Strategies for Improving MIPS Score

MACRA, the current framework for Medicare’s physician quality incentive payments, took effect January 1, 2017. David Harlow, JD, MPH, suggests several strategies to improve your MIPS score in his article “MACRA Time: Value Based Payment Writ Large,” (RCM Answers, March 2, 2017).

MACRA is a value-based payment rule which lays out potential penalties and bonuses that start small and eventually ratchet up to 9%, with additional bonuses available for top performers, writes Mr. Harlow. The measurement period began January 1, 2017, and the first payment adjustments will be effective in 2019.

Under MIPS in 2017, eligible providers may choose which measures to report. They can also choose which reporting period to use: either 90 days or the entire calendar year. Of course, these choices have consequences; earning the full bonus requires fuller reporting as well as appropriate performance, but not participating at all in 2017 would mean an automatic 4% penalty, which would be assessed in 2019.

CMS lays it all out for providers on its new QPP website: https://qpp.cms.gov.

Most providers will be proceeding under MIPS, which poses its own set of challenges. There are four categories containing various measures that can be applied simultaneously to one or more categories in order to help practices score well. The categories are:

- **Quality** (replaces PQRS)
- **Improvement Activities** (new)
- **Advancing Care Information** (replaces Meaningful Use)
- **Cost** (replaces Value-Based Modifier)

Winning strategies offered by Mr. Harlow as well as other industry consultants like David Chou of CIO.com, an IDG Enterprise (“Winning Strategies for MACRA and MIPS, October 24, 2016) are valuable on their own and are also likely to improve a practice’s scoring on these metrics:

- **Implement a chronic care management (CCM) program.** The CCM program which pays practices to proactively manage patients with multiple chronic conditions makes a great deal of sense: for the patient (better care); for the practice (better reimbursement for doing the right thing; and for the program (improved efficiency and effectiveness of care). CCM also subsidizes the foundational technology and operational capabilities necessary to succeed under MACRA such as interoperability across all care settings and better care management methodologies. By using CPT code 99490, practices are being offered a financial incentive for providing a more structured, consistent and proactive approach to patient care between office visits to improve outcomes.

- **Expanding care coordination.** Care coordination, executed well, will deliver positive results in each of the four categories being measured under MIPS. While cost of care is not going to be figured into payment calculations for the first payment year, it is an important component of the MIPS score over time. Costs associated with a patient attributed to a practice cannot be managed without coordinating services. The ability to coordinate patient care through referrals and/or transitions across all care settings will no doubt be a key area of differentiation for strong performers. Care coordination and electronic document exchange are components of all four categories.

- **Improve Patient engagement.** There are patient communication and patient engagement elements to be tracked and reported in three of the four categories of MIPS, so the successful practice will need to devote some resources to the implementation of communication channels that are more patient-friendly than EHR patient portals. Current “push” strategies of making information available via patient portals have not been terribly effective at improving patient engagement. To effectively engage patients, clinicians will need to provide real value to patients, proactively engaging them in a relevant, meaningful way at every stage of their healthcare journey.

In sum, clinicians eligible to participate in MACRA should do so. Standing on the sidelines risks significant financial penalties in the near term and in the long term, as well as damage to reputation and referrals (given the requirement that each clinician participating in MIPS will be given an overall score on a scale of 1 to 100).

Clinicians need to dig into MACRA sooner rather than later.
CPT Code Changes for Health Risk Assessments

CPT code 99420 (administration and interpretation of health risk assessment instrument) was deleted for 2017 but in its place, two new codes were added for reporting the administration and scoring of a patient-centered health risk assessment and a caregiver-focused health risk assessment. More detailed information on the new health risk assessment codes is provided below.

Code 99420 (administration and interpretation of health risk assessment instrument, e.g., health hazard appraisal) was deleted and replaced with code 96160 (administration of a patient-focused health risk assessment instrument).

Code 96161 should be reported for the use of a standardized instrument to screen for health risks in the caregiver for the benefit of the patient. It is intended that code 96161 will be reported to the patient’s health plan as it is a service for the benefit of the patient.

For example, code 96161 is appropriate for maternal depression screening if the encounter is focused on the baby, and concerns about maternal depression lead to a postpartum depression screening. If the mother is the patient, however, and depression is suspected, report 96160.

It is also important to make sure that you are appropriately reporting for the specific screen or assessment you are performing. Listed below are the codes in the 2017 CPT manual that describe emotional/behavioral screening procedures.

96110 Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument

96127 Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument

96150 Health and Behavior assessment (eg, health-focused clinical interview, behavioral observations, health-oriented questionnaires), initial assessment

96151 Re-assessment of above

Several standardized instruments for screening or assessments of different conditions are listed in the following table with their corresponding CPT administration code. These screens/assessments are listed for coding purposes only.

<table>
<thead>
<tr>
<th>INSTRUMENT</th>
<th>CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Concussion Evaluation (ACE)</td>
<td>96160</td>
</tr>
<tr>
<td>Conners Rating Scale</td>
<td>96127</td>
</tr>
<tr>
<td>Patient Health Questionnaire (PHQ-2 or -9)</td>
<td>96127</td>
</tr>
<tr>
<td>Beck Depression Inventory</td>
<td>96127</td>
</tr>
<tr>
<td>CRAFFT Screening Interview</td>
<td>96127</td>
</tr>
<tr>
<td>Parents’ Evaluation Developmental Status</td>
<td>96160</td>
</tr>
<tr>
<td>Geriatric Depression Scale</td>
<td>96110</td>
</tr>
</tbody>
</table>

Improving Clinical Data Integrity through EHR Documentation – Kyle Murphy, EHR Intelligence, March 1, 2017

Findings from a recent EHR usability study conducted by the National Institute of Standards and Technology (NIST) once more brought to the fore the problem of clinical documentation in the digital age of healthcare. AMIA cited the increasing documentation burden on clinicians as the impetus behind the use of copy-and-paste functionality and the resulting bloat in EHR documentation.

The study of EHR use, particularly the copy-and-paste functionality, led to three major findings:

1. Clinicians participating in the study were concerned about EHR data integrity as a result of copying and pasting information.
2. Clinicians identified entering the wrong information into the wrong record as a high potential risk.
3. Participants reported that over documentation introduced challenges to accessing “accurate, relevant and timely information on a patient” at the point of care.

Despite its intended purpose to improve the ease and efficiency of clinical documentation, NIST concluded that the copy-and-paste functionality “has introduced overwhelming and unintended safety-related issues into the clinical environment.” Concerns about the accuracy and quality of EHR documentation are nothing new.

ROOT CAUSES OF EHR DOCUMENTATION PROBLEMS

The benefits of EHR use more generally range from timely access to clinical data and alerts to avoid medical errors to care coordination and improved billing and coding. EHR documentation is the means of realizing these benefits.

“Documentation is often the communication tool used by and between providers. Documenting a patient’s record with all relevant and important facts, and having that information readily available, allows providers to furnish correct and appropriate services that can improve quality, safety, and efficiency,” CMS stated in a 2015 fact sheet on EHR technology.

In that same guidance, the federal agency identified a handful of common EHR challenges that healthcare organizations and providers need to address. For EHR documentation in particular, these challenges include an inability to log clinicians entering data, cloning data from record to record, and upcoding to receive higher payment.

A year later, CMS released guidance focused specifically on preserving EHR documentation integrity with an emphasis on helping prevent fraud, abuse, and improper payments.

“Providers and others should use program integrity-related EHR software features and capabilities to ensure the integrity of the EHR documentation. Some EHR features may create information integrity concerns; however, providers and others can mitigate these concerns by implementing proper policies and processes,” the federal agency concluded.
Around the same time, both the AMA and AMIA set out to improve future EHR use by recommending EHR design changes that address the causes of poor EHR documentation.

For the latter, the first area of EHR improvement involved simplifying and speeding up documentation and included recommendations germane to EHR documentation improvement.

AMIA cited the increasing documentation burden on clinicians as the impetus behind the use of copy-and-paste functionality and the resulting bloat in EHR documentation.

The second recommendation called for separating data entry from data reporting.

Templates are often used to capture data as discrete observations, in place of free-text narratives. The resulting documentation sometimes has limited relevance to the visit being documented, and important aspects of patients’ stories can only be effectively captured by narratives. Compared to human narrative, purely coded templates neither distinguish informational wheat from chaff, nor capture the subtle details of each patient’s unique circumstances. Further, coded templates impede effective clinician communication.

According to AMIA, EHR documentation requirements were responsible for making structured data preferable to unstructured data.

Similarly, the AMA released guidance for improving EHR usability that included an emphasis on reducing clinical documentation demands on clinicians. The eight recommendations are:

1. Enhance physician’s ability to provide high quality patient care: EHRs should not distract physicians from patients
2. Support team-based care: ability to delegate work to appropriate members of the care team
3. Promote care coordination: automatically track referrals
4. Offer product modularity and configurability: enable EHRs to meet individual practice requirements
5. Reduce cognitive workload: EHRs should support medical decision making and manage information flow
6. Promote data liquidity: EHRs should facilitate connected health care
7. Facilitate digital and mobile patient engagement
8. Expedite user input into product design and post-implementation feedback: incorporate end-user feedback into the design and improvement of a product.

In a similar vein, AMA also called on EHR developers to focus on EHR designs that help reduce the cognitive workload existing systems impose on end users.

The solution to these and the other EHR usability challenges comes down to user-centered designs with clinicians providing substantial input into how developers go about designing their EHR technology.

MGMA calls for delay in 2015 Edition Certified EHR – March 1, 2017, MGMA bulletin

MGMA joined more than 100 medical organizations on a letter calling for CMS and the Office of the National Coordinator for Health Information Technology to defer requiring use of 2015 Edition Certified EHR Technology (CEHRT) in the Quality Payment Program (QPP) or Medicaid Meaningful Use (MU) Program.

Of the over 3,700 products currently 2014 certified, just 54 to date have been recertified to meet the more stringent 2015 CEHRT requirements. With such limited choice, MGMA is concerned group practices may be forced to incur significant cost to switch vendors, utilize a system that is not suitable for their specialty or patient population due to the tight timeline, or be subject to unfair financial penalties because vendors have not certified their 2015 products in a timely manner.

The letter recommends that use of 2015 CEHRT remain voluntary until such technology is widely available, no sooner than January 2019. Excerpts from the letter dated February 27, 2017 state:

“The undersigned organizations are writing to request a deferment from implementing 2015 Edition certified electronic health record technology (CEHRT) until such technology is widely available, and, in no event, sooner than January 2019. The physician community thanks the Centers for Medicare & Medicaid Services (CMS) for permitting the use of both 2014 and 2015 Editions in the Quality Payment (QPP) and the Meaningful Use (MU) programs in 2017.

These programs, however, require the use of 2015 Edition technology starting in 2018. For reasons described in this letter, we believe that the technology will not be readily available to physicians across a wide variety of specialties and that the use of 2015 Edition CEHRT should remain voluntary.

The vast majority of the certified 2015 Edition products are from a small number of vendors. Requiring physicians to upgrade to 2015 Edition technology by 2018 limits choice by forcing physicians to select a system from approximately one percent of existing products.

Physicians should not be subject to financial penalties under the QPP and MU because vendors have not certified their 2015 Edition products in a timely manner.

While we acknowledge that the 2015 Edition contains functionality that may improve data access, integration of patient generated health data, and document sharing, initial implementation and utilization of these new tools may prove complex.

To effectively and safely use these new features, health systems must develop internal guidance, principles, and practices to ensure they improve, not detract from, patient care.

We are concerned that requiring the use of 2015 Edition CEHRT by 2018 will result in rushed upgrades, installations, a lack of user training, and an overall disruption to physicians’ practices.
As such, physicians should identify their own 2015 Edition roll-out timeline independent of federal regulation.

We are also concerned that, in addition to the significant changes that the QPP will bring to a physician’s practice in 2017, the current CEHRT timeline ignores the needs of practices with few technology resources. The new Edition also includes new measures that will likely be challenging and demanding for practices. To assist these practices, CMS should continue to allow the use of both 2014 and 2015 Editions and permit participants to meet modified Stage 2 MU and Advancing Care Information (ACI) measures. “

Signatories included:

- American Medical Association,
- American Osteopathic Association,
- American Academy of Dermatology Association,
- American Academy of Emergency Medicine,
- American Academy of Family Physicians,
- American Academy of Neurology,
- American Academy of Orthopedic Surgeons,
- American Academy of Otolaryngic Allergy Inc,
- American College of Allergy, Asthma and Immunology,
- American College of Cardiology,
- American College of Emergency Physicians,
- American College of Gastroenterology,
- American College of Radiology,
- American College of Rheumatology,
- American College of Surgeons,
- State associations – almost all states

52% of Practices Use Various Reminders to Stop Patient No-Shows -- Jacqueline Belliveau, RevCycle Intelligence, March 15, 2017

Most practices contact their patients using calls, texts, and emails to prevent patient no-shows and protect their healthcare revenue cycle, MGMA reported.

To prevent patient no-shows, a recent MGMA poll showed that providers are using a variety of communication methods to protect their healthcare revenue from missed appointments.

The recent survey of 1,279 healthcare stakeholders revealed that most practices are going beyond just a phone call to remind patients about upcoming appointments. About 52 percent of respondents said that their practice employs multiple communication methods to connect with their patients and prevent no-shows.

Just calling the patient, however, was still a common strategy for reminding patients about their appointments. Almost 30 percent of participants stated that their practice only contacts patients by phone to prevent no-shows.

Other less popular strategies were text message reminders with 3.67 percent of respondents and email reminders with 1.17 percent of stakeholders.

While employing just one type of communication method to stop no-shows was not the most prevalent strategy, the survey showed the majority of practices used a blend of contact strategies to ensure their revenue would not be impacted by no-shows.

Out of the respondents who said their practice used a variety of communication methods, the majority reported that their office staff calls, texts, and emails patients.

In addition, the poll uncovered that most practices wait until two days before the appointment to remind patients regardless of communication method. Another 25 percent stated that their practices sent reminders only one day prior to the appointment.

According to MGMA’s 2016 Practice Operations Report, patient no-show rates differed across specialties, but the median rate was 5 percent.

Lowering patient no-show rates is key to running a high-performing healthcare revenue cycle. A 2014 MGMA study stated that top performing practices maintained lower patient no-show rates than their peers in addition to lower operating costs and higher patient satisfaction rates.

With the 2016 report showing average patient no-show rates around 5 percent for most specialties, the 2014 study found that high-performing practices had rates around 4 percent.

The practices with lower rates were also more likely to charge a missed appointment fee, which was as much as $30. As part of the recent poll report, MGMA explored some best practices for reducing patient no-show rates in 2017.

Factors to consider are:

1. How long it takes for a patient to schedule an appointment -- The longer it took for patients to see the doctor, the higher the no-show rate.

2. How effective a practice’s appointment notification system is at reminding patients and getting them through the door – Make sure your system has the ability
to contact patients to send reminders and confirm appointments. Having different automated methods of reaching your patients will help decrease no-shows. (Please note that Harris Caretracker offers a Patient Notification system that calls, emails or texts reminders.)

3. Live phone calls are more effective at preventing no-shows – A healthcare IT company in Florida studied and confirmed this in the Boston area and built an application so that calls are only made to patients at the highest risk of missing their appointments.

4. Regardless of the communication method, have patients confirm that they received the reminder.

Malpractice Payment Rates Down for All Specialties -- Nicola M. Parry, Medscape Medical News, March 27, 2017

The overall rate of paid medical malpractice claims made on behalf of US physicians fell by more than half between 1992 and 2014, a new study shows. However, the median amount per claim increased during the same period.

Adam C. Schaffer, MD, from Brigham and Women's Hospital and Harvard Medical School, Boston, Massachusetts, and colleagues published the results of their study online March 27 in JAMA Internal Medicine. By linking NPDB (National Practitioner Data Bank) claims data with physician specialty, they found that the rate of claims paid on behalf of all physicians declined by 55.7% from 1992 to 2014, with considerable variation by specialty.

Dr Schaffer and colleagues investigated the trends in paid medical malpractice claims for US physicians, as well as whether they vary by specialty. They linked all NPDB claims data from 1992 to 2014 to physician specialty, analyzing a total of 280,368 malpractice claims for 175,667 physicians.

However, when analyzed by specialty, the researchers found that the magnitude of the decline varied widely by specialty and was significant in each specialty except cardiology.

Pediatrics had the largest decrease in paid claims and cardiology had the smallest. Among the 280,368 claims paid from 1992 to 2014, the mean payment across all periods was $329,565 (all payments adjusted to 2014 dollars). The mean payment increased by 23.3% between 1992-1996 and 2009-2014, rising from $286,751 to $353,473. According to the researchers, the increases ranged from $17,431 in general practice to $114,410 in gastroenterology and $138,708 in pathology.

Overall, 21,271 (7.6%) claims exceeded $1 million. The proportion of catastrophic claims showed a numerical increase during the study period in 23 of the 24 specialties analyzed, but was statistically significant in only 13 of them.

Neurosurgery had the highest proportion of catastrophic payments, followed by obstetrics and gynecology, and neurology; plastic surgery had the lowest proportion of catastrophic payments.

The researchers also analyzed 109,865 paid claims from 2004 (when severity-of-injury outcomes were first included in the NPDB malpractice payment reports) to 2014, and found that 32.1% involved a patient death. This rate ranged from 2.7% for ophthalmologists to 64.8% for pulmonologists.

Diagnostic error was the most common type of allegation involved in paid malpractice claims, the authors noted. They analyzed 111,066 paid claims from 2004 (when allegation type categories were also first included in malpractice payment reports) to 2014, and found that diagnostic error accounted for 31.8% of these claims.

The proportion of paid claims attributable to diagnostic errors also varied markedly among specialties, ranging from 3.5% in anesthesiology to 87.0% in pathology.

Although the drop in the rate of malpractice payments shown in this study is consistent with findings from previous studies, the authors noted that specialty-specific information about paid claims may help guide physicians’ decision making.

"A better understanding of the causes of variation among specialties in paid malpractice claims may help reduce patient injury and physicians’ risk of liability," they concluded

Often-Overlooked Areas of Medical Practice Risk -- Karen Zupko, Physicians Practice, November 9, 2016

The end of the year is a great time for physicians to review practice operations and policies and assess what’s been done well, what can be improved, and where priorities for next year lie. Reducing overhead and improving collections are no doubt high on that list. But don’t overlook the importance of managing risks — here are a few that we find, all too often, are unaddressed in practices.

Being too casual about electronic safety -- Do front-desk staff members keep their computer and clearinghouse login credentials on a Post-it Note stuck to their desk? Do some employees know each other’s passwords because they’ve been set up using the names of children or pets? Do physicians and/or the outside billing service login to the practice management system or EHR remotely, using an unencrypted Internet channel? If you can answer yes to any of these questions, you are not alone. A lackadaisical attitude about Internet safety is a common risk in physician practices. But with the number of healthcare data breaches increasing, it’s more important than ever to practice good cyber-hygiene.

Start with simple steps, such as insisting that staff use strong passwords and not share them. Hire an IT consultant to conduct a data security assessment (an annual HIPAA requirement that many practices skip). And cease and desist with emailing patients; move to secure messaging instead.

Under-coding E&M services -- This is a revenue risk that can double as an audit risk if you under-code consistently. First, coding a level below the service you actually deliver and document is a financial faux pas. You may think that under-coding five established visits each week is no big deal but $25
less in reimbursements each time you under-code, multiplied by 48 weeks per year, adds up to $6,000 annually. And assuming you under-code new patients at this same volume, you’re up to $12,000.

Second, consistent under-coding can also draw unwanted payer attention to the practice. For example, CMS analyzes coding patterns of physicians in the same specialty and state, as well as national averages so falling outside the bell curve of your peers’ coding patterns can make you a potential audit target.

**Sloppy cash controls**

Poor cash controls are still one of the most common risks we discover during our consultations. Make sure the practice’s “daily close procedure” balances charges and collected amounts with the totals shown on computer reports. Reconcile patient encounter forms and electronic numbers daily to be sure each has been balanced and “closed out.” Make sure the month-end bank balance matches the practice-management system report of total collections. Don’t allow the person who opens the mail to post payments or write refund checks. *And no one but physician owners should sign checks. Period.*

Contact your accountant and arrange for a year-end assessment of cash handling procedures. Make 2017 the year you seal the holes and make cash controls airtight.

**Abdicating vital knowledge**

Although physicians and administrators don’t need to know every last software feature or operational protocol, the medical practice is at risk if physician leaders don’t understand essential business functions and review vital reports. If you take the time to review the adjustments report at least quarterly, you’ll be more apt to ask questions about why so much is being written off to categories you don’t recognize.

Karen Zupko is president of practice-management consulting and training firm KarenZupko & Associates, Inc., which has been working for and with physicians for more than 30 years.

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**ANNOUNCEMENTS**

**Meaningful Use appeal applications now available**

The application and instructions can be downloaded from the CMS website or you can contact your Account Representative directly or call 1.800.568.4311.

**TRICARE Alert - Provider Response Needed**

Health Net Federal Services LLC (HNFS) is the new managed care contractor for the TRICARE West Region, which is comprised of 21 states. Providers are being asked to partner with them to become a fully contracted and credentialed TRICARE network provider.

The transition is currently underway for the new T2017 TRICARE program. Letters and *Join the Network* forms are being mailed out to providers and need to be completed and returned as soon as possible. Providers are encouraged to be on the lookout for correspondence from HNFS TRICARE T2017.

Providers can also send their completed forms to your Account Representative or call 1.800.568.4311 for assistance.

**Change to new Medicare ID – NO MORE SS#’**

MACRA requires CMS to remove Social Security Numbers from all Medicare cards by April 2019. A new Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN) on the new Medicare cards for Medicare transactions like billing, eligibility status, and claim status.

CMS currently uses an SSN-based HICN to identify people with Medicare and administer the program. Under the new system, for each person enrolled in Medicare, CMS will:

- Assign a new MBI
- Send a new Medicare card

The MBI is confidential like the SSN and should be protected as Personally Identifiable Information

*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 contact your Account Representative or call 1.800.568.4311.*