CODOXO
AI Solutions for Healthcare

EBOOK

Forensic AI Alerts eBook:

2022 FWA Trends to Inform 2023 Cost Containment Strategies

Introduction

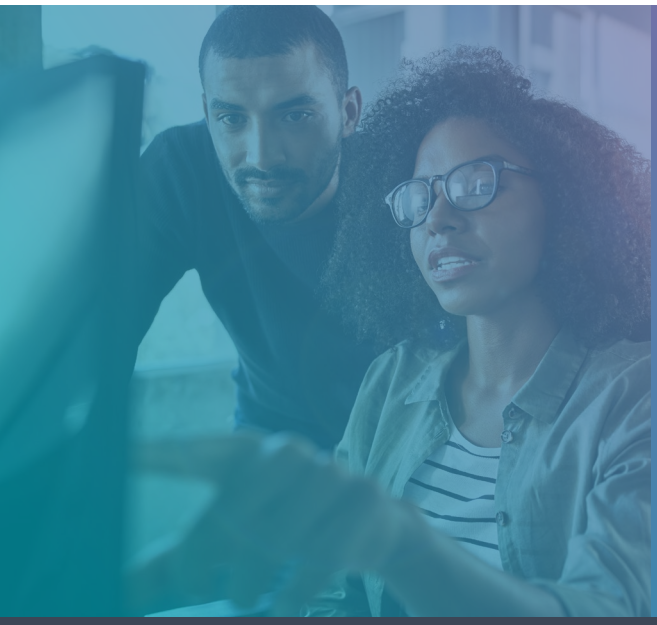
Due to the complex and ever-changing healthcare landscape, we believe it's critical to educate leaders across the healthcare ecosystem about the latest fraud, waste, and abuse (FWA) opportunities that require real-time action, while informing strategic decisions for the year ahead. Codoxo is committed to sharing timely updates with the cost containment community to impart the knowledge needed to save time and money in the fight against fraud.

Throughout the year, Codoxo's team of payment integrity and FWA experts publish Forensic AI Alerts in response to time-sensitive topics currently making headlines or emerging and going undetected. These AI Alerts equip healthcare insurers, agencies and PBMs with real-time news and information about new trends as well as FWA threats and schemes that may impact billing and their bottom lines. They also provide best practices and tips and tricks on using CPT codes, including various updates published throughout the year.

Whether the population is fighting viruses like COVID-19 and RSV or exploring the latest trends and schemes, healthcare companies need to provide effective and affordable care while simultaneously managing the threat of FWA. This requires staying up to date on the latest CPT codes and schemes and leveraging new innovations.

Artificial intelligence (AI), machine learning (ML), and automation solutions like Codoxo's Forensic AI Engine provide an added layer of financial protection for healthcare companies looking for ways to minimize risk and contain costs. Explore how Codoxo's AI solutions can help you analyze your data, detect problems, and build connections across your data to provide actionable insights. This will be especially relevant as payers look ahead to 2023 and beyond, with a post-pandemic rise in utilization, much of which is due to chronic illnesses post-pandemic (diabetes, hypertension, obesity, and mental health).

THIS EBOOK IS A TESTAMENT TO OUR MISSION TO HELP MAKE HEALTHCARE MORE AFFORDABLE AND EFFECTIVE FOR EVERYONE.



DID YOU KNOW?

The U.S. spends $2.8 trillion each year on healthcare? And, a significant portion — **over $380 billion** — is lost to FWA?

Table of Contents

The chapters in this eBook offer insights and recommendations for managing FWA across a variety of healthcare areas that Codoxo experts have identified as trending in the past year.

Chapter 1

Know Your Mohs, Part 1 and 2

Mohs (micrographically oriented histographic surgery) micrographic surgery is performed by a dermatologist or a plastic surgeon to treat skin cancers. It is an efficient and extremely effective way to tackle the most common forms of skin cancer according to the Skin Cancer Foundation, with a 99% cure rate for cancer that has not received previous treatment.

Patients appreciate the outpatient format and the goal of removing all cancer in the affected area before the procedure is considered complete. Surgeons remove layers of tissue, examine them for cancerous cells and repeat the procedure until the samples are cancer-free. A dual specialty aspect exists during Mohs micrographic surgery because the surgeon also functions as the pathologist to determine if the margins are clear to ensure all cancerous tissue is removed.

CODOXO RECOMMENDS: MOHS CPT CODES TO WATCH OUT FOR

There are a variety of CPT codes for the Mohs procedure; the AMA manual offers complete descriptions. It's worth noting that the Mohs micrographic surgery codes are inclusive of the biopsy, excision, and pathology components. And the wound closures are separately reportable.

Given the large number of codes and the propensity for error, common FWA schemes to watch out for include:

- Billing for 'special stains,' instead of a 'routine stain,' pathology codes with higher volume than their peers
- Upcoding of the wound closures

Visit the November 2021 AI Alert, Know Your Mohs, Part 1, to view CPT code groups for Mohs procedures and CPT code sets for special stains, interpretation, and reports.

BILLING MOHS SURGERY WOUND CLOSURES

Once the dermatologist has removed all the diseased tissue, the wound needs to be closed. Wound closures or repairs are categorized as simple, intermediate, or complex. The determining factor for the type of closure billed is based on where on the body the wound is located and size and depth of the defect to be closed. If closure cannot be completed by a simple, intermediate, or complex procedure, adjacent tissue transfer or rearrangement may be used. Typically, closures for larger surface areas or more complex closures are reimbursed at a higher rate.

Detailed repair codes are outlined in our December 2021 AI Alert, Know Your Mohs, Part 2: The Closure. You can also discover how the Codoxo Forensic Platform and the Query Aggregates tool can help you identify potential schemes and issues.

ENSURING ACCURATE BILLING

To ensure correct billing, we recommend that any wound closures utilizing adhesive strips as the sole repair material be coded using the appropriate E/M code and may be present in a simple, smaller surface area close.

Each patient has a unique path to recovery and that can complicate the billing process. Becoming familiar with billing codes and utilizing references like those provided here and in our AI Alerts can help minimize error and costly mistakes.

It is our recommendation that health plans assess their overall payments and utilization for simple, intermediate, and complex closures using the codes provided through the Fraud Scope Query, Aggregates tool (if applicable).

IDENTIFYING FWA SCHEMES

When billing for wound closures, be on alert for these common FWA-related schemes:

- High volume billing of complex wound closures when compared to lower paying wound closure codes
- High utilization of adjacent tissue transfers or rearrangement compared to peers
- High volume of larger body surface areas compared to peers
- Utilization of 14301 and 14302 by a plastic surgeon for any diagnosis related to weight loss, or post-weight loss surgery which would be considered cosmetic in nature and may not meet coverage criteria

For a complete list of codes and references, read our AI Alerts: Know Your Mohs, Part 1, and Know Your Mohs, Part 2.

Chapter 2

Diving into Hyperbaric Oxygen Therapy

With the ever-changing nature of healthcare, new treatments and codes are constantly appearing on claims. Understanding potential targets for fraud or inadvertent incorrect billing is critical for cost containment. One type of treatment where claim issues have been identified is with hyperbaric oxygen therapy (HBOT).

Hyperbaric oxygen therapy is a specialized treatment used in the medical profession to treat a wide range of conditions. According to the Mayo Clinic, it is commonly used to treat decompression sickness for scuba divers, serious infections, air bubbles in blood vessels, and wounds not healing due to diabetes or radiation injury.

For treatment, the patient is placed in the HBO chamber that is pressurized to 2.5-3x the normal atmospheric pressure to allow greater absorption of oxygen throughout the body and fight bacteria. Patients who receive this specialized therapy are closely monitored and observed for oxygen toxicity or other serious side effects of HBO therapy.

CODOXO RECOMMENDS: COMMON FWA RELATED SCHEMES TO WATCH OUT FOR

The Office of Inspector General has reviewed HBO therapy many times, most recently in 2017, when they found patients were receiving treatment for non-covered conditions, receiving treatment longer than medically necessary, and documentation did not support the treatment.

Based on these findings, we recommend monitoring the following areas in your claims:

- Unsupported diagnosis for treatment or physician services
- Excessive units of G0277 (greater than 4 units or 2 hours)
- Performing topical HBO and billing it as traditional HBO therapy
- High concentration of patients with long-term HBO
- Billing 99183 and G0277 on the same date by the same provider (typically the facility would bill for the G0277)

WHAT TO KNOW ABOUT MEDICARE COVERAGE CRITERIA

HBO therapy coverage under Medicare and Medicaid reimbursement for HBO therapy is limited to what is administered in a chamber and only for 15 conditions, including diabetic wounds of the lower extremities and chronic refractory osteomyelitis (chronic bone infections). View the National Coverage Determination (NDC 20:29) for CMS.

TO MINIMIZE ERRORS IN BILLING, WE RECOMMEND THE FOLLOWING APPROACH:

REVIEW

your plan's policies for commercial and governmental lines of business for coverage criteria.

REMEMBER

when a diabetic patient with a wound receives HBO therapy, two diagnoses need to be appended to the claim for Medicare, one for diabetes and the other specific to the wound to satisfy medical necessity.

IDENTIFY

the outlier providers in terms of your professional vs. facility spend for HBO therapy.

Understanding areas for potential billing errors in specialized treatments, such as HBOT, can help you and your team contain costs and lower the risk for fraud, waste and abuse.

PROCEDURE CODES

99183: Physician or other qualified healthcare professional attendance and supervision of hyperbaric oxygen therapy, per session

G0277: Hyperbaric oxygen under pressure, full body chamber, per 30-minute interval(s)

A4575: Topical hyperbaric oxygen chamber, disposable, note – this is considered investigational and may not be approved for coverage or payment criteria

For a complete list of Covered Single Diagnosis Codes and Coverage Dual Diagnosis Codes, visit AI Alert: Diving into Hyperbaric Oxygen Therapy.

Chapter 3

Let's Talk Physical Therapy Emerging Trends

As the country continues to return to pre-pandemic activities, there is an increased demand for physical therapists. A physical therapist's scope of practice allows them to provide a variety of services in multiple patient settings. Review your health plan's policy coverage criteria in your state.

The Codoxo team discovered emerging trends in physical therapy treatment that should alarm all healthcare payers and agencies. For example, several therapies are being advertised and promoted by numerous physical therapy practice websites in multiple states. What's alarming? We are finding that these therapies may not be within the scope of practice for a physical therapist.

The 969XX codes are appropriately found in a physician's fee schedule, which would pay considerably more, and are not typically listed in a physical therapist fee schedule because they are dermatologic codes. See the codes to the right to identify specific codes to watch. One exception: HCPCS code G0283, which is for electrical stimulation. Your health plan's policies may include additional exceptions for codes and services performed by a physical therapist.

CODOXO RECOMMENDS:
KNOW WHAT CODES TO WATCH OUT FOR

96910:

Photochemotherapy; tar and ultraviolet B or petroleum and ultraviolet B

96920:

Laser treatment for inflammatory (psoriasis) skin condition, total area less than 20 sq. cm

S8948:

Application of modality (requiring constant attendance) to 1 or more areas; low-level laser, each 15 minutes (not covered by CMS)

After experiencing a 16% revenue decline during the pandemic, physical therapy is now a **$34 billion industry**.

TOOLS YOU CAN USE TO ASSESS TRENDS IN YOUR NETWORK

Codoxo's patented Forensic AI Engine and the query tool can help your plan identify potential problems and assess unusual physical therapy trends in your network.

The following query criteria will allow you to surface services outside of the expected code range for physical therapy:

- **Query =** Professional, Aggregates, Rendering, Procedure Code
- **Specialty =** Physical Therapy
- **Procedure code =** Not Within This Range = 97010 to 97799
- **Provider Payment Received =** Minimum $1

When the query aggregate results return, build a chart to identify the total payments for unlikely services using the following steps:

- **Click Show Chart**
- **Variable 1 =** Procedure Code
- **Variable 2 =** Provider Payment Received
- **Chart Type =** Sum
- **Click Plot Chart**

UNDERSTANDING GROWTH IN THE PHYSICAL THERAPY INDUSTRY

- **$34 billion:** in physical therapy spend annually...and growing
- **6.2%:** forecasted industry growth, totaling $43 billion by 2025
- **42,300:** approximately how many clinics provide physical therapy, occupational therapy, speech therapy and audiology
- **$855,000:** average annual receipts per clinic, with a net profit margin of 14%

Source: MarketResearch.com

For a complete list of reference materials and resources, visit our AI Alert: Let's Talk About Physical Therapy Emerging Trends.

Chapter 4

ICD-10-CM Coding Update: Post COVID-19 Conditions

Throughout 2022, Codoxo's AI Alerts provided updates related to COVID-19 testing, diagnosis and vaccination based on news from the American Medical Association (AMA), Food and Drug Administration (FDA) and the Center for Disease Control (CDC). In this ever-evolving pandemic, our goal has been to share the latest information on the status of pending vaccinations and boosters and CPT codes to help you monitor and manage COVID-19-related healthcare claims.

Now three years into the pandemic, post-COVID-19 conditions have become an issue for recovering patients. According to the CDC, post COVID-19 conditions "are a wide range of new, returning, or ongoing health problems people can experience four or more weeks after first being infected with the virus that causes COVID-19." As of July 2021, post-COVID-19, also known as long COVID, can be considered a disability under the Americans with Disabilities Act (ADA).

USE OF CODE U09.9 FOR POST COVID-19 CONDITIONS

It is important to understand the proper use of code U09.9, post COVID-19 conditions, unspecified. In the 2022 International Classification of Diseases, 10th revision, clinical modification (ICD-10-CM) guidelines, a new section, I.C.1.g.1.m., specifies that for sequelae of COVID-19 or associated symptoms or conditions that develop following a previous COVID-19 infection, assign codes for specific symptoms or conditions related to the prior COVID-19 infection and code U09.9.

- Report U09.9 instead of B94.8, sequelae of other and unspecified infectious and parasitic disease.
- ICD-10-CM added a "code first" note under U09.9 that instructs coders to list first the code for the specific condition related to COVID-19, such as chronic respiratory failure (J96.1), loss of smell or taste (R43.8), or multisystem inflammatory syndrome (M35.81). This means U09.9 is intended to be used as a secondary diagnosis code.

Read our AI Alert, ICD-10-CM Coding Update: Post COVID-19 Conditions, for additional clarifications on using U09.9.

CODOXO RECOMMENDS:
AREAS TO MONITOR

- Continued utilization of B94.8 in lieu of the new U09.9 will result in a higher MS-DRG payment
- Some of these patients with U09.9 may require more supportive services post-discharge, such as:
    - Physical rehabilitation stays
    - Nursing home care
    - Durable Medical Equipment (DME), including one or more of the of following: walkers, wheelchairs, and oxygen
    - And more

Over the past three years, the healthcare industry has adeptly responded to the evolving nature of the pandemic through planning and coordination of testing and diagnosis, treatment of the virus and post-COVID conditions, and vaccinations. As long as COVID-19 remains active in the population and a source of fraud, waste and abuse, we will keep our customers updated on the latest developments from both the medical and billing perspectives.

EXAMPLES OF THE CORRECT USE OF U09.9

EXAMPLE A:

Patient is in the hospital with multisystem inflammatory syndrome related to a previous COVID-19 infection. The patient has a history of a COVID-19 infection 3 months ago but is not currently infected.

ASSIGN:

- M35.81, multisystem inflammatory syndrome
- U09.9, post COVID-19 conditions, unspecified

EXAMPLE B:

Patient is in the hospital with re-infection with COVID-19 and COVID pneumonia.

Patient also has COVID-19 related multisystem inflammatory syndrome from a previous infection.

ASSIGN:

- U07.1, COVID-19
- J12.82, COVID-19 pneumonia
- M35.81, multisystem inflammatory syndrome
- U09.9, post COVID-19 conditions, unspecified

For a complete list of COVID-19 codes, reference materials and resources, review our AI Alerts: COVID-19 Updates and ICM-10-CM Coding Update: Post COVID-19 Conditions.

Chapter 5

Telehealth Place of Service Coding Changes

Telehealth as an option for managing medical appointments became increasingly popular during the COVID-19 pandemic — and it's here to stay. The American Medical Association conducted a physician survey in late 2021 and found that even though there has been some decline in virtual appointments, 85% of the physicians who responded say they currently use telehealth, with most reporting they conduct a mix of in-person and telehealth visits. The survey also revealed that barriers to telehealth include "lack of insurer coverage of telehealth services" (76% of respondents) and "low or no reimbursement" (64% of respondents).

NOTABLE TELEHEALTH CODE CHANGES

In early 2022, the Centers for Medicare and Medicaid Services (CMS) made changes to the Place of Service (POS) code set. The POS code set provides setting information necessary to pay claims correctly. The CMS POS Workgroup revised the description of POS code 02 and created a new POS code 10 to meet overall industry needs. The new POS code was effective January 1, 2022.

POS 02: Telehealth Provided Other than in Patient's Home

POS 10: Telehealth Provided in Patient's Home

While CMS did not recognize the need for the new place of service code within their own billing guidelines, they did recognize the need for greater specificity for the healthcare industry.

FWA CONSIDERATIONS

The enhanced specificity of the POS adds an additional element for analysis for fraud, waste, and abuse. Why? It provides an opportunity to analyze where patients are located when receiving telehealth services at the time of service compared to the previous traditional telehealth indicators.

According to a report (OEI-02-20-00521) from the Health and Human Services, Office of Inspector General, most Medicare beneficiaries received telehealth services only from providers with whom they had an established relationship. Additionally, beneficiaries saw providers in person for about four months prior to their first telehealth service, on average. The report noted that the proportion of beneficiaries receiving telehealth services varied by type of service.

This data snapshot can be used to inform decisions about how to best use telehealth for policy considerations — particularly decisions about which services are allowed to be delivered via telehealth on a more permanent basis and the extent that beneficiaries should have a relationship with their providers prior to receiving certain telehealth services.

Trends show that medical professionals and their patients will continue to utilize telehealth as a convenient option for care, particularly in rural settings where there is limited access to physicians. As healthcare plans continue to adapt in order to address this need, it's important to stay up to date with the latest codes to ensure accurate claims processing.

CODOXO RECOMMENDS:
MONITORING FOR FRAUD, WASTE AND ABUSE

- Beneficiaries with high units of service via multiple places of service on the same date
- Beneficiaries with overlapping POS 02 and 10 codes on the same date of service
- Consecutive days of telehealth for beneficiaries
- Trends/baselines prior to new POS code 10 being implemented compared to current utilization
- High number of beneficiaries receiving treatment without an established prior relationship with the provider

For a list of references and more information on this topic, read the AI Alert, Telehealth Place of Service Coding Changes.

Interested in learning more about fraud, waste and abuse related to telehealth?

Download our white paper:
Fraud Schemes in a Telehealth Era: What Healthcare Payers Need to Know.

Chapter 6

Educating Your Pharmacy Network for Audit Preparedness

Pharmacies serve as a vital resource for the healthcare system, as well as for the communities they serve — in fact, the U.S. government recognized pharmacies as a critical touch point for medical care in the community during the COVID-19 pandemic, and issued a new scope of practice to pharmacists to help their communities during these tough times.

That said, pharmacy workers are increasingly stretched thin due to staffing shortages exacerbated by the onset of COVID-19. A late 2021 survey of pharmacy administrators conducted by the American Society of Health-System Pharmacists (ASHP) reported turnover rates of at least 21% in 2021, with nearly 10% of respondents reporting that they had lost 41% or more of their pharmacy technicians.

High turnover and heavier demands on workers can increase chances for error. To ensure state and federal standards are being followed, pharmacies must be prepared for routine audits mandated via CMS and Pharmacy Benefit Managers (PBMs). Pharmacy audits can consist of comprehensive desktop audits or even a visit to the pharmacy to conduct an onsite audit, involving physical review of the pharmacy and prescriptions at the dispensing site.

The Codoxo pharmacy analyst team conducted a holistic trend analysis of our audit activity to determine which pharmacy audit discrepancies occurred the most. After review, the two most common discrepancies are unclaimed prescriptions and prescription lacks specific, calculable directions.

COMMON PHARMACY DISCREPANCY #1: Unclaimed Prescriptions

Unclaimed prescriptions are those that have not been shipped to or claimed by the patient within a timeframe set by the pharmacy's contract agreement with the pharmacy claims processor (typically PBMs).

If the prescription goes unclaimed, the pharmacy must reverse the claim via the Point of Sale (POS) system and return the medication to stock. Any prescription claims not picked up or shipped within the contracted timeframe are subject to recoveries and may yield overpayments for violation of the pharmacy contract/agreement.

CODOXO RECOMMENDS:

- Request a copy of the pharmacy manual from the pharmacy claims processor. The manual should specify how many days the patient has to pick up the medication before the pharmacy returns it to stock.
- Ask for the signature log or tracking information, which should include the transaction date, when requesting prescription records from the pharmacy.
- Compare and calculate the number of days between the signature log date/shipping date and the fill date.

COMMON PHARMACY DISCREPANCY #2: Prescription Lacks Specific, Calculable Instructions

Sometimes prescriptions lack specific, calculable instructions or the prescriber instructions are incomplete. The prescriber may write "Take as Directed" (UTD) and leave out the information required to calculate the correct quantity to bill, such as frequency, the affected area, patient weight, max daily dose, or duration of treatment. This can cause the pharmacy to bill incorrectly or miscalculate patient copayment and it could result in a patient taking medication incorrectly.

CODOXO RECOMMENDS:

- Educate pharmacies to avoid this common issue. The pharmacy manual should outline what needs to be on the prescription to properly calculate the dose.
- If the prescriber does not include sufficient or clear instructions, advise the pharmacy to reach out to the prescriber's office to get clarification.
- Pharmacies should correctly document prescription changes or they will not be used during the audit process.

If a high number of these errors are found at a pharmacy during an audit, we recommend re-auditing at a later date.

Educating your pharmacy network proactively helps to reduce the burden on this already overwhelmed team of healthcare practitioners. The practice of pharmacy audit is necessary, but some discrepancies can be avoided with proper education of both pharmacies and prescribers.

For a complete list of references, visit our AI Alert: Educating Your Pharmacy Network for Audit Preparedness.

Chapter 7

Dental Fraud, Waste and Abuse: A Billion(s) Dollar Problem

Fraud, waste and abuse in the dental industry has a significant price tag. According to the National Health Care Anti-Fraud Association, of the $250 billion spent on dental care procedures annually nationwide, an estimated $12.5 billion (or 5%) is lost to dental fraud, waste and abuse (FWA). Not only does fraudulent billing lead to legal trouble for the practice owner and sometimes loss of the practice, but it also drives up the cost of dental coverage for patients and employers.

WHAT CAN YOU DO?

How can you help your customers contain costs as they review and process claims? Make sure that those who manage billing staff are knowledgeable about common errors that can easily be identified and avoided. Provide examples of potential discrepancies so they understand what constitutes FWA. Also insist they are armed with the latest codes, stay up to date on code changes and have resources to tap when questioning which code to use.

CODOXO RECOMMENDS: CODES TO WATCH

The following are examples of upcoding trends and services to monitor, including specific dental codes that may represent potential concerns for fraud:

D1351 – Sealant (per tooth)

Potential for fraud if filing sealants as one surface resin-based composite, D2391. A typical upcoding error for dentists is billing for a restoration after placing only a sealant or preventive resin.

D4341/D4342 – Periodontal scaling and root planning

Potential for fraud if the dentist performs a dental prophylaxis (prophy) D1110, but files the claim for scaling and root planning.

D2751 – Crown, porcelain fused to base metal

Potential for fraud if the dentist files the claim as D2750, porcelain fused to high nobel metal (“gold alloy) to increase reimbursement amounts.

D7140 – Extraction of erupted tooth or exposed root/D7210 – Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, including elevation of mucoperiosteal flap if indicated

Potential for fraud if the dentist submits extraction at one level of tooth impaction at a greater level.

ADDITIONAL DENTAL TRENDS TO MONITOR

D0180 – Comprehensive periodontal evaluation

Potential for fraud if the dentist performs a regular exam (D0120) but files a comprehensive periodontal evaluation, D0180.

D0210 – Intraoral complete film series

Potential for fraud if files reimbursement for D0210 when only a few intraoral films were taken.

Inaccurate billing – whether over-billing, under-billing or using incorrect codes – can have costly implications for dental practices, insurers and patients. Billing professionals who are up to date on billing codes and familiar with the risks of inaccurate billing will be less likely to make errors.

EXAMPLES OF DENTAL FRAUD, WASTE AND ABUSE:

- Billing for services not rendered
- Performing services not clinically necessary or justified
- Upcoding
- Misrepresentation of service
- Misrepresentation of the provider of the dental service
- Dental procedures performed outside their scope of practice (assistants, hygienists, etc.)

For a complete list of references, additional examples of dental FWA, and more, read our AI Alert: Dental Fraud, Waste and Abuse: A Billion(s) Dollar Problem.

Chapter 8

Mpox (Monkeypox) Declared a Public Health Emergency

As cases of COVID-19 continued a downward trend across the United States in the summer of 2022, the virus Mpox (formerly known as Monkeypox) began making headlines. Mpox, a type of orthopoxvirus responsible for causing cowpox and smallpox infections, was declared a public health emergency in the United States on August 4, 2022.

Mpox causes a rash with sores that look like pimples or blisters and turn into scabs before healing. Presently there is no known treatment available for this disease, though studies are underway. As of December 2022, the CDC reports there are two vaccines available to help prevent mpox spread. The CDC also provides guidelines for who should consider getting vaccinated, and, at the time this eBook was published, did not recommend broad public vaccination.

CODOXO RECOMMENDS: CODES FOR TESTING, DIAGNOSIS AND VACCINATION (AS OF DECEMBER 2022)

The American Medical Association (AMA) published the coding details for testing and the two current vaccines on July 26, 2022. Please refer below for an explanation of codes.

ADMINISTRATION CODES

Existing CPT vaccine administration codes (90460, 90461, 90471, 90472) should be used to report the administration of the vaccine products described by codes 90611 and 90622 depending on the age of the patient and the administration(s) provided during the encounter.

Inevitably, there are new viruses and illnesses on the horizon that will require a quick response by medical professionals and those who manage billing and compensation. It is critical for billing managers and healthcare partners to keep abreast of new codes as they are created, to understand how and when they apply, and to be on the lookout for discrepancies related to fraud, waste and abuse.

For a complete list of references, review our AI Alert: Monkeypox Declared a Public Health Emergency – Coding Guidelines and Health Plan Preparation.

TESTING CODE – 87593:

- infectious agent detection by nucleic acid (DNA or RNA)
- orthopoxvirus (e.g., mpox virus, cowpox virus, vaccinia virus), amplified probe technique

VACCINE CODES:

- **90611:** Smallpox and monkeypox vaccine, attenuated vaccinia virus, live, nonreplicating, preservative free, 0.5 mL dosage, suspension, for subcutaneous injection and requires two injections 28 days apart
- **90622:** Vaccinia (smallpox) virus vaccine, live, lyophilized, 0.3 mL dosage, for percutaneous use single injection

DIAGNOSIS CODE – B04: MPOX

Chapter 9

Double-down on Single Diagnosis Care Management Codes

According to the Center for Disease Control (CDC), more than half of Americans live with at least one chronic condition, such as (but not limited to) Alzheimer's, arthritis, cancer, diabetes, heart disease, and obesity. Chronic conditions typically last a year or more and require ongoing care, physician engagement, healthcare plan management, and coordination between patients, physicians and clinicians, and caregivers.

The population needs assistance with managing chronic conditions, and care management has become a "leading practice-based strategy for managing the health of populations," according to the Agency for Healthcare Research and Quality. Beyond developing care plans and coordinating services, benefits of care management may include early intervention for conditions, which could decrease health risks and keep costs down.

Care management services are defined as the management and support services provided personally by the physician or by their clinical staff (under the direction of a physician or other qualified healthcare professionals) to a patient residing at home, in a domiciliary, rest home, or assisted living facility.

THE MANAGEMENT AND/OR COORDINATION OF CARE MANAGEMENT SERVICES INCLUDES:

ESTABLISHING
implementing, revising, or monitoring the care plan

COORDINATING
the care of other professionals and agencies

EDUCATING
the patient or caregiver about the patient's condition(s), care plan, and prognosis

THE UMBRELLA OF CARE MANAGEMENT INCLUDES THREE CATEGORIES:

1. Chronic Care Management:

- Requires two or more chronic conditions or episodic health conditions which are expected to last for at least the next 12 months or until the death of the patient
- These chronic conditions must put the patient at a significant risk of death, acute exacerbation/ decomposition, or functional decline
- Comprehensive care plan established, implemented, revised, or monitored

2. Complex Care Management:

- Requires two or more chronic conditions expected to last at least 12 months or until the death of the patient
- Chronic conditions that place the patient at significant risk of death, acute exacerbation/ decomposition, or functional decline
- Comprehensive care plan established, implemented, revised, or monitored
- Moderate or high complexity of medical decision making

3. Principal Care Management:

Focuses on the medical and/or psychological needs manifested by:

- a single, high-risk disease, expected to last at least three months that place the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death
- the condition requires the development, monitoring, or revision of a disease-specific care plan
- the condition requires frequent adjustments to the medication regime and/or the management of the condition is unusually complex due to comorbidities
- ongoing communication and care coordination between relevant practitioners furnishing care

CODOXO RECOMMENDS:

If you find you have payments for complex or chronic care management for a single diagnosis, consider a documentation review to ensure the documentation supports the use of the code and time requirements.

For a list of CPT code examples for chronic care, complex care and principal care management; as well as a complete list of references, check out our AI Alert: Double-down on Single Diagnosis Care Management Codes.

Chapter 10

A Sharper View of Evolving Optometry Specialty Emerging Schemes

In recent months, Codoxo's partners have observed a procedure being performed by the optometry specialty that warrants monitoring. The procedure uses amniotic membrane to accelerate healing, especially in cases of severe inflammation. Per CMS guidelines, the indications for use for amniotic membranes include acute chemical burns, corneal scars, or defects, to cover glaucoma drainage, keratitis, keratoconjunctivitis, and ocular herpes. We highly recommend reviewing policies for coverage and limitations. The CPT code 65778 covers the application of amniotic membrane placed directly on the ocular surface (or cornea) without suturing, much like a contact lens.

The amniotic membrane comes either cryopreserved or dehydrated which is prepared from placentas obtained following a cesarean section. The procedure may be performed by either an optometrist or ophthalmologist depending on what plan policy allows. The HCPCS code for the membrane itself is V2790, which was not observed as billed in association with the 65778. Please note, some health plans prohibit optometrists from performing this procedure or the procedure code contains bundled payment for the membrane and the procedure.

PREVENTING BILLINGS ISSUES

To prevent discrepancies or issues in billing, optometrists performing this procedure must keep detailed medical records and ensure billing specialists are familiar with the CPT codes. According to Ophthalmology Management, the 65778 code is used for both dry and cryopreserved amniotic membranes, and the procedure is generally covered when medically necessary. However, prior-authorization may or may not be required.

CODOXO RECOMMENDS:
RED FLAGS TO WATCH OUT FOR

- The frequency at which the provider is performing this procedure per patient
- Use of the 79 Modifier. It is not appropriate in this situation if it is applied to both eyes, especially if performed by an optometrist since they are not allowed to perform surgical procedures.
- Separate billing for use of 69990, operating microscope

Health plans and agencies should monitor high-risk providers, those with the highest overall payments, and highest paid per-patient values to identify overutilization and/or policy violations.

Visit our AI Alert, A Sharper View of Evolving Optometry Emerging Schemes, to:

- Review our 10-step process for focusing on high-risk providers using the Fraud Scope Schemes module
- Explore how to use Codoxo's Query Aggregates tool for optometry specialty emerging schemes
- Sharpen your view of coding errors and policy violations using our Query Claims
- See a complete list of references

Chapter 11

Identifying Outlier Utilization of Synagis During the RSV Season

While respiratory syncytial virus (RSV) has long been a formidable threat to children, hospitalization rates over the first six weeks of the typical RSV season (November to March) have increased dramatically over recent years.

RSV hospitalizations for infants, ages newborn to six months, were nearly two and a half times what they were during the first six weeks of the 2021-2022 RSV season. Rates for children who are six- to 12- months-old quadrupled. Percentage data generated by Codoxo shows the alarming increase of hospitalizations between the first six weeks of the prior RSV seasons to the first six weeks of the 2022 season for high-risk populations.

PERCENT INCREASE OF RSV HOSPITALIZATIONS

RSV SEASON	0-<6 MONTHS	6-<12 MONTHS	1-<2 YEARS	2-4 YEARS	5-11 YEARS
2018-2019	1088%	1024%	984%	1868%	1678%
2019-2020	821%	774%	929%	1147%	2157%
2021-2022	248%	431%	324%	475%	487%

RSV commonly produces mild, cold-like symptoms; however, patients with pre-existing respiratory issues or immune-compromised systems, including premature babies, may become infected with pneumonia, bronchiolitis, and other respiratory tract issues that result in hospitalization. Parents who heartbreakingly watch their children suffer are desperate for relief and treatments. The good news is an FDA-approved treatment called Synagis (palivizumab) is available for high-risk pediatric patients.

SYNAGIS AS A TREATMENT

Synagis is an FDA-approved, monoclonal antibody, injectable treatment to prevent acute lower respiratory infection (ALRI) for pediatric patients with a high-risk of RSV (see table on page 23). It is administered once per month during the RSV season, starting at the onset of the season, typically for a maximum of five treatments, and is prescribed based on patient weight.

Synagis is an expensive, prophylactic treatment that requires pre-authorization. Claims may appear in a health plan as a medical benefit or pharmacy benefit, identified by a CPT, HCPCS, or NDC code. Injections occur most commonly in a physician's office, patient's home, or a facility.

Specialty pharmacies in collaboration with health plans have Synagis pre-authorization forms that are submitted by the prescribing physician. Pre-authorization using a premature pediatric patient growth chart can help catch potentially excessive dosages. It also assures payment for the approved services or drugs and allows a health plan to recover payments retrospectively.

DIAGNOSTIC CONDITIONS THAT PUT CHILDREN AT HIGH RISK FOR RSV

History of premature birth and 6 months of age or younger at the beginning of RSV season

Bronchopulmonary dysplasia (BPD) that required medical treatment within the previous 6 months and who are 24 months of age or younger at the beginning of RSV season

Hemodynamically significant congenital heart disease (CHD) and who are 24 months of age or younger at the beginning of RSV season

CODOXO RECOMMENDS:

Reference premature age-to-weight compensatory growth charts (see AI Alert) as a tool to identify excessive dosage requests. This is a countermeasure to assess the requested Synagis dosage from the prescribing providers for pediatric patients whose history contains ICD-10 CM codes specific to low birth weights, gestation periods less than 37 weeks and percentile benchmarks.

At the conclusion of your region's RSV season, identify high-risk pediatric patients whose dosages are 100mL or more (especially those who are less than one year of age and who were born prematurely). Also review patient records that precede the Synagis request. The objective is to identify prescribers whose requested dosages appear to exceed the amount needed compared to their expected growth.

There are many nuances associated with prescribing and processing claims for Synagis. It's important to educate prescribing providers about proper dosage requests and billing codes. Codoxo's goal is to help our clients minimize discrepancies and waste, and protect their bottom line.

For more information and insights about RSV, Synagis, and a complete list of references, please see the comprehensive Forensic AI Alert: Identifying Outlier Utilization of Synagis During the RSV Season.

DIAGNOSED CONDITION	ICD-10 CM CODES OR RANGE
Respiratory syncytial virus	B974
Cardiomyopathy, unspecified	I429
Heart failure, unspecified	I509
Premature birth	P0721 to P0738
Bronchopulmonary dysplasia	P271 to P279
Pulmonary hypertension of newborn	P2930
Arterial/Ventricle/Coronary/Aortic/Venous [range of issues]	Q200 to Q269

* Your healthcare plan may offer coverage for diagnosed conditions in addition to the FDA recommendations. Please review and consider those conditions when reviewing pre-authorization requests for Synagis.

Conclusion

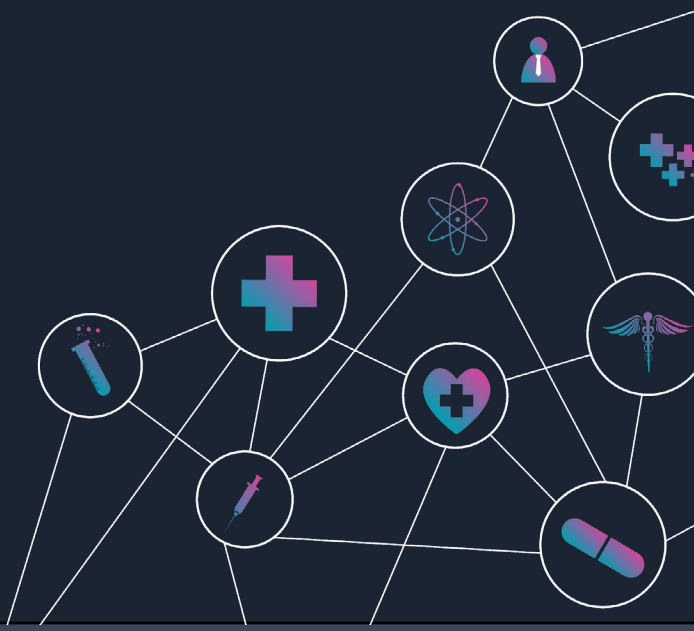
The U.S. healthcare system continues to be overburdened with rising healthcare costs and an increasing amount of dollars lost to fraud, waste, and abuse – and 2022 was no exception. Healthcare leaders are often working with limited resources and time and struggle to proactively stay ahead of evolving FWA and keep informed of ways to minimize FWA and ensure payment integrity within their organizations.

The Forensic AI Alerts provided by Codoxo throughout the year keep healthcare payers, agencies and PBMs informed about trends, new and changing CPT codes, and emerging FWA threats that could impact their bottom line. The alerts also include best practices and pragmatic tips and guidance that can be realistically, and quickly implemented by Special Investigation Units (SIUs) and/or cost containment teams for immediate results.

We are committed to helping clients contain healthcare costs and ultimately make the U.S. healthcare system more affordable and effective. We recommend leaders leverage artificial intelligence (AI), machine learning (ML) and automation solutions like Codoxo's Unified Cost Containment Platform because threats to the bottom line happen quickly, and healthcare leaders need solutions that act faster. Technologies like these add a layer of protection through rapid and accurate detection of evolving schemes and speed to actionable insights for early intervention. With a post-pandemic rise in utilization, much of which is due to treatment of chronic illnesses (diabetes, hypertension, obesity, and mental health), healthcare leaders will be faced with even greater opportunity for bad actors in 2023 and beyond.

Our payment integrity and FWA experts will continue to keep a pulse on the latest trends in FWA and across the healthcare industry that impact cost containment so that we can regularly keep our healthcare payers and PBM customers informed and ahead of bad actors.

Interested to learn how we are using AI technology to re-envision healthcare affordability and effectiveness? View our monthly Forensic AI Alerts.



ABOUT CODOXO

With a mission to make healthcare more affordable and effective for everyone, Codoxo is the premier provider of artificial intelligence-driven solutions and services that help healthcare companies and agencies proactively detect and reduce risks from fraud, waste, and abuse and ensure payment integrity. The Codoxo Unified Cost Containment Platform helps clients manage costs across network management, clinical care, provider coding and billing, payment integrity, and special investigation units. Our software-as-a service applications are built on our proven Forensic AI Engine, which uses patented AI-based technology to identify problems and suspicious behavior far faster and earlier than traditional techniques. Our solutions are HIPAA-compliant and operate in a HITRUST-certified environment. For additional information, visit www.codoxo.com.

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