coordination and Maintenance Committee Meeting notes: www.cdc.gov/nchs/data/icd/Topic-packet-September-8-9.2020.pdf