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In this issue

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Coding

More than 250 new ICD-10 codes proposed for Oct. 1

The proposed ICD-10 code changes — released with the FY2025 Hospital Inpatient PPS (IPPS) proposed rule on April 10 – include three new codes to better track the severity of patients with hypoglycemia.

The proposed rule includes 252 new codes, 13 revised code descriptors and 36 codes deemed invalid. If finalized, these changes would take effect Oct. 1.

A proposal including the new hypoglycemia codes was previously discussed during the virtual ICD-10-CM Coordination and Maintenance (C&M) Committee meeting in September 2023.

The proposed codes are:

- **E16.A1** (Hypoglycemia level 1).
- **E16.A2** (Hypoglycemia level 2).
- **E16.A3** (Hypoglycemia level 3).

Hypoglycemia is broken down into a classification system of levels, the proposal in September explained:

- Level 1 is defined as a glucose concentration < 70 mg/dL and should be used as an 'alert value' to help individuals avoid more severe hypoglycemia.
- Level 2 is defined as a glucose concentration < 54 mg/dL, and is the threshold at which neuroglycopenic symptoms begin to occur.
- Level 3 is defined as a severe event characterized by altered mental and/or physical functioning.

"Hypoglycemia largely occurs in diabetes type I and diabetes type II patients," the proposal states. "When the hypoglycemia severity level is documented, it demonstrates the impact on patient management, diabetic research and physician decisions to order continuous glucose monitoring systems (CGMs)."

Also proposed are new codes to capture patients who are presymptomatic for type 1 diabetes mellitus including **E10.A0** (Type 1 diabetes mellitus, presymptomatic, unspecified, **E10.A1** (Type 1 diabetes mellitus, presymptomatic, Stage 1) and **E10.A2** (Type 1 diabetes mellitus, presymptomatic, Stage 2).

Encounter for sepsis aftercare

The proposed code update also includes a new code to capture a post-acute encounter for sepsis aftercare, **Z51.A** (Encounter for sepsis aftercare).

A proposal for this code was presented at the March 2023 ICD-10 C&M Committee meeting.

The new code would give clinicians the opportunity to warn patients and family members about the risks, such as new or recurrent infections, and could provide the chance to rehabilitate new impairments.

"Sepsis survivors have a high readmission risk due to post-acute complications and sequelae of sepsis after hospital discharge," the March proposal stated before adding that around 40% of sepsis survivors discharged to post-acute care are readmitted to the hospital within 90 days.

More detail for eating disorders

The next ICD-10-CM update will replace four codes for anorexia nervosa, restricting type, anorexia nervosa, binge eating/purging type, bulimia nervosa and binge eating disorders with 24 codes that describe the stage of the condition.

For example, **F50.2** (Bulimia nervosa), will be replaced with six codes:

- **F50.20** (Bulimia nervosa, unspecified).
- **F50.21** (Bulimia nervosa, mild).
- **F50.22** (Bulimia nervosa, moderate).
- **F50.23** (Bulimia nervosa, severe).
- **F50.24** (Bulimia nervosa, extreme).
- **F50.25** (Bulimia nervosa, in remission).

Two more proposed codes would address pica in adults (**F50.83**), a condition where adults eat things that aren't usually considered food and rumination syndrome in adults (**F50.84**), a condition in which the patient regularly spits up food and either rechews and swallows or spits out the food shortly after they eat.

Check out additional proposals

- **Expansion in the musculoskeletal and connective tissue codes.** Two codes for intervertebral disc degeneration of the lumbar region (**M51.36**) and lumbosacral region (**M51.37**) will be replaced by seven new codes based on whether the patient has

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discogenic back pain, lower extremity pain or there is no mention of either type of pain. You'll also say goodbye to **M65.9** (Synovitis and tenosynovitis, unspecified) and hello to 23 codes that specify the site of the condition.

- **More social determinants of health codes.** The next code set will continue to refine social determinant of health codes by splitting **Z59.7** (Insufficient social insurance and welfare support) into two codes that describe either insufficient social insurance (**Z59.71**) or insufficient welfare support (**Z59.72**).

To view the rule and tables, visit *https://tinyurl.com/4bk8kkdy*. — *Megan Herr* (*megan.herr@decisionhealth.com*) with additional reporting by *Julia Kyles, CPC* (*julia.kyles@decisionhealth.com*) ■

ICD-10-CM Chapter	New	Revised	Invalidated
Chapter 1: Certain infectious and parasitic diseases (A00-B99)	0	1	0
Chapter 2: Neoplasms (C00-D49)	63	0	14
Chapter 3: Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism (D50-D89)	1	0	0
Chapter 4: Endocrine, nutritional and metabolic diseases (E00-E89)	16	0	2
Chapter 5: Mental, Behavioral and Neurodevelopmental disorders (F01-F99)	26	1	4
Chapter 6: Diseases of the nervous system (G00-G99)	7	1	1
Chapter 7: Diseases of the eye and adnexa (H00-H59)	0	5	0
Chapter 8: Diseases of the ear and mastoid process (H60-H95)	0	0	0
Chapter 9: Diseases of the circulatory system (I00-I99)	4	2	0
Chapter 10: Diseases of the respiratory system (J00-J99)	7	0	0
Chapter 11: Diseases of the digestive system (K00-K95)	27	1	3
Chapter 12: Diseases of the skin and subcutaneous tissue (L00-L99)	8	0	3
Chapter 13: Diseases of the musculoskeletal system and connective tissue (M00-M99)	33	0	3
Chapter 14: Diseases of the genitourinary system (N00-N99)	0	0	0
Chapter 15: Pregnancy, childbirth and the puerperium (O00-O9A)	0	0	0
Chapter 16: Certain conditions originating in the perinatal period (P00-P96)	0	0	0
Chapter 17: Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99)	4	1	1
Chapter 18: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)	1	0	0
Chapter 19: Injury, poisoning and certain other consequences of external causes (S00-T88)	30	0	3
Chapter 20: External causes of morbidity (V00-Y99)	0	0	0
Chapter 21: Factors influencing health status and contact with health services (Z00-Z99)	25	1	2
Chapter 22: Codes for special purposes (U00-U85)	0	0	0
Total	**252**	**13**	**36**

Practice management

As urgent care rises, maintain connections with patients to keep them coming

A recent survey shows that many Medicare-eligible patients are visiting urgent care instead of their primary care provider, a tendency that PCPs may be able to stem with some extra attention.

A University of Michigan National Poll on Healthy Aging released April 8, which surveyed more than 2,600 50-to-80-year-olds, found that 60% of respondents had visited an alternative site such as an urgent care or retail clinic rather than a traditional primary care provider in the previous two years. About 47% of respondents had been to an urgent care site, and 23% had gone more than once.

The figures suggest that the lack of a PCP was not an issue. Among respondents who reported a regular primary care provider, the number who had used an alternative was 61%. Only 9% of these respondents cited cost as the alternative's advantage, but 47% said it was more convenient. Most preferred the PCP for quality (51%) and for "feeling connected to [their] health care provider" (67%). Nearly two-thirds, or 62%, said they were either very or somewhat likely to return to the alternative provider.

Susan Reinhard, senior vice president and director of the AARP Public Policy Institute, says, "access to timely and convenient care was critical for older adults during the pandemic, and our research shows alternative care options will continue to be in demand for the long-term." AARP and the University's academic medical center, Michigan Medicine, partnered with the University's Institute for Healthcare Policy and Innovation to conduct the survey.

More service, more loyalty

In an era of expanding alternative care options, it's not surprising that patients who have a regular PCP might go to a drugstore nurse practitioner if they think that alternative meets both their time availability and the level of care they believe they need.

Given those variables, the price of care may be a lesser concern, at least for some patients. The Healthy Aging poll found that patients from households with $60,000 or more in income were much more likely to use alternative care than those in households that made less (65% vs. 53%).

But practices needn't resign themselves to a fate of fleeing patients. Thomas Pontinen, M.D., LCP-C, anesthesiologist and co-founder of Midwest Anesthesia and Pain Specialists in Chicago, believes patients will tend to stick with their primaries if they're sufficiently bonded by the quality of their care and attention.

"I think many doctors fail to build and maintain relationships [and] the rising popularity of urgent care facilities are, in part, a symptom of that," Pontinen says. "Patients come to us from places of vulnerability and emotional/physical stress, so we should do our best to maintain a high standard when it comes to accommodating and respecting that."

Pontinen gives as an example a visit for ingrown toenail care, which M.D.s will tend to refer to a podiatrist — understandably, he admits: "[It's] not because they're unable to perform the procedure," he says, "but more so because it's not convenient, practical or commercially ideal to do so for most primary care practices."

In such cases, however, the patient may feel slighted and more likely to preemptively decide that the PCP isn't the place to go for even simple services.

"The journey is never easy," Pontinen says, "but I believe that the physicians who consistently value human connection end up being the most successful." — *Roy Edroso (roy.edroso@decisionhealth.com)* ■

RESOURCES

- University of Michigan National Poll on Healthy Aging, "Alternative Sites for Health Care," April 8: https://deepblue.lib.umich.edu/bitstream/handle/2027.42/192767/0365_NPHA-Alternative-Sites-of-Care-report-FINAL-doi_04-09-2024.pdf?sequence=4&isAllowed=y

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Benchmark of the week

X-tra special: 59-alternative X modifiers dial back the denials

When practices turn to a substitute for modifier **59** (Distinct procedural service), two options from the series of Medicare-approved **X[EPSU]** modifiers stand high above the rest, and in most cases the claims-approval rates are superior.

Modifier 59 remains the go-to for many practices. In 2022, Medicare received more than 41 million 59-appended claims, compared to 6.9 million claims with one of the X modifiers, according to the latest available Medicare claims data. Of the X-caliber group, the top two alternatives were **XS** (Separate structure, a service that is distinct because it was performed on a separate organ/structure), featured on 2.6 million claims; and **XU** (Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service), on 3.5 million claims.

The charts below reveal the top 10 services reported with XS and XU in 2022, with full claims data, including total services, payments and denial rates. Modifier XS shares the most overlap with modifier 59's top-billed services, with lesion-destruction codes **17003** and **17000** appearing near the top of both lists (*PBN 4/1/24*), and the use of XS returned a more favorable denial rate in those cases, having nearly 1% fewer denials compared with 17003/17000 claims with modifier 59. Practices also found greater success with XU. For example, the denial rate for **G0444**-XU was 11%, compared to a loftier 15.5% for the G0444-59 combo.

Overall, 59's denial rates performed better than the XS and XU alternatives on just two of the services that appeared on the respective modifier's top 10 lists of services. (Stay tuned to future issues for more 59 and X[EPSU] analysis.) — *Richard Scott* (*richard.scott@decisionhealth.com*)

Top 10 codes reported with modifier XS, 2022, with claims data

Code	Modifier	Services	Denials	Denied amount	Payment	Denial rate
17003	XS	610,587	12,965	$283,466	$2,792,523	2.1%
17000	XS	242,925	4,728	$702,403	$6,038,438	1.9%
11721	XS	197,011	13,968	$1,347,835	$6,064,774	7.1%
96372	XS	155,914	6,555	$372,254	$1,452,723	4.2%
45380	XS	100,862	2,540	$3,347,617	$6,149,551	2.5%
11102	XS	87,308	1,814	$353,336	$4,126,101	2.1%
11720	XS	84,596	4,529	$302,724	$1,997,602	5.4%
G0127	XS	67,070	4,294	$195,572	$831,687	6.4%
43239	XS	59,796	1,218	$1,420,115	$2,993,813	2.0%
11103	XS	40,637	906	$86,846	$1,497,211	2.2%

Top 10 codes reported with modifier XU, 2022, with claims data

Code	Modifier	Services	Denials	Denied amount	Payment	Denial rate
G0444	XU	326,639	36,079	$1,361,662	$4,742,625	11.0%
87798	XU	326,151	47,603	$3,559,486	$9,646,810	14.6%
93000	XU	140,784	5,944	$373,831	$1,407,066	4.2%
87150	XU	139,641	20,212	$1,426,325	$4,130,941	14.5%
96375	XU	113,413	3,700	$352,174	$1,389,859	3.3%
G0442	XU	107,626	10,985	$456,060	$1,591,175	10.2%
96372	XU	96,840	5,546	$322,683	$1,008,399	5.7%
93010	XU	87,380	5,112	$221,518	$526,534	5.9%
88341	XU	77,634	6,296	$1,179,894	$4,985,813	8.1%
96367	XU	64,683	2,580	$344,480	$1,495,981	4.0%

Source: Part B News *analysis of 2022 Medicare claims data*

Billing

CMS eases longstanding ban on P.O. boxes in NPPES rule

Individual providers who only work from home can now use a United States Postal Service post office box (P.O. box) for their practice location address in the National Plan and Provider Enumeration System (NPPES). The update went into effect April 3, 2024.

CMS announced the exception in a notice published March 3, 2024. The change comes 20 years after the U.S. Department of Health and Human Services (HHS) issued the final rule that adopted the national provider identifier (NPI) system. In the NPI rule, HHS barred all providers from using a P.O. box for their practice location address.

The new option "does not apply to hybrid providers who see patients face-to-face in an office and perform telehealth services from their homes as they have an office location that is not a home address," a CMS spokesperson said in response to follow-up questions from *Part B News*. But CMS is considering enrollment changes that would apply to hybrid providers (*see sidebar on this page*).

New option ends confusion, protect providers

The part of the notice that allows individual providers to use a P.O. box or personal mailbox offered by a private delivery as their first and second line address location in NPPES addresses concerns raised by the fact that NPPES information is publicly available online. According to the notice, posting the home address of a provider who only performs telehealth services could make patients think they can receive in-person treatment at the listed address. In addition, some providers are worried that posting their home addresses "also poses privacy and potential safety concerns for themselves and their families."

The ban on P.O. boxes placed providers who only work from home "in a bind," said Daniel Kalwa, deputy director of CMS' National Standards Group, during CMS' Physicians, Nurses and Allied Health Professionals Open Door Forum on April 10.

The expansion gives eligible providers a new choice, but "there is no requirement to alter your NPI registration, and so unless you choose to, there is no requirement to interact with these changes," Kalwa explained.

Understand the new option's limits

Make sure your team understands this exception is for individual providers who "only work remotely or deliver telehealth services and as a result their only address or place of work ended up being their home address," Kalwa said during the call.

According to the notice the address can only include a P.O. box or personal mailbox offered by a private delivery service if the provider's NPI is "entity type code = 1" – that is, an "individual human being who furnishes health care," and the provider's only physical location is their home address.

Billing

Hybrid providers: Keep using your office address, watch for new rules

CMS' new National Plan and Provider Enumeration System (NPPES) policy is limited to individual providers — typically telehealth providers — who only work from home (*see story on this page*). The address exception is not an option for hybrid providers, such as those who are currently offering telehealth services under the telehealth waiver extension.

"This change does not apply to hybrid providers who see patients face-to-face in an office and perform telehealth services from their homes as they have an office location that is not a home address," a CMS spokesperson said in response to questions from *Part B News*.

For billing and enrollment purposes, hybrid providers should continue to use their office address. "CMS will continue to permit the distant site provider to use their currently enrolled practice location instead of their home address when providing telehealth services from their home through CY 2024. Hybrid providers should continue to report their office location instead of their home address," the CMS spokesperson confirmed.

Watch for more rulemaking

During the COVID-19 public health emergency (PHE), CMS created a waiver that allowed hybrid providers to bill from their office address. As the PHE wrapped up, CMS initially announced that it would require providers to add their home address to their enrollment. However, the agency extended the waiver through the end of 2024 in the final 2024 Medicare physician fee schedule, after providers and other interested parties objected to the plan to end the waiver.

In the final rule, CMS also asked for more information about how adding their home address to their enrollment might affect providers "when that address is the distant site location where they furnish Medicare telehealth services," the spokesperson said.

The agency wants "clear examples of how the enrollment process shows material privacy risks to inform future enrollment and payment policy development," CMS wrote in the final rule. — *Julia Kyles, CPC* (julia.kyles@decisionhealth.com)

In addition, the change only applies to NPPES. CMS does not allow P.O. boxes for enrollment and the change does not apply to providers "who enroll with commercial health plans, Medicare or Medicaid … for the purposes of satisfying enrollment requirements," the CMS spokesperson explained. — *Julia Kyles, CPC* (*julia.kyles@decisionhealth.com*) ■

RESOURCES

- National Plan and Provider Enumeration System (NPPES) data changes: *www.federalregister.gov/documents/2024/03/04/2024-04517/national-plan-and-provider-enumeration-system-nppes-data-changes*
- HIPAA administrative simplification: Standard unique health identifier for health care providers: *www.federalregister.gov/documents/2004/01/23/04-1149/hipaa-administrative-simplification-standard-unique-health-identifier-for-health-care-providers*
- NPI file: *https://download.cms.gov/nppes/NPI_Files.html*

Patient encounters

Measles in your office? Follow CDC rules, take caution in telling patients

With serious diseases spreading in some communities, now is a critical time to review your responsibilities if a person infected with a rare illness comes through your office, and how you should interact with your health care providers and other personnel.

On March 18 CDC put out an Emergency Preparedness and Response alert that measles is on the upswing in parts of the country (*see resources, below*). The agency also recently put out an alert about resurgent meningococcal disease and a warning on a single case of H5N1 (bird flu) in Texas.

Every so often, dangerous infectious diseases presumed eradicated by near-universal immunization and other public health measures suddenly flare up in parts of the U.S. Measles, for example, was declared "eliminated" in the U.S. in 2000, but there have been outbreaks in 2015 and 2019.

Practices that had to revisit their infectious disease protocols in such cases got an unwanted but useful refresher on such procedures during the recent COVID-19 pandemic. But COVID precautions were general and ongoing, whereas infectious disease flare-ups will come and go. It's important to know how to handle a suspected case in your office.

Follow the rules

Along with your usual diagnostic procedure, you are obliged by law to report any such infections to your state health agency (or tribal, local, or territorial authority, if applicable) by means available at their website, as well as to the CDC. But you also have to find ways to handle the exposure to the disease of your providers and other practice staff.

Elizabeth L.B. Greene, a partner with Mirick O'Connell in Worcester, Mass., and a member of the firm's health law and litigation group, notes that along with the alerts the CDC offers detailed guidance in its March 28 "Infection Control in Healthcare Personnel: Epidemiology and Control of Selected Infections Transmitted Among Healthcare Personnel and Patients" release, which specifically mentions measles and meningococcal disease.

"The prophylaxis recommendation and work restriction recommendations are dependent on whether the provider is asymptomatic or symptomatic, with or without presumptive immunity, and whether they are immunocompromised," Greene says.

For example, the guidance for health care workers exposed to measles specifies that, for asymptomatic personnel "with presumptive evidence of immunity to measles," such as documented appropriate vaccination, laboratory evidence, or a birthdate before 1957, neither postexposure prophylaxis nor work restrictions are necessary, though they should be monitored daily for symptoms from "the 5th day after their first exposure through the 21st day after their last exposure."

Asymptomatic health care personnel without presumptive evidence of immunity should get prophylaxis (e.g., MMR vaccine within 72 hours of exposure) and stay off the floor during the 5th/12th day period. Symptomatic personnel should avoid work four days after the rash appears and, if immunocompromised, for the duration of the illness. If there is an acknowledged outbreak in their area, all personnel should receive appropriate vaccination.

For patients (coming or going)

One of the lessons of COVID has been the importance of pre-entry screening. Greene says best practice is to triage by phone and, if measles or other such disease is suspected, make special arrangements. For example, you should:

- Create an alternate entrance to the practice, a remote exam room and a clear path to it.
- Offer appropriate protective equipment for involved personnel.
- Per CDC guidelines, leave the "exam room empty for two (2) hours after the patient encounter, and steps to sanitize the exam room thereafter," Greene says.

Again, it's worth checking with your local health authority, which may have other guidelines.

Richard F. Cahill, vice president and associate general counsel of the Doctor's Company in Napa, Calif., says one thing the CDC does not address directly is whether or how the practice should inform other patients who may have been inadvertently exposed to the infected patient while in the waiting room.

In Cahill's view, "once the diagnosis is confirmed, an audit of clinic records should be immediately conducted to identify all individuals, including patients, vendors and visitors who were on the premises during the period when the infected individual was considered contagious."

Once you've got a list, these people should be notified, but the notification should be "consistent with the confidentiality requirements of federal and state laws regarding protected health information." That is, you should not state that the notified party was under treatment at that time. Rather, state that an infectious patient was present on a certain date and time, that others in the office at the time may be at risk, and that your office is available to test and, if necessary, treat such individuals. — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCES

- CDC, "Increase in Global and Domestic Measles Cases and Outbreaks: Ensure Children in the United States and Those Traveling Internationally 6 Months and Older are Current on MMR Vaccination," March 18, 2024: *https://emergency.cdc.gov/han/2024/han00504.asp*
- CDC, "Increase in Invasive Serogroup Y Meningococcal Disease in the United States," March 28. 2024: *https://emergency.cdc.gov/han/2024/han00505.asp*
- CDC, "Highly Pathogenic Avian Influenza A (H5N1) Virus: Identification of Human Infection and Recommendations for Investigations and Response," April 5, 2024: *https://emergency.cdc.gov/han/2024/han00506.asp*
- CDC, "Infection Control in Healthcare Personnel: Epidemiology and Control of Selected Infections Transmitted Among Healthcare Personnel and Patients," March 28, 2024: *www.cdc.gov/infectioncontrol/pdf/guidelines/IC-Guidelines-HCP-H.pdf*

Brief

Lack of behavioral health providers in Medicare and Medicaid impedes enrollees' access to care

On April 3, the OIG published a report on how low behavioral health provider participation in Medicare and Medicaid impacts enrollees' access to care.

The OIG conducted this review due to congressional interest in ensuring Medicare and Medicaid enrollees have access to behavioral health services. The report is focused on outpatient behavioral health service claims in 2021 by providers in 20 counties across 10 states.

The OIG determined that few behavioral health providers in the selected counties actively served Medicare and Medicaid enrollees. On average, there were fewer than five active behavioral health providers per 1,000 enrollees in each program. Compared to urban counties, rural counties had fewer than half the number of active providers per 1,000 enrollees.

Despite the unprecedented demand for behavioral health services after the COVID-19 pandemic, the OIG determined that less than 5% of Medicare and Medicare Advantage enrollees received services from a behavioral health provider in 2021.

The OIG had the following recommendations for CMS:

- Take steps to encourage more behavioral health providers to serve enrollees.
- Explore options to expand coverage to additional behavioral health providers.
- Use network adequacy standards to drive an increase in behavioral health providers.
- Increase monitoring of enrollees' use of behavioral health services and identify vulnerabilities.

CMS concurred with (or concurred with the intent of) all four recommendations. — *DecisionHealth staff* (*pbnfeedback@decisionhealth.com*) ■