ADVANCED DATA SYSTEMS RCM

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INSIGHTS

Articles of Interest in the World of Revenue Cycle Management from Advanced Data Systems RCM

Telemedicine's Tele-Evaluations

In the really old days, patients with questions about their health or healthcare would call their doctors' offices, leave messages. Physicians or nurses would typically return calls at the end of the day, or possibly during lunch. An urgent call might get the doctor or nurse to the phone while the patient waited on hold.

Those patients' calls were simply "part of the job" for which, unfairly, no revenue was derived. Rarely if ever were patients ever billed for those calls although in retrospect, they should've been.

Today, there's telemedicine complete with visual connections creating virtual encounters and then secondarily, what's become known as audio-only telemedicine ("old days" telephone calls/consults) for which revenue can – and should – be obtained. In fact, there are specific CPT® codes to be used for tele-consult reimbursements.

But we all know CPT codes can come and go. Two of them, 99441 and 99442, have left us as of January 7 as part of the CPT 2025 updates and the 2025 Medicare Physician Fee Schedule, both of which went into effect on January 1. The two codes were originally created to describe telephone E/M services.

But don't worry because they've been replaced for more specificity as follows for audio-only sessions for both new and existing patients:

✓ **New Patients:**

- **98008:** Synchronous audio-only visit for the evaluation and management of a new patient, requiring a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion.
- **98009:** Calls requiring low medical decision making, and more than 10 minutes of medical discussion.
- **98010:** Calls requiring moderate medical decision making, and more than 10 minutes of medical discussion.
- 98011: Calls requiring high medical decision making, and more than 10 minutes of medical discussion.

✓ **Established Patients:**

- **98012:** Synchronous audio-only visit for the evaluation and management of an established patient, requiring a medically appropriate history and/or examination, straightforward medical decision making, and more than 10 minutes of medical discussion.
- **98013:** Calls requiring low medical decision making, and more than 10 minutes of medical discussion.
- **98014:** Calls requiring moderate medical decision making, and more than 10 minutes of medical discussion.

- **98015:** Calls requiring high medical decision making, and more than 10 minutes of medical discussion.

The common denominator for both patient groups, as you may have noticed, is that **calls must be *more* than ten minutes**. If they are, and if they fit into any of the decision making parameters, claims can be submitted for reimbursement.

(ADSRCM and our team can handle the new audio-only coding helping to solidify your reimbursements on them.)

Update on Medical Debt and Consumer Credit Reports

It's now become official: the Consumer Financial Protection Bureau (CFPB) has finalized its rule which prohibits medical debt from appearing on patients'/guarantors' credit reports. The rule will remove close to $49 billion from the credit reports of about 15 million people. On average, that's about $3,300 per person.

The CFPB explains that medical debt on consumer reports can be inaccurate since medical billing may be inaccurate, or that insurance or financing may be in play. As such, credit reports with medical debt can cause overbearing collections efforts by third party collectors when the debt itself may be questionable.

Another factor, according to the Urban League, is that nearly two-thirds of adults with medical debt had incomes below 250% of the federal poverty line.

Interestingly from a provider's perspective, removing medical debt from consumer credit reports could be detrimental to the provider; that having medical debt being reportable might help incentivize patients to pay so their credit ratings aren't negatively affected.

In any case, you'll want to have every possible tool to ensure patients pay their responsibility amounts:

- ✓ Eligibility verifications on scheduling appointments and then intermittently prior to appointments.
- ✓ Out-of-network alerts ideally on scheduling appointments or at any point in advance.
- ✓ Access to a patient responsibility estimator on scheduling appointments to avoid surprises by preparing the patient as to what will be owed based on the appointment reason.
- ✓ Access to that same estimator as patients leave based on the actual procedures performed which often differ from their pre-appointment estimates.
- ✓ Interactive balance due reminder texts and/or emailable statements, both with built-in payment mechanisms for online payments directly to you.

Other features that help ensure being paid are:

- ✓ An automated prior authorizations option.
- ✓ An AI-driven denial prevention utility enabling claims to be edited first prior to submitting them.
- ✓ NCCI edit alerts whenever multiple claims for a single patient should be combined into one master claim to avoid those denials.

The CFPB's final rule is a final rule: medical debt can't appear on consumer credit reports. That doesn't mean you need to be unnecessarily vulnerable when patients can pay.

Click here for the CFPB Final Rule and here for the Urban League's report.

(Clients rely on ADSRCM with our AI-driven platforms and teams of billing experts to support the protections mentioned above empowering them to capture patient responsibility balances.)

Insurance Deniers: "the Biggies"

According to ValuePenguin by way of an October 2024 CMS report, the top deniers for 2024 are:
United Healthcare, 33%
Molina Healthcare, 26%
Anthem and Medica, 23% each
Aetna, 22%
Cigna and CareSource, 21% each
Blue Cross/Blue Shield, 20%

The list is extensive but we're only showing payers with at least a 20% denial rate.

Conversely, here are the 2024 payers with the lowest denial rates:
Avera Health Plans, 1%
PacificSource Health Plans, 2%
Providence Health Plan, 4%
Sanford Health, 5%
Kaiser Permanent, 6%

Obviously, you don't need to worry too much about the second group, but the first group is a problem. We're not suggesting they're going out of their way to deny; maybe they're just more finicky than the second group.

Obviously again, you'll need to ensure as best as possible that claims sent to payers in the first group are as clean and accurate as possible and that prior authorizations were gotten when needed.

Click here for the ValuePenguin report.

(ADSRCM supports a nearly 100% success rate on first attempt HCFA, UB, WC, and NF clearinghouse claims submissions. Our proactive Denial Preventer avoids so many denials in advance while out-of-network alerts help prevent those potential problems. And we're payer agnostic We'll help prevent denials by the highest and lowest percentage deniers!)

Unblocking Information Blocking

Reminder about what "information blocking" (IB) is: it's the act of preventing a patient's medical records (medical information) from being shared legitimately with other healthcare providers, entities, facilities, HIEs, the patient's own authorized caregivers, and even with the patient themselves. (Click here for a link to an article about an ambulance service that was fined for not making the patient's information available to the patient.)

IB goes against one of the tenets of the 21st Century Cures Act (CA) which is why your EHR should (must) be ONC certified, since that designation means the EHR is CA compliant.

Now comes word that the Health Data, Technology and Interoperability: Protecting Care Access (HTI-3) final rule adds a new IB exception to protect access to reproductive healthcare.

The protecting care access exception allows for restricting the exchange of health information where those restrictions "could reduce the risk of exposing persons to legal action because they were involved in care that was lawful in or under the circumstances that care was furnished." Most notably, this would apply to persons who obtained, or provided, or facilitated reproductive healthcare.

For the exception to apply, those involved must act based on a good faith belief that persons seeking, obtaining, providing or facilitating reproductive healthcare are at risk of being exposed to legal action because of sharing specific EHI.

Click here for the HHS proposed HIT-3 rule on IB exceptions.

(ADSRCM clients can access the ONC-certified MedicsCloud EHR with its MedicsSpeakAI® natural language data capture platform for expedited and virtually hands-free encounters. Clients can also keep their existing EHRs interfaced with ADSRCM!)

Fraud of the Month Club: January

On January 15, a doctor in TX was sentenced to ten years and ordered to pay **$26,622,522.82** in restitution for his involvement in a scheme to defraud Medicare by prescribing durable medical equipment and cancer genetic testing without seeing, speaking to, or otherwise treating patients.

The evidence showed that the doctor fraudulently signed thousands of orders and prescriptions for orthotic braces and genetic tests, including for undercover agents who posed as Medicare beneficiaries, many of whom the doctor never spoke with, saw, or treated.

False prescriptions were then used to bill Medicare approximately $70 million for which the doctor received $475,000 in exchange for those prescriptions.

Click here for the Justice Department's details.

A Good Thing: Healthcare Spending at $4.8 Trillion in 2023

Ending this month's InSights on a good note: the stats are in: healthcare spending hit $4.8 trillion in 2023 per a report by HealthAffairs.

That's good since it was reported that the growth rate from 1970 (yes, 55 years ago!) to 2019 was "unsustainable." The economics of it, including GDP factors and something called the National Health Expenditure deflator can be seen in the report noted above.

In its simplest form, the major spending was for hospital care, private health insurance, Medicare, physician and clinical services, Medicaid, and retail prescription drugs.

4,800,000,000,000. That's more zeros than in the calorie count at the July 4th hot dog eating contest at Coney Island.

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We hope you enjoyed the read.

Next: February with more items of interest even if it's only 28 days!

Contact us at **844-599-6881** or by emailing **rcminfo@adsc.com** for more about how you can drive maximized revenue and productivity with ADSRCM, which includes access to the ONC-certified MedicsCloud EHR and its built-in MedicsScribeAI for natural language data capture during encounters. Clients can also retain their existing EHRs if preferred. The platform we use (the MedicsCloud Suite) is available from ADS if in-house automation is preferred.

Our monthly newsletters are issued with news articles from the same month!

Feedback or comments on our newsletters/content are greatly appreciated.
Please opine by emailing marc.klar@adsc.com or by calling 800-899-4237, Ext. 2061.
We'd love to hear from you!
-Marc E. Klar, Vice President, Marketing, ADS RCM.