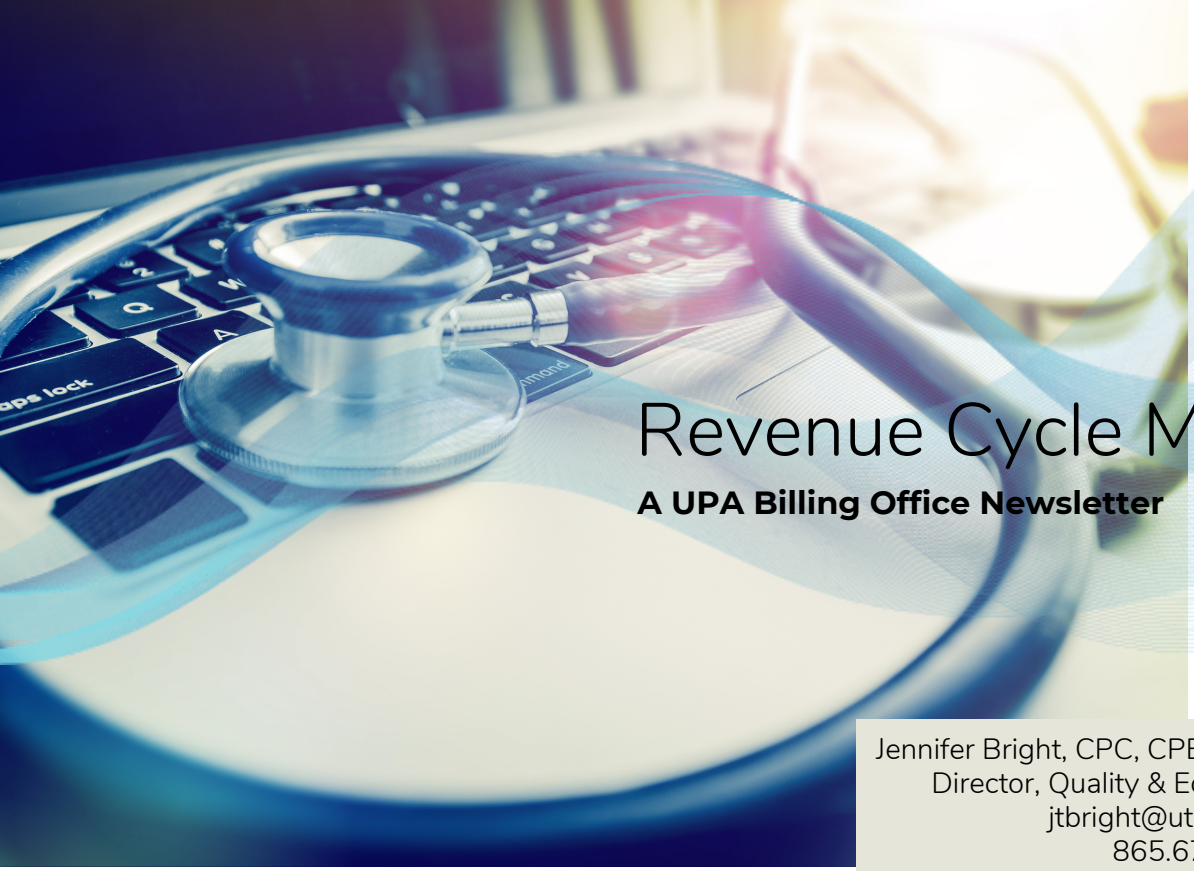

Revenue Cycle Management

A UPA Billing Office Newsletter

September 2023

Jennifer Bright, CPC, CPB, CPPM
Director, Quality & Education
jtbright@utmck.edu
865.670.6700

Reminders for Advanced Care Planning

Advanced Care Planning (ACP) continues to be a top denial in many practices due to bundling to another visit or for documentation, etc. In practices like palliative care, oncology, and primary care, there are a high volume of these services billed, many times more than once per patient, and documentation is not always sufficient to justify the medical necessity of the service.

One of the biggest challenges to seeking reimbursement for subsequent ACP services is the issue that there is no change to the directives outlined in the medical record. Per the CMS Frequently Asked Questions document on ACP, CMS advises that "When the service is billed multiple times, we would expect to see a documented change in the beneficiary's health status and/or wishes regarding his or her end-of-life care."

CMS FAQ on the subject addresses multiple ACP services and what should be documented. Full FAQ found HERE: Frequently Asked Questions about Billing the Physician Fee Schedule for Advance Care Planning Services (cms.gov)

Additional recommendations for documentation improvements including the content or change of any advanced directives (along with the completion of any forms), names or relationships of those participating in the discussion, time spent in the face-to-face encounter, the content and medical necessity of the related discussion and the voluntary nature of the encounter.

The link below has an On-Demand version of the Palmetto webinar from December on Advanced Care Planning Jurisdiction J Part B - Did You Miss It? Part B Medicare Advance Care Planning Services Webinar On Demand (palmettogba.com)

Advance Care Planning (ACP) 99497 & 99498 (codingintel.com)
Advance Care Planning CPT® | End of Life Planning | CPT® Code 99497 & 99498 (codingintel.com)

Flu Vaccine 2023-2024 Season

The flu season is upon us, and we'd like to remind our clients of a few tips for flu vaccine billing.

Medicare and Medicare Advantage plans require HCPCS code G0008 when billing for the administration of a flu vaccine, instead of 90471/90472.Commercial plans require CPT 90471 or 90472 for the administration of a flu vaccine.

Medicare and Medicare Advantage plans may require HCPCS codes Q2034-Q2038 instead of CPT codes, if there is an equivalent for the vaccine brand; otherwise report appropriate CPT. Commonly reported flu vaccine HCPCS codes are listed below. Always verify with the vaccine manufacturer what CPT should be used for billing purposes.

- Q2034- Agriflu
- Q2035- Afluria
- Q2036- Flulaval
- Q2037- Fluvirin
- Q2038- Fluzone
- Q2039- Unspecified

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Reminders:

- Verify that the NDC number is correct based on the vaccine packaging
- Update annually any billing "cheat sheets" that are used for CPT or NDC information
- Vaccine administration is separately reimbursed on the same day as an E/M visit if E/M documentation is significant, separately identifiable and modifier 25 is appended
- CMS Resources for flu vaccine billing, coding, and reimbursement can be found HERE: Flu Shot | CMS

Pediatric EPSDT Screenings

As kids head back to school, well visits and sports physical volumes are increasing. Remember when reporting EPSDT checkups for Tenncare patients, it's important to complete all components of that well-child exam. Tenncare patients are eligible to receive well-child exams and screenings on schedule recommended by the American Academy of Pediatrics. The periodicity schedule can be found here: periodicity_schedule.pdf (aap.org)

BCBST of TN Lab Policy Updates

BCBS of TN has new Laboratory Testing Code Reimbursement Policies for certain lab services billed on a professional or institutional claim form. To review the reimbursement policies for laboratory testing, please see the Coverage & Claims page of provider.bcbst.com by visiting the link:

Coverage & Claims | BCBS of Tennessee (bcbst.com)

Telehealth Reminders

With the end of the Public Health Emergency period in May 2023, many payers have adopted permanent telehealth policies for coverage of these services. CMS has continued to cover a variety of services performed as telehealth, however there are still changes to come. Coverage for telehealth for traditional Medicare patients is not a permanent benefit, and temporary allowances will be made through December 31, 2024. We encourage providers to continue to verify coverage for telehealth based on the specific plan benefits, as coverage and billing requirements for telehealth vary by payer. UPA publishes a telehealth billing reference guide for our most commonly billed insurance plans. That resource can be found on our website at the following link: https://www.upasolutions.com/solutions/revenue-cycle-management/telehealth/

For more information on permanent and temporary telehealth coverages for traditional Medicare, you can review the link here: Telehealth policy changes after the COVID-19 public health emergency | Telehealth.HHS.gov

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