AQREVA

Medical Billing & Consulting

Client Memo
November 2019

"We should certainly count our blessings, but we should also make our blessings count."

-- Neal A. Maxwell

NEWS Update

Unpacking Proposed MIPS Changes

CMS recently proposed Merit-Based Incentive Payment System changes in 2020 and beyond, including a new participation framework and higher performance thresholds

Jacqueline LaPointe's article for *Revcycle Intelligence*, August 7, 2019, explores the changes proposed by CMS, including the MVP methodology, and how CMS plans to make the transition.

CMS proposed revisions to the Medicare Physician Fee Schedule and Quality Payment Program for the 2020 calendar year. Chief among the revisions was the MIPS Value Pathways (MVPs), a conceptual participation framework that would streamline MIPS reporting by requiring eligible clinicians to report on a smaller set of measures that are specialty-specific, outcome-based, and more closely aligned with alternative payment models starting in the 2021 performance year.

The MVP framework would address provider burdens and other concerns by shifting clinicians towards an aligned set of measures that are relevant to the clinician's scope of practice, CMS explained.

CMS plans to have clinicians report on the same "foundational" measures, which are based on Promoting Interoperability measures and a set of administrative claims-based quality measures that focus on population health and public health priorities.

Clinicians would then report on measures across the Quality, Cost, and Improvement Activities categories based on their specialty or the condition being treated.

Another key component of the MVP framework proposal is enhanced data and feedback to clinicians, the agency stated. CMS is planning to analyze existing Medicare information in order to provide timely and better feedback to clinicians on how to improve health outcomes.

CMS plans to shift eligible clinicians to the MVP framework within the next two years. In the meantime, clinicians will face a transitional year in 2020.

CMS does plan to move forward with full MIPS implementation by the 2022 performance year, which is the sixth year of the Quality Payment Program. At that time, the agency intends to set the performance threshold as the mean or median of the final scores for all MIPS eligible clinicians for the previous period.

MIPS tips and tricks

CMS recently announced that 98.4% of eligible clinicians participated in the second year (2018) of MIPS reporting and that 97.6% of those earned a positive payment adjustment, writes Amy Amick in her article "5 Ways to Create and Implement Better MIPS Quality Improvement Strategies" in *Physicians Practice,* September 26, 2019.

MIPS promises to get even more difficult for physicians and other providers in 2020.

CMS has increased the threshold for "exceptional" performers from 70 to 75, meaning physicians will have to do more to earn the designation of top performers. The negative penalty threshold, meanwhile, has doubled from 15 points to 30 points.

Practices that want to earn positive payment adjustment in the years ahead should adopt the following MIPS reporting strategies used by practices that enjoyed exceptional performer status in 2018.

1. **Determine Eligibility and Target Most Relevant Quality Measures**

   CMS asks practices to report on six measures, or a complete specialty measure set, including one outcome measure. Ms. Amicks suggests providers select at least 10 measures to track throughout the year so they have options when choosing their top six quality measures.

2. **Access Consistent Data Elements to Demonstrate Achievement.**

   Too often, physicians improve one performance metric (e.g., blood sugar stabilization) but use multiple workflows to capture this data across a practice or health system. As a result, performance scores do not always reflect the quality of care being provided.

   Providers should examine their performance by using a consistent measuring tool rather than multiple workflows to capture the data

3. **Mine Data with Core Competencies in Mind**

   Practices have droves of data stored in their EHRs but they only need a small portion of that data to make improvements that align with MIPS goals.

   Once a practice has selected its 10 or so measures to focus on for the entire year, providers can improve their data extraction efforts by mining quality data codes, other codified data, and structured texts to ensure they're capturing all essential population health information.

4. **Develop Physician and Patient Engagement Plans**

   To engage physicians, review CMS rules, develop a work plan and ensure that continuing education plans focus on educating physicians in a way that is convenient and accessible.

   For patients, focus on tools that engage patients between visits. For example, some practices have employed flu shot campaigns that include timed, targeted email reminders to high-risk patients, and those efforts have led to major improvement in a MIPS performance metric.

5. **Assess Your Data Throughout the Year**

   Quality improvement is a year-round activity that requires dedicated staff to monitor data and implement quality improvement programs. Avoid the end-of-year rush by reviewing performance at regular intervals, such as quarterly or monthly.

   This way, if a problem arises, it can be addressed before it escalates. In addition, continuous improvement positions the organization well for the additional increases in MIPS thresholds and financial impact in 2020 as outlined by CMS in the 2020 Quality Payment Program proposed rule.

While CMS is upping the ante with elevated 2019 MIPS thresholds, practices can see this change as an opportunity to strengthen quality improvement initiatives.

CDC Issues Vaping Coding Guidelines

An ACDIS.org bulletin was issued on October 24, 2019, announcing that the CDC had issued vaping coding guidelines. Details can be found at:

https://www.cdc.gov/nchs/data/icd/Vapingcodingguidance2019_10_17_2019.pdf

The purpose of this document is to provide official diagnosis coding guidance for health care encounters and deaths related to e-cigarette/vaping product use associated lung injury (EVALI).

Other codes for conditions unrelated to e-cigarette, or vaping, products may be required.

Lung-related complications: For patients documented with e-cigarette, or vaping, product use associated lung injury (EVALI), assign the code for the specific condition, such as:

- J68.0, Bronchitis and pneumonitis due to chemicals, gases, fumes and vapors; includes chemical pneumonitis
- J69.1, Pneumonitis due to inhalation of oils and essences; includes lipoid pneumonia
- J80, Acute respiratory distress syndrome
- J82, Pulmonary eosinophilia, not elsewhere classified
- J84.114, Acute interstitial pneumonitis
- J84.89, Other specified interstitial pulmonary disease

For patients with acute lung injury but without further documentation identifying a specific condition (pneumonitis, bronchitis), assign code:

- J68.9, Unspecified respiratory condition due to chemicals, gases, fumes, and vapors

Poisoning and toxicity: Acute nicotine exposure can be toxic. Children and adults have been poisoned by swallowing, breathing, or absorbing e-cigarette liquid through their skin or eyes. For these patients assign code:

- T65.291-, Toxic effect of other nicotine and tobacco, accidental (unintentional); includes Toxic effect of other tobacco and nicotine NOS.

Substance use, abuse, and dependence: For patients with documented substance use/abuse/dependence, additional codes identifying the substance(s) used should be assigned.

When the provider documentation refers to use, abuse and dependence of the same substance (e.g. nicotine, cannabis, etc.), only one code should be assigned to identify the pattern of use based on the following hierarchy:

- If both use and abuse are documented, assign only the code for abuse
- If both abuse and dependence are documented, assign only the code for dependence
- If use, abuse and dependence are all documented, assign only the code for dependence
- If both use and dependence are documented, assign only the code for dependence.

Specifically, for vaping of nicotine, assign code:

- F17.29-, Nicotine dependence, other tobacco products. Electronic nicotine delivery systems (ENDS) are non-combustible tobacco products.

Tobacco cessation counseling – Renee Dowling, *Medical Economics*, September 25, 2019

Tobacco cessation counseling codes **(99406-99407)** have been included in the CPT® book since 2008, and, since 2016, they may be reported separately and in addition to other E/M services.

There are several guidelines for these codes, so it is important to bill and document them appropriately.

The codes for tobacco cessation counseling are:

- **99406** Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes,
- **99407** intensive, greater than 10 minutes

These codes are covered in the outpatient and inpatient setting for Medicare patients with the disorder(s) listed below.

F17.210	**Nicotine dependence, cigarettes, uncomplicated**
F17.211	in remission
F17.213	with withdrawal
F17.218	with other nicotine-induced disorders
F17.219	with unspecified nicotine-induced disorders
F17.220	**Nicotine dependence, chewing tobacco, uncomplicated**
F17.221	in remission
F17.223	with withdrawal
F17.228	with other nicotine-induced disorders
F17.229	with unspecified nicotine-induced disorders
F17.290	**Nicotine dependence, other tobacco product, uncomplicated**
F17.291	in remission
F17.293	with withdrawal
F17.298	with other nicotine-induced disorders
F17.299	with unspecified nicotine-induced disorders
T65.221A	**Toxic effect of tobacco cigarettes, accidental (unintentional), initial encounter**
T65.211A	**Toxic effect of chewing tobacco, accidental (unintentional), initial encounter**
T65.292A	**Toxic effect of other tobacco and nicotine, accidental(unintentional),initial encounter**
Z87.891	**Personal history of nicotine dependence**

*NOTE: Additional ICD-10 codes may apply. Contact your Medicare Administrative Contractor (MAC) and private payers for specific codes and coverage guidelines.

Additional Billing Information

In addition to at least one of the disorders listed, patients must also:

i. use tobacco (regardless of whether they exhibit signs or symptoms of tobacco-related disease)
ii. be competent and alert at the time of counseling
iii. the counseling must be furnished by a qualified physician or other non-physician provider.

Counseling sessions may be performed "incident to" the services of a qualified practitioner.

Medicare will cover **two cessation attempts per year.** Each attempt may include a maximum of four intermediate or intensive counseling sessions. **The total annual benefit** covers up to eight smoking and tobacco-use cessation **counseling sessions in a twelve-month period**. The patient may receive another eight counseling sessions during a subsequent year after eleven months have passed since the first cessation counseling session was performed.

Medicare will not cover tobacco cessation services if tobacco cessation is the primary reason for the patient's hospital stay. Medicare waives copay/ coinsurance and deductible for these services.

Required Documentation

Since these are time-based codes, documentation needs to include the time spent counseling the patient and the counseling detail. It is also important to note that additionally-reported E/M services must be distinct, and the time spent performing the tobacco cessation counseling service may not be used as a basis to select the E/M code level.

Expanding State Medical Licenses

Physicians looking for relief from the burden of having to apply for medical licenses in several states when their work crosses borders got affirmation on September 24, 2019, that the American Academy of Family Physicians (AAFP) is working to change that.

Delegates voted to lobby for more states to sign on to the Interstate Medical Licensure Compact here at the AAFP 2019 Congress of Delegates. Since the inception of the Compact in 2017, 27 states plus Guam and the District of Columbia have joined, reports Marcia Frellick in her article for *Medscape Medical News*, September 25, 2019

The Interstate Medical Licensure Compact (IMLC) is now active in more than half of the United States. Kentucky and North Dakota recently enacted legislation to join the Compact, making them the 26th and 27th states to join, announced the FSMB (Federation of State Medical Boards) on April 11, 2019.

The following jurisdictions are IMLC members: Alabama, Arizona, Colorado, District of Columbia, Guam, Idaho, Illinois, Iowa, Kansas, Kentucky, Maine, Maryland, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Hampshire, North Dakota, Pennsylvania, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin and Wyoming.

The initiative remains under consideration in Florida, Georgia, Oklahoma and South Carolina.

With this interstate approach, licenses are expedited for qualified physicians who want to practice in multiple areas, according to the IMLC website. A physician's home state can attest to the qualifications of an applicant seeking licensure in another state.

The primary mission of interstate licensing is to increase patient access to medical experts in underserved areas and to allow patients to more easily connect with medical experts through telemedicine.

> "Having to get licensed in another state often limits the number of volunteers available to help out, especially in underserved areas."

Assisting Patients With Rising Costs Of Prescription Drugs

Prescription drug prices are on the rise. Data from CMS reveals that on average, Americans spend approximately $1,200 a year on prescription medications, numbers that have gone up due to rising prices.

As of July 2019, more than 3,400 drugs have increased in price, a 17% increase compared with the nearly 2,900 drug price hikes at the same time in 2018, according to a new analysis by Rx Savings Solutions, which provides pharmaceutical advice to health plans and employers.

Resources, including assistance programs offered by pharmaceutical companies, nonprofit groups or state governments, are available that can help those who are eligible.

To get the assistance process started, patients need to fill out an application with the drug manufacturer. If the patient qualifies, the doctor might have to provide additional information.

Many states offer drug assistance programs. These vary and tend to be geared toward the elderly, the disabled, those in financial need, or patients with specific conditions, like HIV/AIDS or end-stage renal disease.

-- courtesy of edbellisinc.com

In addition, there are assistance programs run by nonprofit groups, such as Partnership for Prescription Assistance, that help low-income, uninsured patients get free or low-cost brand-name medications.

The table on the next page lists a multitude of apps that doctors and patients can use to help find lower prices for prescription drugs.

RESOURCES FOR PATIENTS

Here are organizations and apps you can point patients to for drug price help:

- **NeedyMeds:** maintains an extensive online database of patient assistance programs, drug discount programs and drug coupons
- **RxAssist:** an online database of drug company programs that provide free or affordable drugs and co-pay assistance
- **Center for Benefits:** provided by the National Council on Aging, which shares information about assistance programs for low-income seniors and young adults with disabilities.
- **Honeybee Health:** an online pharmacy founded by pharmacists, offers an evident drug pricing search that helps consumers check and compare the cost of their prescription medications.

And some additional apps that physicians recommend include:

- **GoodRx:** An app that's free to download that provides drug discounts for patients and allows comparison shopping at different local pharmacies. There is a paid version that provides more discounts in some cases.
- **Easy Drug Card:** A discount prescription app for uninsured patients or who have insurance that won't cover the cost of a particular medicine. It can help people save up to 80 percent on FDA-approved drugs at over 60,000 pharmacies nationwide according to its website.
- **FamilyWize:** Another free app that provides a discount card for use at most major pharmacies. The average savings is 40 percent per prescription, according to data on its website.
- **ScriptSave WellRX:** Especially helpful for those without insurance or whose insurance does not cover a prescription medication, this app also provides a card that can help people save up to 80 percent on prescriptions.

CMS is Watching: PDPM changes

Changing Therapy Patterns Raise Concerns About Skilled Nursing Audits, Care Quality

The first week of the new Medicare payment model for nursing homes has brought stories of rapidly shifting therapy patterns among some providers, and voices from the consulting and advocacy worlds are warning that any sudden movements could cause adverse effects, both immediately and down the road, writes Alex Spanko, in the October 7, 2019, edition of *Skilled Nursing New.*

The advent of the Patient-Driven Payment Model (**PDPM**) on October 1, 2019, triggered layoffs and strategy changes at several major companies, as *Skilled Nursing News* reported last week. But while the staffing reductions garnered the most attention, both from industry-watchers and therapists struggling with sudden job losses, the changes have gone beyond layoffs, according to American Physical Therapy Association director of regulatory affairs, Kara Gainer.

In addition to workforce reductions, Gainer said her organization's members have reported significant conversions to PRN, or as-needed, status, as well as pressures from leadership to maximize the use of group and concurrent therapy services and boost individual productivity**.**

PDPM, in the works for more than 18 months, marks a significant sea change in how skilled nursing facilities and their contract therapy providers offer their services. Where the old system directly linked payment levels with the amount of therapy provided, the new model seeks to connect reimbursements to individual resident needs, with greater funding for services associated with higher-acuity residents.

The model is also meant to be revenue-neutral, meaning the federal government will not be increasing its total amount of Medicare spending on nursing homes.

CMS has placed a 25% cap on group and concurrent therapy programs, down from an initially proposed limit of 50%, but that threshold still gives operators significant headroom to expand

Gainer emphasized that she's received positive reports from therapists at skilled nursing facilities that have taken PDPM's patient-first message to heart, and many of the operators that have spoken to SNN since the change took place emphasized that they took pains to clearly communicate their staffing and strategy changes well before PDPM took effect.

"Really, it was CMS's intent that this model would re-empower therapists to use their clinical judgment, because it was no longer based on minutes — it's based on what the patient needs," Gainer said.

Still, the preliminary news reports were enough for APTA and its fellow therapy advocacy organizations — the American Occupational Therapy Association and the American Speech-Language-Hearing Association — to issue a joint statement last week to announce that they had been sharing members' stories about therapist layoffs to CMS officials.

"We voiced our concerns that, as a result of these changes, Medicare beneficiaries may be harmed if they do not have access to the medically necessary skilled therapy that they need," the joint statement read.

The bumpy transition period reveals a difficult truth about any new payment model: Every change will have a cascading set of effects, with winners and losers emerging in both the immediate wake and the long term.

The revenue neutrality of PDPM means that there should still be plenty of reimbursement money for appropriate therapy treatments moving forward, though potentially not at the same levels of high-intensity therapy as under the previous system.

CMS itself was blunt in warning providers about its monitoring plans as early as last year.

But the exact form that CMS's actions will take remains to be seen. The agency could potentially refer cases to the Department of Health and Human Services' (HHS) Office of the Inspector General (OIG), its top fraud watchdog, according to Gainer.

"There will be no penalty for exceeding the 25% combined concurrent and group therapy limit. Providers will receive a warning edit on their assessment validation report that will inform them that they have exceeded the 25% limit."

That warning edit will note that "consistent violation of this limit" could result in additional medical review.

PDGM News

The Patient-Driven Groupings Model (PDGM), a new payment model for the Home Health Prospective Payment System, will take effect January 1, 2020.

In conjunction with the implementation of the PDGM there will be a change in the unit of home health payment from a 60-day episode to a 30-day period.

Currently, HHAs are paid for each (up to) 60-day episode of care provided. However, more visits tend to occur in the first 30-day period of a 60-day episode of care. For the PDGM, payment is made for each 30-day period, as required by the BBA of 2018.

This will only affect payments; no changes are being made to the requirements for certification/recertification, completion of OASIS assessments, or updates to the patient's plan of care, all of which will continue to be done on a 60-day basis.

For more information, please follow the link below: https://www.cms.gov/Outreach-and-Education/Outreach/NPC/Downloads/2019-02-12-PDGM-Presentation.pdf

Medicare News

REMINDER: Starting January 1, 2020, new Medicare Beneficiary Identifiers (MBIs) must be used when billing Medicare regardless of the date of service:

- Medicare will reject claims submitted with Health Insurance Claim Numbers (HICNs).
- All eligibility transactions submitted with HICNs

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

AQREVA would like to wish everyone a very Happy Thanksgiving!

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 your account representative or call 1.800.568.4311.

For more information about any of these articles, we invite you to contact your Account Representative directly or call 1.800.568.4311.

www.aqreva.com