ANO REVENUE CYCLE MANAGEMENT MONTHLY NEWSLETTER

February 2024

CODING HIGHLIGHT

Low Back Pain

M54.5 is not a billable DX code, it was expanded a few years ago and needs to have a fifth digit.

- M54.50 – Low back pain, unspecified
- M54.51 – Vertebrogenic low back paid
- M54.59 – Other low back pain

Please make sure you are using the highest specificity for your diagnosis codes.

Monthly humor

Q&A

Q: Respiratory syncytial virus (RSV) vaccine is listed as a monoclonal antibody, should it be reported with Z29.11 or Z23?
A: This would be coded with Z23. Z29.11 Encounter for prophylactic immunotherapy for respiratory syncytial virus (RSV), is reserved for high risk patients – infants, cystic fibrosis patients, and immunocompromised patients.

Q: Your questions could be here next month....
A:

Do you have a question you would like answered? Send us your questions at info@ano-rcm.com

"What you want exists. Don't settle until you get it." ~ Jay Shetty

ANXIETY SCREENING:

The US Preventive Services Task Force (USPSTF) recommends screening for anxiety disorders in adults 64 years old and younger, this should include pregnant and postpartum women and adolescents and children ages 8 to 18.

A review of the ICD-10-CM book or the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders fifth edition) will show various anxiety disorder, which will include (a few listed below):

- Generalized anxiety disorder (F41.1)
- Panic disorder (F41.0
- Phobias (F40.2x)
- Social phobia (F40.1x)
- Separation anxiety disorder (F93.0)
- Anxiety not otherwise specified (F41.9)

Anxiety disorders to not typically present alone, most often there are other associated mental health conditions such as depression. Anxiety may be a co-morbid condition to other disorders such as attention deficit hyperactivity disorder (ADHD), eating disorders and depression.

USPSTF recommendations now give primary care providers an opportunity to screen for these conditions during annual wellness visits. If the patient's issues or complaints are significant enough during the wellness visit a separate E&M service can be billed. Documentation must show the additional work. A primary care provider may initiate behavioral health integrations services, if it is warranted, and report with the following Psychiatric Collaborative Care Management Service codes:

- 99492 – Initial psychiatric collaborative care management, first 70 minutes
- 99493 – Subsequent psychiatric collaborative care management, first 60 minutes
- +99494 – Initial or subsequent psychiatric collaborative care management, each additional 30 minutes

The following elements are required for each code listed above (per the code description):

- Ongoing collaboration with and coordination of the patient's mental healthcare with the treating provider and any other treating mental health providers;
- Participation in weekly caseload consultation with the psychiatric consultant;
- Additional review of progress and commendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant;
- Monitoring of patient outcomes using validated rating scales;
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; and
- Relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.

Services will include collaboration between the treating practitioner and other providers such as behavioral healthcare manager, psychiatric consultant and the patient. Documentation will include pertinent care team communication.

**AAPC: Healthcare Business Monthly; December 2023 issue; *USPSTF Recommends Anxiety Screening*

WHEN TO USE G2211

New HCPCS level II code G2211 became effective January 1, 2024. Qualified healthcare providers can use this new add-on code to report the extra effort, time and associated practice expense involved with the care of Medicare patients across the continuum of healthcare.

Before beginning to utilize this code there are a few things to consider:

- This add-on code is for providers who will provide longitudinal care to the patient.
    - If you do not intend to have an ongoing longitudinal relationship with the patient (ex. Consultants, second opinions, urgent care, etc.) do not use this code.
- Primary care physicians and specialists may bill this add-on code.
- G2211 is billed in conjunction with an E&M service.
- G2211 MAY be billed with telehealth services.
- G2211 should not be billed when the E&M is reported with modifier 25, a procedure rendered by the same provider.
- G211 should not be billed if chronic/complex conditions are documented but not addressed or considered in the E&M of the patient.

As add-on code G2211 is going into effect without any specific documented guidelines it is important to put steps in place for compliance and to reduce the risk of abuse or fraudulent activity.

DO's

- Furnishing provider education.
- Analyze if this code is appropriate for you and your practice.
- Create a policy for proper use, documentation and billing practices.
- Update your software to include the new code.
- Create an audit process for this code.

DON'T's

- Create an automated process to include this code with all E&M services.
- Forget the intent for this service; promote a longitudinal relationship between patient and provider, to improve better care management.

CMS has acknowledged that reimbursement for providers related to their expertise and cognitive work has been lacking for years and assumes about 38% of E&M services in 2024 will be billed with G2211. The national average for reimbursement of G2211 is $16.04.

**AAPC The Magazine; January 2024 issue; *When Is It Time to Use G2211?*

2024 CODING UPDATES

Every year brings changes to the CPT world. Effective January 1, 2024 there are 230 new codes, 70 revised codes and 49 deleted codes. This year there are no changes to anesthesia, the digestive system, the auditory system, the integumentary system, or the male genital system. The biggest changes effect the sections for evaluation and management services, lab and pathology, COVID-19 and RSV Vaccinations, the phrenic nerve stimulation system and Category III codes.

- **Evaluation and Management** – the E&M section (99202 – 99215) was revised and removed the time ranges. Ex. 99213 now read "…20 minutes must be met or exceeded." This section also added guidelines for split/shared visits.
- **Musculoskeletal System** – three new codes were added for anterior thoracic vertebral body tethering: 22836 / 22837 / 22838.
- **Respiratory System** – this section has two new codes for the destruction of the posterior nasal nerve during nasal/sinus endoscopy: 31242 / 31243.
- **Cardiovascular System** – there are eight new codes for the phrenic nerve stimulation system, also includes introductory guidelines and parentheticals: 33276 / +33277 / 33278 / 33279 / 33280 / 33281 / 33287 / 33288.
- **Urinary System** – one new code for cystourethroscopy with mechanical urethral dilation and urethral therapeutic drug delivery using a drug-coated balloon catheter for urethral stricture or stenosis in a male patient: 52284.
- **Female Genital System** – one new code for transcervical radiofrequency ablation of uterine fibroid(s): 58580
- **Nervous System** – three new codes for skull-mounted cranial pulse generator or receiver procedures: 61889 / 61891 / 61892. Three new codes for insertion or replacement of the initial electrode array for the percutaneous electrode array of a peripheral nerve with an integrated neurostimulator: 64596 / +64597 (used with 94596) / 64598. Also, four revised codes in this section: 63685 / 63688 / 64590 / 64595.
- **Eye and Ocular Adnexa** – one new code for injection of a pharmacologic agent in the suprachoroidal space: 67516.
- **Radiology** – one deleted code: 74710 (Pelvimetry). Also included are five new codes: 75580 / 76984 / 76987 / 76988 /76989.
- **Pathology and Laboratory** – nine revised codes: 81171 / 81172 / 81243 / 81244 / 81403 / 81404 / 81405 / 81406 / 81407. This section also has six new genomic sequence analysis panel codes: 81457 / 81458 / 51459 / 81462 / 81463 / 81464. Three new codes for immunology: 86041 / 86042 / 86043. New code for hepatitis D: 87523 and new code for monkeypox virus: 87593. Three other new codes: 81517 (liver fibrosis) / 86366 (muscle-specific kinase antibodies) / 86043 (modulating antibody).
- **Medicine** – two new codes for respiratory syncytial virus (RSV) for the monoclonal antibody, seasonal dose: 90380 (0.5 mL dose) and 90381 (1 mL dose). There are many changes related to COVID-19, 90480 (administration for any COVID-19 vaccine for any patient, pediatric or adult) this replaces all previously approved specific vaccine administration codes, this also includes counseling. Pfizer has three new product codes: 91318 patients 6 months – 4 years, 91319 patients 5 years – 11 years, and 91320 patients 12 years and older. Moderna has 2 new product codes: 91321 patients 6 months – 11 years and 91322 patients 12 years and older. RSV has two new codes: 90679 (reF, subunit, and bivalent, for intramuscular use) and 90683 (preF, recombinant, subunit, and adjuvanted for intramuscular use).
- **Caregiver Training** – three new codes created 97550 / 97551 / 97552.
- **For more new / revised / deleted codes review the 2024 CPT code book**

**AAPC: Healthcare Business Monthly; December 2023 issue; *CPT 2024 Is Here!*

If you have any questions or would like a specific code highlighted in our next newsletter, please send those requests to info@ano-rcm.com.

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