OCTOBER 2021 | VOL. 2

REVENUE CYCLE MANAGEMENT

A UPA Billing Office Newsletter
upasolutions.com

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ICD-10 ANNUAL CODING UPDATES 2022

Effective 10-1-2021

159 New Codes
25 Deleted Codes
27 Revised Codes

New code highlights include ICD-10 U09.9 for "Post COVID-19 condition, unspecified" will be used for sequela of COVID-19, or associated symptoms or conditions that develop following a previous COVID-19 infection.This should be assigned as a secondary diagnosis code in additional to the appropriate code to report the associated symptom or condition, such as Multisystem inflammatory syndrome (MIS).

Code U09.9 should not be used to report manifestations of an active COVID-19 infection.

New & Revised Codes of Interest:

C56.3 Malignant neoplasm of bilateral ovaries
C79.63 Secondary malignant neoplasm of bilateral ovaries
C84.7A Anaplastic large cell lymphoma, ALK-negative, breast

D75.838 Other thrombocytosis
D75.839 Thrombocytosis, unspecified

F32.A Depression, unspecified

G44.86 Cervicogenic headache (Code also associated cervical spinal condition, if known)

G92.00-G92.05 NEW SUBCATEGORY Immune effector cell-associated neurotoxicity syndrome, (see code specifics for grade being reported.)

Coding Updates Continued on Pages 2-3

BlueCross BlueShield

BCBS See Page Four

I5A Non-ischemic myocardial injury (non-traumatic)

K22.81 Esophageal polyp
K22.82 Esophagogastric junction polyp
K22.89 Other specified disease of esophagus
K31.A0-K31.A29 NEW SUBCATEGORY Gastric intestinal metaplasia (see code specifics for sites and additional conditions being reported.)

L24.A0-L24.B3 NEW SUBCATEGORY for Irritant contact dermatitis (see code specifics for details of reporting cause of conditions.)

M45.A0-M45.AB NEW SUBCATEGORY Non-radiographic axial spondyloarthritis (see code specifics for the site being reported.)

M54.50-M54.59 NEW SUBCATEGORY Low Back Pain (see code specifics for the screened condition being reported.)

P00.82 Newborn affected by (positive) maternal group B streptococcus (GBS) colonization

P09.1-P09.9 NEW SUBCATEGORY Abnormal findings on neonatal screening (see codes specifics for the screened condition being reported.)

R05.1 Acute cough
R05.2 Subacute cough
R05.3 Chronic cough
R05.4 Cough syncope
R05.8 Other specified cough
R05.9 Cough, unspecified

R35.81 Nocturnal polyuria
R35.89 Other polyuria

R45.88 Non suicidal self-harm
R63.30 Feeding difficulties, unspecified
R63.31 Pediatric feeding disorder, acute
R63.32 Pediatric feeding disorder, chronic
R63.39 Other feeding difficulties

T40.711-T40.726 NEW SUBCATEGORY Poisoning by, Adverse Effect of Underdosing of Narcotics & Psychodysleptics (see codes specifics for the poisoning or adverse effect being reported.)

New codes to describe social determinates of health (SDOH):
Z55.5 Less than a high school diploma
Z58.6 Inadequate drinking-water supply
Z5900 Homelessness, unspecified
Z59.01 Sheltered homelessness
Z59.02 Unsheltered homelessness
Z59.41 Food insecurity
Z59.48 Other specified lack of adequate food
Z59.811 Housing instability, housed, with risk of homelessness
Z59.89 Other problems related to housing and economic circumstances
Z71.85 Encounter for immunization safety counseling
Z91.014 Allergy to mammalian meats
Z91.51 Personal history of suicidal behavior
Z91.52 Personal history of non-suicidal self-harm

Please note this is not an inclusive list of every ICD-10-CM update for 2021. UPA managed software; Intergy, Intergy EHR, and MedAptus will automatically be updated to reflect the code changes for ICD-10-CM. If you need updates to frequently used diagnosis code lists, please contact UPA Information Systems.

COVID-19 Vaccines:
On August 23, 2021, the FDA approved the first COVID-19 vaccine, Pfizer-BioNTech, for the prevention of COVID-19 disease in persons 16 years of age or older. This vaccine continues to be available under Emergency Authorized Use (EAU) for individuals age 12-15, and for the administration of a third vaccine dose in certain immunocompromised individuals. For more details on COVID-19 vaccination approval please visit the CDC or FDA websites.

The AMA has issued new HCPCS codes the administration of a third dose of the COVID-19 vaccines from Pfizer and Moderna.You can see the full AMA guidance, vaccine administration codes, and vaccine CPTs at the AMA website link: Find your COVID-19 Vaccine CPT® Codes | American Medical Association (ama-assn.org)

All COVID-19 vaccination providers must report vaccine inventory to Vaccines.gov daily. Also note, that while COVID-19 vaccines are being provided for free, the administration of the vaccine can be reported for reimbursement. At this time, most insurance plans are not requiring the CPT for the vaccine to be submitted, only the administration code and appropriate vaccine administration ICD-10 code, Z23. For payers that do require the vaccine code for reimbursement of the administration, please submit the appropriate code for COVID-19 vaccine with a $0 charge amount, since reimbursement is not expected for the vaccine furnished at no cost to the provider.

Reimbursement varies by payer, but up to $40 per dose administered may be available for participating providers. For more information on becoming a CDC COVID-19 Vaccination Program Provider, see the CDC website link: COVID-19 Vaccination Provider Requirements and Support | CDC

CMS Influenza Vaccine Reimbursement Rates:

Medicare has published their reimbursement rates for Part B Flu vaccines. The Annual Part B deductible and coinsurance rates do not apply for the flu vaccine when provided under Part B benefits for providers who accept assignment from CMS on the claim. Annual Influenza vaccine season rates are effective from August 1-July 31 of the following year and can be found HERE

Temporary Suspension of Tenncare PCP Assignment:

The Division of Tenncare released an updated memo on September 3, 2021, reinstating the suspension of Tenncare MCO PCP assignment requirements effective immediately, and until further notice.

No claims should be denied for PCP assignment until the requirement is reinstated. Any denials for PCP after July 31, 2021, should be reprocessed.

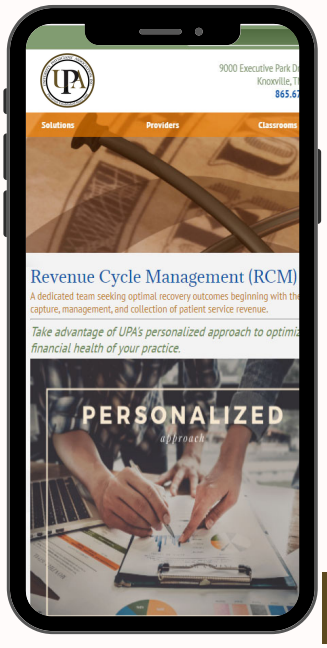
You can view the full memo from the Division of Tenncare HERE

Transitional Care Management Billing & Coding Reminders:

Transitional Care Management (TCM) services are reported for services provided for patients after a hospitalization or other inpatient facility stay (acute care hospital, long-term acute care hospital, skilled nursing facility/nursing facility, inpatient rehab facility, hospital observation status.)

The patient may be dealing with a medical crisis, new diagnosis, or change in medication therapy. Family physicians often manage their patients' transitional care from a facility back into their community.

- CPT 99495- Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge
- CPT 99496- Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge



Requirements for billing TCM Services:

- Obtain and review discharge information.
- Contact the patient or caregiver within two business days following a discharge. The contact may be via telephone, email, or face-to-face. Any attempts to communicate with the patient should continue after the first two attempts in the required business days until successful.
- Conduct a follow-up visit within 7 or 14 days (based on TCM code description) of discharge, depending on the complexity of medical decision making involved. The face-to-face visit is part of the TCM service and should not be reported separately. During COVID-19 pandemic some health plans may allow this service to be provided via telehealth.
- Medication reconciliation and management must be furnished no later than the date of the face-to-face visit.
- Review the need for diagnostic tests/treatments and/or follow up on pending diagnostic tests/treatments.
- Establish or re-establish referrals with community providers and services, assist in scheduling follow-up visits, when necessary.

Blue Cross Blue Shield Prior Authorization Requirements:

Lab-Based Sleep Studies for some BCBS of TN Commercial members with Networks P, S, L may require prior authorizations beginning October 1, 2021.Please be sure to verify benefits and prior authorization requirements.

Updated ASH Consent Form Instructions:

The Division of Tenncare has made updates to the Sterilization Consent Form FAQ and instructions for completing the Hysterectomy Acknowledgement Form. These charges were effective July 1, 2021. The revised documents can be found HERE

Retrospective ASH Reviews:

BCBS of TN announced that in late 2021, they will be performing retrospective ASH review which will include in-depth audits of selected claims submitted between July 2020 and June 2021.Documentation that was not required at the time the claims were submitted may be requested and reviewed.Payment recovered may be made for any claims that lack supporting documentation.

Risk Adjustment Coding for more than 12 Dx Codes:

If more than 12 actively managed Dx codes need reported for a Medicare Advantage risk adjustment contact, please do so by reporting CPT 99499 with the additional Dx codes above 12.This will ensure all actively managed conditions are reported to the contractor. For UPA Billing specific process questions, please email BillingUPA@utmck.edu for more details.

BlueCare Tennessee | BlueCare℠ TennCare*Select* CoverKids

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May 6, 2021

Important Update: Claim Billing Requirements for 340B Drug Pricing Providers

Dear Health Care Provider,

Thank you for caring for our BlueCare Tennessee and CoverKids members. We're writing to share important information about the 340B Drug Pricing Program and related Division of TennCare policy.

In March 2021, we sent you a letter about some changes related to billing and pricing for drugs obtained through the 340B Drug Pricing Program. Since then, the Division of TennCare has made several additional policy changes. Here's what you need to know.

Modifier Requirements Effective Dec. 1, 2021
Our previous notification said that participating 340B providers would need to use certain modifiers on all professional and facility claims for drugs administered in an office/outpatient setting beginning May 1, 2021. We noted that if the modifiers weren't used, drug services would be disallowed.

While we encourage you to begin using the appropriate modifiers effective May 1, 2021, we won't begin disallowing drugs administered in an office/outpatient setting until Dec. 1, 2021. Professional and facility claims with a date of service on or after Dec. 1 for drugs administered in an office/outpatient setting will **need to include one of these modifiers**:

- **JG** – Drug or biological acquired **with** the 340B drug pricing program discount for Medicare Part B drugs for TennCare dual-eligible members; **OR**
- **TB** – Drug or biological acquired **with** the 340B drug pricing program discount for Medicare Part B drugs for TennCare dual-eligible members (reported for informational purposes); **OR**
- **UD** – Drug or biological acquired **with** the 340B drug pricing program discount; **OR**
- **UC** – Drug or biological acquired **without** the 340B drug pricing program discount.

Effective Dec. 1, 2021, if a drug service is disallowed because a modifier isn't included on each applicable claim line, the line level denial will show:

- *Reason code 16 – Claim/Service lacks information or has submission/billing error(s).*
- *Remark code N822 – Missing procedure modifier(s).*

We encourage all claims to be submitted with defined 340B modifiers as soon as possible so that you can be ready for the Dec. 1, 2021 implementation. Please note that claims paid on a case rate or bundled payment are excluded from the modifier requirement.

340B Drug Ceiling Prices Update
The Division of TennCare will no longer be developing the TennCare 340B Quarterly Ceiling Price announced in our March letter. This means there will be **no** changes to the current reimbursement for drugs administered on an office/outpatient basis through the 340B Drug Pricing Program. If you have questions, please contact your Provider Network Manager.

Sincerely,

Your Provider Service Team