DOCTORS' RESOURCE SPECIALISTS

"Once a new technology rolls over you, if you're not part of the steamroller, you're part of the road."

-- Steward Brand

Client Memo September 2018

NEWS Updates

Changes to E&M Coding & Fee Schedule

After more than 20 years, CMS is proposing to make major changes to the E&M coding and payment structure. The provisions are part of the recently released 2019 Physician Fee Schedule proposed rule which will affect most providers and all specialties.

CMS is redefining the 1995 and 1997 guidelines for E&M coding in 2019. The payment structure for new and established patient office visits will be changed to a single specific RVU.

The proposal offers $93 for established office visit codes and $135 for new patient visits.

CPT Code	2018 Non-Facility Payment Rate	Proposed 2018 Non-Facility Payment Rate
99201	$45	$44
99202	$76	$135
99203	$110	
99204	$167	
99205	$211	
99211	$22	$24
99212	$45	$93
99213	$74	
99214	$109	
99215	$148	

CMS also wants to simplify E&M coding by letting providers choose the office visit code based upon the most important component of the visit:

- medical decision making (MDM), or
- face time spent with the patient, without the existing requirement that the visit be counseling-dominated.

Other provisions of the 2019 Proposed Physician Fee Schedule Rule include:

- New add-on G-codes to increase the payment for those providers who see sicker patients with more complex conditions;
- A new G-code to cover prolonged services,
- Office visits billed on the same day as a procedure with modifier 25 would be paid 50% less;
- No need for providers to personally document patient histories.

Please note that the final rule may be different from the summaries provided above.

The proposed rule can be found at: https://www.federalregister.gov/documents/2018/07/27/2018-14985/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions

Thoughts On CMS's Dramatic Proposal For E/M Guidelines - Lucien W. Roberts, III, *Physicians Practice,* Aug 8, 2018

I have long been a critic of the complexity and subjectivity of the current guidelines. However, I think these changes will be both a good thing and a challenge to physicians, particularly those who derive much of their income from office visits.

CMS has proposed to bundle both established patient visit codes 99212 through 99215 into a single code and new patient visit codes 99202 through 99205 into a single code. The lowest established and new patient visit codes, 99211 and 99201, would remain, but given the small frequency with which they are used, the biggest impact to physicians will be from providing care under the bundled codes

Here are my five impressions of the proposed rule that, if passed, would take effect Jan. 1, 2019.

The winners and losers

Physicians who frequently code level 4 and 5 services will see a decrease in E/M reimbursement, as the proposal sets future service payment at less than the current reimbursement rate for level 4 services. Conversely, physicians who code the majority of their services as level 3 will see their E/M reimbursement go up since the services will be paid at more than the current reimbursement for level 3 services.

Objectivity at last

Coding E/M services is subjective and confusing. Fewer than 6 in 10 physicians would code an office visit at the same level. And yet, Medicare and other payers have penalized physicians for over-coding using Recovery Audit Contractors, chart audits, and other tools. Those days of selecting the wrong code and thus being accused of fraud should go away under the proposed plan.

No more note bloat

The new codes will require minimum documentation, enough to meet what is needed today for a level 2 visit, and that's it. Physicians can focus on what has changed rather than redocumenting what has not. All of the note bloat that adds nothing to patient care—and is glossed over by anyone receiving your note, anyway—will be marginalized.

Since the advent of click-and-count documentation in EHRs, the use of level 4 and 5 codes has nearly doubled. They account for almost half of all E/M services today and have been trending steadily upwards for nearly 20 years.

Care will improve

Providers can now focus on their patients and on documenting what really matters: the care provided and the care plan. Documentation will be better and, I think, easier. Notes received from other doctors will be similarly streamlined and—dare I say—cogent.

Like the Lorax, I have spent years advocating for changes that seemed obvious to me but oblivious to those in power. CMS is at long last moving in the right direction. There will be losers, this being a zero-sum game, but these proposed changes are good for all of us and our patients. I believe that, and overall, I am pleased with CMS's proposal.

Lucien W. Roberts, III, MHA, FACMPE, is the administrator of Gastrointestinal Specialists, Inc., a 25-provider practice in Central Virginia.

CMS Proposes 50 Percent Reduction in Claims Submitted with Modifier 25

CMS has proposed modifications to the reimbursement model for the outpatient/office E&M code sets, as well as the anticipated documentation relaxation accompanying the proposal, writes Shannon DeConda in the August 28th, 2018 article for *ICD 10 Monitor.*

These two portions of the proposed changes are getting much publicity, but what seems to be getting missed with all of the E&M hype is the proposed reimbursement changes to services billed with a Modifier 25.

CMS's proposed change in this area would impact not the documentation requirements, but rather the reimbursement model associated with Modifier 25. Currently, if a claim is received by CMS that includes an E&M service with a Modifier 25 and a procedure, both the E&M and the procedure are reimbursed at 100 percent of the allowed amount.

CMS proposes to reduce the reimbursement for the service with the lower value by 50%.

Why is CMS proposing this change? It has provided two reasons:

- Multiple payment reduction: CMS is comparing an E&M with a procedure to a surgical encounter in which multiple payment reductions are applicable.
- Efficiencies: CMS feels that there are "efficiencies" associated with an E&M encounter and procedure on the same visit that the multiple payment rule should be applied to these instances.

Based on the current rules associated with the proper use of Modifier 25, I am not really sure how either of these reasons are valid.

Modifier 25 is used when a procedure (with a 0-10-day global period) is performed on the same day as an E&M encounter. If the patient presents to the office for a problem, regardless of whether the provider has seen the patient or treated the problem before, if the provider decides that the patient would benefit from a procedure, then the E&M service is not additionally reimbursed.

Modifier 25 appended to the E&M code indicates that there was more to the encounter other than the standard decision-making for the procedure rendered.

Consider the financial implication this will have on your practice, and consider posting your comments for CMS consideration.

MIPS UPDATE

2017 MIPS Performance Feedback and Payment Adjustment Update

CMS originally displayed a single payment adjustment amount, which included an additional adjustment for exceptional performance available to MIPS eligible clinicians and groups with a final score of 70 or greater.

Based on feedback from various clinicians and groups, CMS has updated the system so that your MIPS payment adjustment, and if applicable, your additional adjustment for exceptional performance, are now displayed separately.

Quality Payment Program Exception Applications Now Available on QPP Website

The 2018 Quality Payment Program MIPS Exception Applications for either the Promoting Interoperability (PI) performance category or Extreme and Uncontrollable Circumstances are now available on the Quality Payment Program website https://www. qpp.cms.gov

Promoting Interoperability Hardship Exceptions

If you're participating in MIPS during the 2018 performance year as an individual, group, or virtual group—or participating in a MIPS Alternative Payment Model (APM)—you can submit a Quality Payment Program Hardship Exception Application for the Promoting Interoperability performance category (aka meaningful use), citing one of the following specified reasons for review and approval:

- MIPS-eligible clinicians in small practices (new for 2018),
- MIPS-eligible clinicians using decertified EHR technology (new for 2018),
- Insufficient Internet connectivity,
- Extreme and uncontrollable circumstances, or
- Lack of control over the availability of certified electronic health record technology (CEHRT)

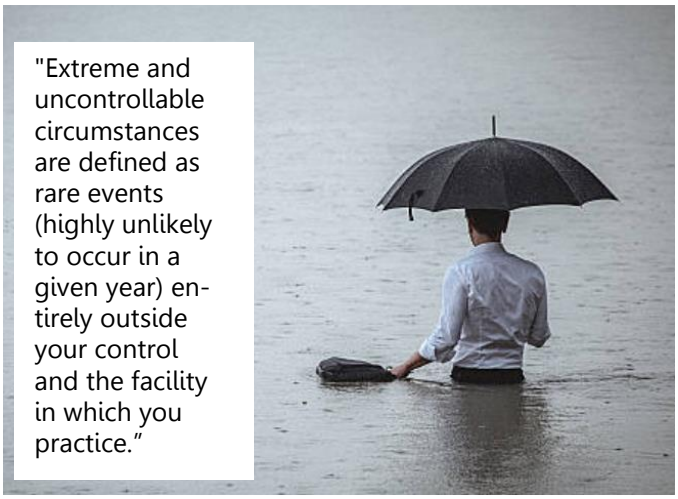
An approved QPP Hardship Exception will:

- Reweight your PI performance category score to 0 percent of the final score
- Reallocate the 25 percent weighting of the PI performance category to the Quality performance category

Please note that simply not using CEHRT does not qualify you for reweighting of your PI performance category.

You must submit a hardship exception application by December 31, 2018 for CMS to reweight the PI performance category to 0 percent.

Extreme and Uncontrollable Circumstances



MIPS eligible clinicians who are impacted by extreme and uncontrollable circumstances may submit a request for reweighting of the Quality, Cost, and Improvement Activities performance categories.

The application for extreme and uncontrollable circumstances must be submitted by December 31, 2018 for the 2018 MIPS performance year.

For More Information:

- Review the 2018 Exceptions FAQ Sheet https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Exceptions-FAQs.pdf
- Contact the Quality Payment Program at QPP@cms.hhs.gov or 1-866-288-8292/TTY: 1-877-715-6222.
- Email: QPP@cms.hhs.gov
- Visit the Quality Payment Program Website https://www.qpp.cms.com

2015 Edition Certified EHR's Mandatory per CMS

CMS is standing firm with its mandate that all providers must use 2015 Edition Certified EHRs in 2019. This version opens APIs, a key ingredient in the effort to achieve full interoperability in healthcare, CMS Administrator Seema Verma announced on Monday, August 6, 2018. An API is a new approach to content management with many advantages over the 'old' way.

Physicians to Expect Greater Competition for Bonuses in 2019 -- Terry Fletcher BS, CPC, *ICD 10 Monitor,* August 14, 2018

Revisions in the QPP proposed rule, tucked into the 2019 Physician Fee Schedule, will make for heightened competition and expectations among physicians participating in MIPS as CMS continues to link performance to patient outcomes.

In looking towards 2019, physicians need to make sure they are not only informed and implementing measures on the performance standards to receive their bonuses, but are also mindful of the penalties they can incur with non-compliance.

In the 2018 QPP final rule, CMS predicted that 74 percent of MIPS-eligible clinicians will earn a score of 70 or greater for the 2018 performance year. This bolsters the expectation that the performance threshold for 2019 will be much higher than for 2018, thereby significantly raising the level of competition for earning incentives and avoiding penalties.

Remember, this is a program that anticipates winners and losers, so you want to be on the winning side, or your monetary penalties for non-participation and/or non-compliance will find their way into the pockets of the proactive physicians, as CMS likes to label "the winners" of their MIPS program.

Waiving Patient Copays or Deductibles

Tom Ambury's comments on the WebPT blog *"Legal Compliance: One More Reason to Collect Patient Deductibles and Copays,"* from July 24, 2017, are just as relevant now as they were a year ago. He has warned that routinely waiving copays and deductibles for patients with a federally funded insurance like Medicare can be a violation of the Federal Anti-Kickback Statute.

For commercial insurances like BlueCross BlueShield, Aetna, and Cigna, Mr. Ambury warns that there are potential legal ramifications for providers who routinely waive copays and deductibles.

Commercial insurance providers have contracts to provide health insurance to employers and employees and now, under the Affordable Care Act, to individuals as well. They must charge a premium for that health insurance, which the employer, employee, and\/or individual must pay.

Because this contract is a legally binding agreement with an employer or individual, if a provider comes along and decides to unilaterally waive patient deductibles and copays, then the provider is reducing the covered person's contractual financial obligation.

If an in-network provider routinely waives deductibles and copays, not only does it interfere with the employer's and/or individual's contractual obligations, it potentially violates the provider's own agreement with the insurance company.

What to Do Instead

- ✓ Adopt the policy of making every reasonable effort to collect all deductibles and copays—unless the patient can demonstrate a financial hardship.
- ✓ Establish a procedure patients must use to demonstrate a financial hardship, and document it. Also, make sure the patient signs an acknowledgment that he or she has a financial hardship.
- ✓ Even if a patient can demonstrate a financial hardship, you don't necessarily have to waive it in full. In other words, you're free to negotiate. Ask the patient, "What can you afford to pay each visit?"

(Tom Ambury has been a physical therapist for 23 years and developed the PT Compliance Group.)

What's the Problem?

Frank Carsonie, JD, and Nathan Sargent, JD, of Benesch, Friedlander, Coplan & Aronoff LLP, Columbus, OH, warn providers of the legal ramification of waiving copays and deductibles in their article "What's the Problem? Providers' Waivier of Patient Copays or Deductibles" for *Anesthesia Business Consultants*, Spring of 2018. Excerpts from their article are presented below.

Plans and healthcare providers establish rates and fee schedules for covered healthcare services by contract. Despite the existence of such contractual arrangements, both in-network and out-of-network health-care providers sometimes waive patient copays, co-insurance and deductibles and they do so for different reasons and under varying circumstances.

HEALTHCARE PROVIDERS WHO GRANT WAIVERS SHOULD KNOW THAT THERE ARE SERIOUS HEALTHCARE FRAUD AND ABUSE IMPLICATIONS UNDER FEDERAL AND STATE LAW

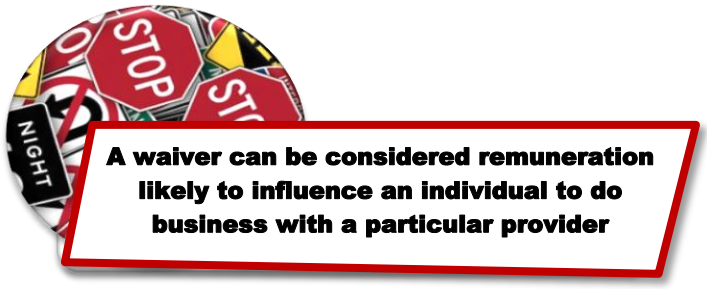
What Laws Apply to Patient Copay or Deductible Waivers?

At the federal level, healthcare provider waivers implicate civil monetary penalties under the Social Security Act as well as the Federal Anti-Kickback Statute.

- **Section 1128A(a)(5) of the Social Security Act**: any person (including an organization, agency or other entity) that offers, or transfers, remuneration to an individual eligible for Medicare or Medicaid benefits, and such person knows or should know the remuneration is likely to influence an individual to order or receive a covered Medicare or Medicaid service from a particular healthcare provider, is subject to a civil monetary penalty (**the CMP Law**).

- **Federal Anti-Kickback Statute**: any person (an entity or individual) that knowingly and willfully pays or offers to pay any remuneration, directly or indirectly, overtly or covertly, in cash or in kind, to any person to induce such person to purchase, lease, order or arrange for any good, service or item for which payment may be made, in whole or in part, by a federal healthcare program, such as Medicare and Medicaid.

Like the civil monetary penalties, a violation of the Anti-Kickback Statute may result in exclusion from participation in Medicare and Medicaid and the imposition of civil monetary penalties in an amount equal to treble damages plus $50,000 per violation.



States often have their own healthcare fraud and abuse laws. Some states even have statutes and regulations that govern the specific practice of healthcare provider waivers.

Others address the issue in provider disciplinary rules and standards of professionalism, expressly prohibiting a licensed practitioner from waiving patient insurance obligations except under certain circumstances

What's Permitted Under Civil Monetary Penalties

As it relates to the CMP Law, "remuneration" is specifically defined to include the waiver of coinsurance, copay and deductible amounts (or any part thereof). However, a waiver does not become remuneration subject to the CMP Law prohibitions if:

- The waiver is not offered as part of any advertisement or solicitation; and
- The healthcare provider does not routinely waive or reduce coinsurance, copay or deductible amounts; and
- The healthcare provider (a) waives or reduces the coinsurance, copay or deductible amounts after determining, in good faith, that the individual is in financial need or (b) fails to collect after making reasonable collection efforts.

Irrespective of when a waiver is granted, there are serious ramifications that must be duly considered. If you have questions about any past, current or proposed waiver practices, you should consult experienced healthcare regulatory counsel.

Four Reasons to Integrate EHR and Practice Management Software

You have EHR software, and you have practice management software. But they aren't on speaking terms. They don't even speak the same language, and this language barrier may be doing more harm to your practice than you realize, writes Avery Hurt in *Physicians Practice*, July 9, 2018.

Simply integrating these two systems can fix a lot of problems. If you've been hesitating to take the plunge, here are a few reasons why you shouldn't wait.

You'll save time

"Integrating medical records and practice management software cuts out a lot of duplicate effort," says Laurie Morgan, a San Francisco-based senior consultant and partner with medical consulting firm Capko & Morgan. If your programs are not integrated, the billing staff has to re-key what providers have written or logged somewhere else.

When the systems are combined, the clinician keys in the information and the codes and other information flow through to billing. You only input the data one time. It greatly speeds up the process.

You'll save money

"Practices often underestimate the costliness of redoing work," says Morgan. Paper super bills can be hard to read, and that means stopping the process to ask questions or redoing work more often.

Saving time is not the only way integration can save you money, however. Integrating EHR and practice management systems can increase revenue because having the data all in one system makes it easier to pull claims to submit to payers. If it's easier to submit claims, you get them in faster. It's also easier for integrated systems to identify and correct improperly coded procedures.a

You'll make fewer mistakes

Putting in data only once reduces errors as well. Each time someone rekeys data, there is another chance for mistakes to creep in. Consolidating patient data increases the accuracy of reports generated and makes for a seamless transition of data between the practice management system and the EHR system. This will increase the accuracy of healthcare data on all fronts.

You have a lower risk of privacy breaches

One unexpected benefit of integration is that the systems can help keep your data safe. An integrated system is easier to maintain and keep secure than multiple systems. It's a low-risk, cost-effective way to make your practice more efficient and more profitable.

MEDICARE & MEDICAID NEWS

New Medicare Card: 0 not O

The Medicare Beneficiary Identifier (MBI) uses numbers 0-9 and all uppercase letters except for S, L, O, I, B, and Z. CMS excludes these letters to avoid confusion when differentiating some letters and numbers (e.g., between "0" and "O").

EPCS Mandatory for Arizona Prescribers

Beginning January 1, 2019, an electronic prescription to a pharmacy for a schedule II drug that is an opioid is required in Maricopa, Pima, Pinal, Yavapai, Mohave and Yuma counties. This same requirement becomes effective in Greenlee, La Paz, Graham, Santa Cruz, Gila, Apache, Navajo, Cochise and Coconino counties on July 1, 2019.

Basic Steps to Get Started with EPCS

- Notify your vendor that your prescribers are ready to begin using EPCS
- Complete identity proofing requirements
- Obtain dual (two-factor) authentication device or process
- Set up security access controls

Prescribers interested in learning more about how to start utilizing EPCS can view a step-by-step video from Surescripts at www.GetEPCS.com.

AHCCCS Extends Meaningful Use Attestation Deadline!!

The Attestation deadline for Program Year 2017 has been extended until September 30th at midnight Mountain Standard Time.

We are working hard to keep you on the edge of healthcare. Help us fulfill our strong commitment to maintain our level of service excellence by providing us with your feedback. Please feel free to contact Sue or Julie at 1.877.845.2969.

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