AQREVA

Medical Billing & Consulting

Client Memo December 2019

"Laughter is the sun that drives winter from the human face." -- Victor Hugo

NEWS Update

Claims Will Reject Without New MBI Numbers Beginning January 1, 2020

Please make sure Medicare patients are turning in their new Medicare cards in order to avoid delayed payments in 2020. Starting on January 1, 2020, all claims will be rejected if the new Medicare Beneficiary Identifiers (MBIs) are not used.

CMS has been recommending that all patient records be updated as soon as possible. The Medicare look-up tool on the Medicare portal will no longer be available at the end of 2019. All eligibility transactions submitted with the old Medicare numbers will also be rejected starting January 1, 2020.

CMS Releases Physician Fee Schedule With 'Significant' E/M Overhaul

CMS released the final 2020 physician fee schedule on Friday, November 1, 2019. The new rule includes major changes in payments and policies for office visits, opioid treatment, and supervision rules for physician assistants, writes Kerry Dooley Young in her November 4, 2019, article for *Medscape Medical News.*

The final rule also carries several changes in Medicare's approach to E/M services, which are slated to take effect in 2021.

These include simplifying the documentation of continuing care for patients with serious and complex chronic conditions. The AMA praised this aspect of the rule, calling it the "first overhaul of E/M office visit documentation and coding in more than 25 years."

"This new approach is a significant step in reducing administrative burdens that get in the way of patient care," said Patrice A. Harris, MD, president of the AMA, in a statement. "Now it's time for vendors and payors to take the necessary next steps to align their systems with E/M office visit code changes by the time the revisions are deployed on January 1, 2021."

The American Medical Group Association (AMGA) also applauded the E/M coding changes. In a statement, AMGA said it had been concerned about an earlier CMS proposal that would have collapsed E/M levels 2 through 5. Instead, the final rule opted to assign a separate payment rate to each of the office and outpatient E/M visit codes.

The AMGA also said it agreed with CMS's decision to maintain the level 1 visit code for established patients since it helps facilitate a team-based approach to care delivery and allows various members of the care delivery team to develop a relationship with a patient.

CMS Sticks With Controversial Rule

In the final rule, CMS stuck with another proposed E/M change that had angered clinicians in some specialties.

CMS plans adjustments in 2021 that may boost certain payments for some specialties, while lowering it for others. This approach earlier drew an outcry from groups targeted for reductions after CMS released the proposed physician fee rule in July.

In an article posted on the AMA website, the organization said it remains concerned about "significant payment reductions anticipated for some physicians." The AMA said it intends to work with CMS to persuade the agency that all specialties' payments for office visits should be recognized as equivalent.

Physician Assistants Get "Greater Flexibility"

The physician fee rule also will give physician assistants "greater flexibility to practice more broadly in the current health care system in accordance with state law and state scope of practice," CMS said in a press release. "In the

absence of state law, if there is documentation at the practice which demonstrates the working relationship that PAs have with physicians in furnishing their professional services, then this would be adequate to ensure that the statutory requirement for PA/Physician supervision is met."

Other Provisions

Separately, the rule also creates new coding and payments for a monthly bundle of services for the treatment of opioid abuse. This includes overall management, care coordination, individual and group psychotherapy, and substance use counseling, as well as an add-on code for additional counseling.

Telehealth services can be used for certain individual psychotherapy, group psychotherapy, and substance use counseling, CMS said.

Revocation of Medicare Rights

CMS also stuck with its intention to create a pathway for revoking or denying Medicare participation to clinicians who have harmed patients. Many medical groups had protested against these provisions in the draft rule.

In the final rule, CMS stressed that it intends to restrict the new revocation authority to "significant cases of patient harm."

More detailed information on the final rule can be obtained from the CMS Fact Sheet:

https://www.cms.gov/newsroom/fact-sheets/finalized-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar

E/M Prep for 2021 Transition

New Medicare office-visit coding guidelines are simpler and more flexible, but physician practices will need to prepare to get the full benefit of the burden relief the changes are designed to bring. Learn more about what you should be doing within your practice to make a smooth transition, writes Andis Robeznieks in the AMA November 5, 2019, bulletin.

The revised coding guidelines for outpatient E/M services represent the first major overhaul of E/M reporting in more than 25 years. They also have significant potential to give doctors more time to spend with patients by freeing them from clinically irrelevant administrative burdens that led to time-wasting note bloat and box checking, Mr. Robeznieks adds.

These changes include:

- Eliminating history and physical exam as elements for code selection.
- Allowing physicians to choose whether their documentation is based on medical decision-making (MDM) or total time.
- Modifying MDM criteria to move away from simply adding up tasks to focus on tasks that affect the management of a patient's condition.

While administrative burdens are reduced, practices still need to get ready for the revisions .when they take effect January 1, 2021.

The AMA offers tools and resources to help practices transition to the new reporting guidelines:

https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management

Three activities that a practice may immediately initiate include the following.

1. Identify a project lead. The transition will require staff education, review of internal policies and procedures, and careful financial tracking. Picking the right person to ensure that all components of the transition are executed in a timely manner is critical.
2. Schedule team preparation time. The best way to educate your practice about these upcoming changes will be to walk through them with the practice's physicians, other clinical staff and administrative personnel. Schedule time for in-person gatherings to review the changes and address questions that arise.
3. Update practice protocols. It is important that practice procedures and protocols are updated to be consistent with the new guidelines. The AMA recommends leveraging your practice's established coding resources and expertise early in the update process.

The revised guidelines were developed by a workgroup assembled by the AMA representing its Current Procedural Terminology (CPT®) Editorial Panel and the AMA/Specialty Society RVS Update Committee (RUC).

The workgroup was led by Barbara Levy, MD, a former RUC chair, and Peter Hollmann, MD, former chair of the CPT Editorial Panel.

Dr. Levy explained that the new documentation will be based on the traditional SOAP—subjective, objective, assessment and plan—in which physicians would document what the patient was there for (subjective), what was learned from their history and exam (objective), and then what the physician assessed to be the problem, and the plan for dealing with it.

2020 Quality Payment Program Final Rule Released – MIPS Gets Tougher

CMS issued its final policies for the 2020 performance year of the Quality Payment Program (QPP) via the Medicare Physician Fee Schedule (PFS) Final Rule.

Key finalized policies for 2020 include:

- Maintaining the weights of the Cost (15%) and Quality (45%) performance categories
- Increasing the performance threshold from 30 points to 45 points
- Increasing the data completeness threshold for the quality data that clinicians submit to 70%
- Increasing the Improvement Activity performance category participation threshold for group reporting from a single clinician to 50% of the clinicians in the practice
- Revising the specifications for the Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) Clinician measures
- Updating requirements for Qualified Clinical Data Registry (QCDR) measures and the services that third-party intermediaries must provide (beginning with the 2021 performance period)

Security Risk Tool Updated

The updates include an enhanced user interface, modular workflows, custom assessment logic, progress tracker, threats and vulnerabilities rating, and detailed reports.

It can be downloaded from the following site:

https://www.healthit.gov/topic/privacy-security-and-hipaa/security-risk-assessment-tool

ONC also added business associate and asset tracking, an area that many providers have struggled to keep pace of in the current expansive digital health environment.

The tool diagrams HIPAA Security Rule safeguards and provides enhanced functionality to document how your organization implements safeguards to mitigate, or plans to mitigate, identified risks.

The new SRA Tool is available for Windows computers and laptops. However, the previous iPad version of the SRA Tool is still available from the Apple App StoreWeb Site Disclaimers (search under "HHS SRA Tool"). The SRA tool is not available for Mac OS.

The tool is now more user friendly, with helpful new features like:

Enhanced user interface
Modular workflow
Custom assessment logic
Progress tracker
Threats & vulnerabilities rating
Detailed reports
Business associate and asset tracking
Overall improvement of the user experience

Security risks must be routinely assessed, at least annually or as needed, such as when new technology is introduced onto the network.

CPT Code Changes for 2020 – AMA Press Release, September 4, 2019

There are 394 code changes in the 2020 CPT code set, including 248 new codes, 71 deletions, and 75 revisions. In making these updates, the CPT Editorial Panel considered broad input from physicians, medical specialty societies and the greater health care community.

Among this year's important additions to CPT are:

- Six new codes to report online digital evaluation services, or e-visits. These codes describe patient-initiated digital communications provided by a physician or other qualified health care professional (**99421, 99422, 99423**), or a non-physician health care professional (**98970, 98971, 98972**).
- Codes **99473, 99474** to better support home blood pressure monitoring that aligns with current clinical practice and to report self-measured blood pressure monitoring.
- New codes for health and behavior assessment and intervention services **96156, 96158, 96164, 96167, 96170** and add-on codes **96159, 96165, 96168, 96171**. These codes replace six older codes to more accurately reflect current clinical practice that increasingly emphasizes interdisciplinary care

coordination and teamwork with physicians in primary care and specialty settings.

- Significant enhancement to the codes for reporting long term EEG monitoring services: **95700-95726**. Four older codes were deleted to make way for 23 new codes that provide better clarity around the services reported by a technologist, a physician, or another qualified health care provider.

New CPT category I codes are effective for reporting as of Jan. 1, 2020.

Avoiding Common CCM Denials

Lisa Eramo's November 13, 2019, *Medical Economics* article, "How to Avoid Common Chronic Care Management Denials," outlines some of the common reasons for denials and how to avoid them as identified by Kim Garner Huey, CPC, owner of KGG Coding and Reimbursement Consulting in Birmingham, Alabama.

Reason for denial: Multiple providers bill CCM for the same patient during the same 30 days.

- How to avoid it: Communicate with specialists regarding who will bill for the CCM. This code was really intended for primary care, but it's not restricted to primary care.

Reason for denial: Physician bills CCM more than once every 30 days.

- How to avoid it: Set up an alert in the practice management system that prevents physicians from reporting CCM before 30 days have elapsed.

Reason for denial: Insufficient documentation.

- How to avoid it: This problem often surfaces during post-payment audits. Avoid recoupments by ensuring that documentation reflects the intent of the code, i.e. to manage all of the patient's chronic conditions.

- CMS intended a very personalized, hands-on type of medical management. Ms. Huey explains that documentation such as 'Patient is taking medications as prescribed' is not sufficient." Instead, the following should be documented:
  - List of all of the patient's conditions with as much specificity as possible
  - Why these conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
  - Comprehensive care plan: What the physician is doing to manage the diagnoses. If a specialist is managing a condition, the primary care physician should note the specialist's name, the date of the last appointment, and a brief summary of the visit.

For more information about CCM, including patient and practitioner eligibility as well as the service elements included in the code, please review the following information provided by CMS:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

90% Healthcare Providers Still Rely on Fax Machines, Posing Privacy Risk

The healthcare sector has rapidly increased the deployment of advanced technologies, such as machine learning, for more than a decade

Despite the availability of more secure messaging platforms and other technologies, 90 percent of healthcare still relies on fax machines, according to a new TigerConnect report, writes Jessica Davis in her article for *Health IT Security,* November 14, 2019.

The report can be reviewed at:
https://pages.tigerconnect.com/State-of-Healthcare-Comms-Report-LP.html

Another 39 percent are still using pagers, while a significant number are also heavily relying on landlines to communicate.

"The shocking lack of communication innovation comes at a steep price," TigerConnect CEO Brad Brooks wrote. "The downstream impact is a health system that commonly experiences chronic delays, increased operational costs that are often passed down to the public, physician and nurse burnout, medical errors that could otherwise have been prevented, or at worst case, lead to patient death."

"While the industry faces serious challenges when it comes to communication — both among care teams and between patients and providers — the good news is that technology exists to address the problems in a meaningful way that can

rapidly lead to improved patient experiences and optimal healthcare outcomes," he added.

In addition to patient safety risk, fax machines pose a risk to patient privacy. There's a long list of breaches caused by patient records being sent to the wrong fax number. Other researchers have found risks to patient data itself, including vulnerabilities in the devices and data left on machines at the end of the product lifecycle.

CMS has also called to an end to fax machine use in healthcare by 2020.

Despite these risks, Tiger Connect found providers are not only still overwhelmingly using legacy technology, 55 percent of the 200 report respondents said their organization is behind or very behind in adopting modern communication technology compared to other sectors.

Traditional calls are the most common form of communication in healthcare, followed by email. But fax communications are the third-most used method, followed by pagers.

As a result, 39 percent said they felt communication between care team members was very difficult or difficult. Another 52 percent said they have experienced communication disconnects that impact patients daily, or several times each week.

Further, there is a 50 percent greater likelihood of daily communication disconnects when secure messaging is not used across the enterprise. Meaning, it's difficult to reach the right person at the right time, causing bottlenecks.

Patients are also noticing the communication gap: 74 percent of patients who spent time in a hospital in the last two years indicated they were frustrated by inefficient communication processes.

However, the report did highlight some promising statistics. Nearly half of organizations use EHR communication as much as whiteboards. And secure messaging is the top communication method for both nurses (45 percent) and providers (39 percent).

Effective communication in healthcare is critical to the efficient delivery of quality healthcare across the continuum, yet it continues to lag in terms of priorities!

90% of SNFs Predict No Shift in Value-Based Payments in 2020 – Jacqueline LaPointe, *RevCycle Intelligence*, November 21, 2019

Long-term and post-acute care providers cannot move forward with value-based payment implementation without the support of technology, according to a recent Black Book Research survey.

Survey results can be viewed at: https://blackbookmarketresearch.newswire.com/news/post-acute-providers-predict-probable-insolvencies-under-value-based-21033595

The survey of 1,640 providers of long-term and post-acute care providers found that nearly 90 percent of skilled nursing and sub-acute facilities predict no shift in the portion of their payments from value-based care models in 2020. The primary reason why: lack of health IT capabilities and preparation.

Specifically, value-based payment implementation will require more robust use of EHR technology and data analytics software to support care coordination, the survey found.

Only 21 percent of inpatient post-acute care providers reported having some technological capabilities of EHRs operational by the end of 2019. This percentage is up from 15 percent in 2016, but still significantly lower compared to other provider types.

Corporate chains and large non-profit systems had the highest EHR adoption rates among network post-acute care facilities at nearly 40 percent by the end of 2019. That percentage is up from 27 percent in 2016, the survey stated.

Data analytics software implementation also remained low among long-term and post-acute care providers surveyed. Only four percent of inpatient long-term care providers said their organization leveraged data-driven analytics to reduce costs, avoid unnecessary hospital readmissions, and ensure facilities earned accurate, complete reimbursement.

Furthermore, nearly three-quarters (72 percent) of post-acute care organizations did not have the internal human resources or capital to implement a health IT strategy and successfully adopt solutions in 2019, the survey revealed.

Additionally, 91 percent of care managers surveyed reported that hospitals send their most complex patients with the highest morbidity to skilled nursing facilities with little to no communication.

The survey showed that 80 percent of long-term care organizations are already struggling to account for care, earn proper reimbursement, manage eligibility, prove medical necessity, and negotiate favorable reimbursement rates.

This problem could get worse as Medicare looks to shift post-acute care providers to a value-based payment system.

HHS Secretary Alex Azar vowed to shift skilled nursing facilities and other post-acute care providers to a value-based system in a 2018 speech at an American Health Care Association and National Center for Assisted Living conference.

HHS followed through on its promise, implementing the Patient Driven Payment Model for skilled nursing facilities in October 2019. The new payment system ties skilled nursing facility reimbursement to patient needs, rather than therapy volume.

Measuring Quality in the Long-Term Care Setting

Last year, *U.S. News* introduced a novel composite quality measure and corresponding Short-Term Rehabilitation rating that assessed the performance of skilled nursing facilities in post-acute care.

The Short-Term Rehabilitation rating has been updated and a Long-Term Care rating has been introduced to help people in need of daily assistance and their families decide where to go for residential care, writes Zach Adams, et al, in *Health US News,* October 15, 2019.

These 2019-20 ratings for nearly 15,000 nursing homes, as well as descriptive information on a few hundred more, were made public on October 29, 2019, on *U.S. News* Best Nursing Homes, replacing the 2018-19 ratings that are currently available there. The website is located at:

https://health.usnews.com/best-nursing-homes

The 2019-20 Short-Term Rehabilitation rating was determined by ten measures of facility quality, and the Long-Term Care rating by nine.

This year the Short-Term Rehabilitation ratings newly incorporate several measures of quality, including consistency of registered nurse staffing, use of antipsychotic drugs, and success in preventing falls.

The Long-Term Care rating includes data on staffing, success in preventing ER visits, hospitalizations and pressure ulcers, use of antianxiety and hypnotic drugs, residents' ability to self-care, pneumonia vaccination rates, and the rate of substantiated complaints coming from residents or their families.

All measures in both ratings were developed from publicly available data released by CMS as of August 2019. It should be noted that CMS publishes its own ratings of nursing homes using some of the same source data; however, its methodology and results are unrelated to those of *U.S. News*. Because the *U.S. News* Best Nursing Homes ratings are derived from a different methodology than the CMS Five-Star Quality Rating System, the ratings assigned may differ.

For example, the *U.S. News* ratings — but not CMS's ratings — factor in the percentage of days each home met federal standards for registered nurse staffing hours. Researchers have found that the CMS methodology, which considers only average staffing levels, can fail to identify recurring lapses in staffing, such as on weekends, that could put residents at greater risk for accidents and neglect.

A detailed report on the methodology behind both *U.S. News* ratings is available at:

https://media.beam.usnews.com/a5/14/e81c1ae849c4b9b6880219e8b704/191025-bnh-methodology-2019.pdf

Each nursing home that was rated in Short-Term Rehabilitation, Long-Term Care, or both, received a *U.S. News* Overall rating. Expressed on a 5-point scale, it summarizes a facility's Short-Term Rehabilitation and Long-Term Care ratings.

In contrast to the current *U.S. News* method, CMS assigns facilities an overall star rating by combining three domain ratings that are not used by *U.S. News*. Because of changes this year to the methodology for producing the Overall rating, a home's 2019-20 Overall rating should not be compared to its 2018-19 Overall rating.

-- *U.S. News* Best Nursing Homes

12% of Medicare Advantage Plans Will Offer Expanded Supplemental Benefits in 2020

The Medicare Advantage boom for home care is almost here writes Robert Holly in his November 4, 2019, article for *Home Health Care News*.

Ever since CMS first expanded the scope of Medicare Advantage supplemental benefits in April 2018, at-home care providers have been trying to figure out how they fit into a potentially new reimbursement puzzle.

At least initially, it appeared that fit was a relatively minor one, as only 3% of MA plans offered in-home support services such as personal care and housekeeping in 2019, according to AARP statistics.

But a new independent study by actuarial consulting firm Milliman now confirms there will be a substantial expansion in 2020.

Overall, at least 364 plans will take advantage of CMS's more flexible MA policies in 2020, according to the Milliman study, which was commissioned by the Washington, D.C.-based Better Medicare Alliance. That's nearly 12% of the 3,148 plans that will be available to Medicare beneficiaries next year.

"The growth in supplemental benefits across Medicare Advantage plans as compared to 2019 tells a remarkable story of how plans are finding new ways to care for the whole person and address social determinants of health," Allyson Y. Schwartz, president and CEO of the Better Medicare Alliance, said in a statement. "These benefits not available in traditional Medicare help enrollees to safely remain in their own homes, avoid social isolation — and lead longer, healthier lives."

The increased number of plans offering expanded MA supplemental benefits is largely tied to CMS's updated guidance allowing plans to cover anything that has "a reasonable expectation" of improving or maintaining the well-being of beneficiaries with chronic conditions.

Broadly, Medicare Advantage plans must provide coverage for all benefits covered by fee-for-service Medicare. Without any additional funding, MA plans may also offer other services and supports not covered by traditional Medicare, such as dental, vision and home care.

Although the number of plans offering expanded supplemental benefits is projected to more than triple from 2019 to 2020, plans will continue analyzing the value of home care and its success in attracting new MA members and lowering re-hospitalization risk.

At least 64 MA plans will cover adult day health services in 2020, according to Milliman's research. Historically, no MA plan has ever provided coverage for adult day services.

Besides adult day health services, at least 58 plans will cover home-based palliative care in 2020, while at least 148 plans will cover in-home support services. Additionally, 77 plans will offer benefits aimed at supporting the caregivers of enrollees.

Another 192 plans will cover things like non-opioid pain management, which includes therapeutic massage.

Only 29 plans offered home-based palliative care benefits last year; just 51 offered in-home support services benefits.

Of the 354 plans offering expanded supplemental benefits in 2020, at least 116 will offer more than one.

In 2019, there wasn't a single plan that offered more than one of the benefits Milliman included in its analysis.

The analysis from Milliman is, more than anything, a snapshot. It does not include the full picture of benefits being offered in 2020, researchers noted, as CMS has not yet released all relevant MA data.

Skilled Nursing Facility 3-Day Rule Billing

In a recent report, the Office of Inspector General (OIG) determined that Medicare improperly paid for SNF services when the Medicare 3-Day inpatient hospital stay requirement was not met.

To qualify for SNF extended care services coverage, Medicare beneficiaries must meet the "3-day rule" before SNF admission. The 3-day rule requires the beneficiary to have a medically necessary 3-day-consecutive inpatient hospital stay and does not include the day of discharge, or any pre-admission time spent in the emergency room (ER) or in outpatient observation, in the 3-day count.

CMS developed the Skilled Nursing Facility 3-Day Rule Billing Fact Sheet to help you bill correctly.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SNF3DayRule-MLN9730256.pdf

MIPS Update

The MIPS submission window is quickly approaching. Please make sure you have created a HARP account and identified roles needed for submission in order to begin the attestation process.

To create a HARP account, please go to:
Harp.qualitynet.org/register

If you already have a HARP account, the following are some tips to keep your account active.

Passwords must:

- Be changed every 60 days.
- Be changed prior to expiration.
- Contain between eight and twenty characters.
- Contain at least one upper case letter, lower case letter, and number.
- Not contain more than four sequential numbers, such as 1234.
- Contain a special character except ? < > ( ) ' " ? | &.

Important Dates for MIPS 2019

December 31, 2019

- Performance year 2019 ends
- QPP Exception Application windows closes January 2, 2019
- Submission Window opens for performance year 2019

March 31, 2019

- Submission Windows closes

Medicare News

2020 Medicare Parts A & B Premiums and Deductibles – CMS Fact Sheet

On November 8, 2019, CMS released the 2020 premiums, deductibles, and coinsurance amounts for the Medicare Part A and Part B programs.

For 2020, the Medicare Part B monthly premiums and the annual deductible are higher than the 2019 amounts. The standard monthly premium for Medicare Part B enrollees will be $144.60 for 2020, an increase of $9.10 from $135.50 in 2019. The annual deductible for all Medicare Part B beneficiaries is $198 in 2020, an increase of $13 from the annual deductible of $185 in 2019.

The Medicare Part A inpatient hospital deductible that beneficiaries will pay when admitted to the hospital will be $1,408 in 2020, an increase of $44 from $1,364 in 2019.

Microsoft will no longer Support Windows 7 on January 14, 2020

AQREVA would like to wish everyone a happy and safe holiday season.

AQREVA Holiday Schedule:

Tuesday, December 24th – AQREVA will be closed.
Wednesday, December 25th – AQREVA will be closed.
Wednesday, January 1st – AQREVA will be closed.

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