AQREVA
Medical Billing & Consulting

Client Memo
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"He conquers who endures." -- Persius

NEWS Updates

Quality Payment Program Updates

CMS Releases Proposed Rule for 2019 Medicare Quality Payment Program

On July 12, 2018, CMS released its proposed policies for Year 3 (2019) of the Quality Payment Program via the Medicare Physician Fee Schedule (PFS) Notice of Proposed Rulemaking (NPRM).

Key proposals for Year 3 of the Quality Payment Program include:

- Expanding the definition of MIPS eligible clinicians to include new clinician types (physical therapists, occupational therapists, clinical social workers, and clinical psychologists).
- Adding a third element (Number of Covered Professional Services) to the low-volume threshold determination and providing an opt-in policy that offers eligible clinicians who meet or exceed one or two, but not all, elements of the low-volume threshold the ability to participate in MIPS.
- Providing the option to use facility-based scoring for facility-based clinicians that doesn't require data submission.
- Modifying the MIPS Promoting Interoperability (formerly Advancing Care Information) performance category to support greater EHR interoperability and patient access while aligning with the proposed new Promoting Interoperability Program requirements for hospitals.
- Moving clinicians to a smaller set of Objectives and Measures with scoring based on performance for the Promoting Interoperability category.
- Continuing the small practice bonus, but including it in the Quality performance category score of clinicians in small practices instead of as a stand-alone bonus.
- Updating the MIPS APM measure sets that apply for purposes of the APM scoring standard.
- Increasing flexibility for the All-Payer Combination Option and Other Payer Advanced APMs for non-Medicare payers to participate in the Quality Payment Program.
- Updating the Advanced APM Certified EHR Technology (CEHRT) threshold so that an Advanced APM must require that at least 75% of eligible clinicians in each APM Entity use CEHRT.
- Extending the 8% revenue-based nominal amount standard for Advanced APMs through performance year 2024.

New language that more accurately reflects how clinicians and vendors interact with MIPS will also be included. CMS looks forward to receiving feedback on this approach. Please note that the official commenting mechanisms are outlined below.

CMS is seeking comment on a variety of proposals in the NPRM. Comments are due by September 10, 2018. You must officially submit your comments in one of the following ways:

- Electronically, through Regulations.gov
- Regular mail
- Express or overnight mail
- By hand or courier

Quality Payment Program Exceeds Year 1 Participation Goal

CMS Administrator, Seema Verma, issued a blog announcing that 91% of all clinicians eligible for MIPS participated in the first year of the Quality Payment Program (QPP).

2017 MIPS Final Performance Reports Available Now

On June 29, 2018, CMS released the final 2017 MIPS reports. Providers who submitted MIPS data through the Quality Payment Program website can now view their performance feedback reports and MIPS final score.

You can access your performance feedback and final score by:

1. Going to the Quality Payment Program website. https://qpp.cms.org;
2. Logging in using your Enterprise Identity Management (EIDM) credentials; or
3. Review the MIPS Payment Adjustment Fact Sheet https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2019-MIPS-Payment-Adjustment-fact-sheet.pdf

QPP Most Frequently Asked Questions

Question: My practice address in the QPP Participation Status Tool is incorrect. How do I correct it?

Answer: The address shown in the QPP Participation Status Tool reflects data pulled from PECOS on September 01, 2017, for your 2018 QPP eligibility status. Please be advised that due to how data is pulled from PECOS, the QPP Participation Status Tool displays the first practice address or mailing/billing address for the TIN which the NPI is affiliated within PECOS. The address displayed does NOT impact your participation. Go to the following site for more information on PECOS or to update your account:

https://pecos.cms.hhs.gov/pecos/login.do#headingLv1

Question: Why am I receiving a low payment adjustment when I earned a high 2017 MIPS final performance score?

Answer: CMS gradually implemented the 2017 performance period, understanding that the Quality Payment Program was a big change for clinicians.

CMS designed a scoring system that would reduce burden and increase flexibility during this transition year. As a result, more clinicians were able to successfully participate.

Because the MIPS payment adjustment is required to be budget neutral, a scaling factor is applied to positive 2019 MIPS payment adjustment factors, which may result in a lower adjustment than clinicians may have anticipated.

Clinicians that were required to participate and did not, received a 4% payment reduction. Clinicians who successfully met the **Partial** reporting requirement scored 0%, thus avoiding the penalty for 2019.

Providers who believe there is an error with their 2017 MIPS final performance score may submit a targeted review request as soon as possible. Targeted reviews can be requested **until October 1, 2018,** but it is strongly recommended that targeted review requests are submitted sooner to ensure that payment adjustments are applied correctly as of January 1, 2019.

You may find more information about targeted review on the qpp.cms.gov website.

MIPS 2019 Payment Adjustment Fact Sheet

CMS posted a Fact Sheet to help eligible clinicians and groups understand their Merit-based Incentive Payment System (MIPS) 2019 payment adjustment based on their 2017 performance. The fact sheet highlights how CMS assigns final scores to MIPS eligible clinicians and how payment adjustment factors are applied for 2019 based on 2017 MIPS final scores.

The fact sheet can be obtained from the following site: https://www.cms.gov/Medicare/Quality-PaymentProgram/Resource-Library/2019-MIPS-Payment-Adjustment-fact-sheet.pdf

Obtaining EIDM Credentials for the QPP Site

To access the Quality Payment Program Portal, providers will need an EIDM User ID and Password.

Once logged in, providers can:

- Submit MIPS performance data
- Access 2017 MIPS final scores
- View 2017 MIPS performance feedback
- Request targeted reviews of their 2017 MIPS final score and 2019 payment adjustment

If you do not have an EIDM account, navigate to the CMS Enterprise Portal: https://portal.cms.gov.

Select 'New User Registration' to create one. The following information is required for registration:

- Application Name
- Application Role
- Organization Legal Business Name, Address, and Phone Number
- Taxpayer Identification Number (TIN) and corresponding individual Provider Transaction Access Number (PTAN)

Once you complete your EIDM account registration, you will receive an email acknowledging your successful account creation with your EIDM User ID. Use your unique EIDM User ID and Password to login to the Quality Payment Program Portal.

For More Information:

1. Review the EIDM User Guide: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Enterprise-Identity-Data-Management-EIDM-User-Guide.pdf
2. Contact the Quality Payment Program at QPP@cms.hhs.gov or 1-866-288-8292/TTY: 1-877-715-6222.

Greater MIPS Participation Needed for Higher Rewards

Members of Congress and AMGA recently asked CMS to implement lower low-volume thresholds in 2019 to promote greater MIPS participation and payment adjustments, reports Jacqueline LaPointe in her article, "Stakeholders Want Greater MIPS Participation," for *RevCycle Intelligence*, July 10, 2018.

News sources reported that CMS notified over 806,800 Medicare providers that they did not have to participate in MIPS in 2017, while just over 418,800 clinicians did.

"The program relies in part on meaningful participation in the program and the current regulations have reduced these payment incentives by excluding many providers from participation," the policymakers stated in their July 3, 2018, letter to CMS Administrator Seema Verma.

Since MIPS is a budget-neutral program, rewards are equal to the penalties incurred by eligible clinicians. The final MACRA implementation rule stated that eligible clinicians could earn a maximum 4% payment adjustment in the first payment year and a maximum 5% adjustment the next year.

Reduced participation in MIPS, however, would impact the payment adjustments, including the maximum eligible reward for high-performing providers.

High performers, for example, are estimated to receive an aggregate payment adjustment in 2019 of 1.1% based on their 2017 performance score, even though adjustments of up to 4% are authorized.

In 2020, CMS is projecting a 1.5% payment adjustment for high-performers, compared to a potential 5% adjustment level authorized under the law.

The lawmakers expressed concerns that the reduced payment adjustments, especially for high-performers, is not enough to incentivize providers to meaningfully improve care quality and reduce costs.

They advised Verma to "ensure providers have a meaningful opportunity to earn a significantly higher payment adjustment, which was authorized by MACRA, up to 7%."

MIPS Requirements Could Be Waived for Certain Clinicians – Elizabeth Snell, *EHR Intelligence,* July 2, 2018

CMS moved forward a demonstration that would waive MIPS requirements for clinicians participating in certain Medicare Advantage plans.

The Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration is being advanced, which would waive MIPS requirements for some clinicians, CMS announced at the end of June, 2018.

The MIPS requirements would impact clinicians participating in certain Medicare Advantage plans that involve taking on risk.

CMS noted that while some Medicare Advantage plans are developing innovative arrangements that resemble Advanced APMs, physicians are still subject to MIPS even if they participate extensively in Advanced APM-like arrangements under Medicare Advantage.

The demonstration still needs formal approval, but CMS said it is asking for public comment on the collection burdens affiliated with the demonstration.

2018 MIPS Quality Measure Changes

CMS recently announced that the 2018 Quality Measures were available on the Quality Payment Program (QPP) website. One important change was made to the measure dealing with Tobacco Use.

Tobacco Use – Screening and Cessation Intervention (NQF #0028 Measure #226)

Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months **AND** who received cessation counseling intervention if identified as a tobacco user. This measure is to be submitted only ***ONCE PER PERFORMANCE PERIOD***.

THERE ARE THREE SUBMISSION CRITERIA FOR THIS MEASURE:

1. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months;
2. Percentage of patients aged 18 years and older who were screened for tobacco use and identified as a tobacco user who received tobacco cessation intervention;
3. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.

SUBMISSION CRITERIA 1: ALL PATIENTS WHO WERE SCREENED FOR TOBACCO USE AT LEAST ONCE WITHIN 24 HOURS

G9902	Patient screened for tobacco use AND identified as a tobacco user
or	
G9903	Patient screened for tobacco use AND identified as a tobacco non-user
or	
G9904	Exception: Screening for tobacco use not done for medical reason(s)

SUBMISSION CRITERIA 2: ALL PATIENTS IDENTIFIED AS A TOBACCO USER AND WHO RECEIVED TOBACCO CESSATION INTERVENTION

G9906	Patient received tobacco cessation intervention (counseling and/or medication)
or	
G9907	Exception: Tobacco cessation intervention not done for medical reason(s)

(Two G-codes G9902 or G9907 are required on the claim form to submit documented circumstances when the action described in the numerator is not performed for medical reasons.)

SUBMISSION CRITERIA 3: ALL PATIENTS WHO WERE SCREENED FOR TOBACCO USE AND, IF IDENTIFIED AS A TOBACCO USER, RECEIVED TOBACCO CESSATION INTERVENTION OR IDENTIFIED AS A TOBACCO NON-USER

4004F	Patient screened for tobacco use AND received tobacco cessation intervention, if identified as a tobacco user
or	
1036F	Current tobacco non-user
or	
4004F with 1P	Exclusion: Tobacco use screening not done or cessation intervention not provided for medical reasons

CMS proposed rule reduces Evaluation and Management coding burden

CMS released a proposed rule for the 2019 Physician Fee Schedule designed to reduce overly burdensome regulations on providers in order for them to spend more time taking care of patients, writes Greg Slabodkin in his July 13, 2018, article for *Heatlh Data Management.*

The initiative could greatly affect the time involved in using electronic health records and how clinicians interact with systems, he adds.

In particular, CMS has set its sights on reducing the burden of E&M codes on physicians, who are required to document specific types of information in patients' medical charts.

E&M visits make up around 40 percent of all Medicare payments under the Physician Fee Schedule, and guidelines have not been updated since 1997—21 years ago, according to CMS Administrator Seema Verma, who added that nearly 750,000 clinicians use these codes.

The requirements often mean that doctors have to cut or paste chunks of information across medical records strictly for billing purposes, she added. Time spent at the computer documenting and coding for visits is time doctors could be spending with their patients.

Calling it one of the most significant reductions to provider burden ever undertaken by a U.S. Administration, Verma estimated that the proposal will save about 51 hours of clinic time per clinician annually.

CMS is proposing to move from a system with four different sets of documentation requirements for physicians to a system with just one set of documentation requirements. There will still be four discrete code levels, but the differences will be meaningless. There will be one single set of requirements for documentation and one single payment amount.

In addition, CMS is also expanding the list of Medicare Part B services that can be delivered via telehealth.

MGMA supports the agency's efforts to reduce regulatory burdens and ensure Medicare quality measurement is meaningful and actionable for medical practices. However, MGMA is disappointed that CMS plans to continue its "burdensome" 365-day MIPS quality reporting policy rather than 90 consecutive days.

CMS also proposes to require physicians to deploy costly EHR upgrades for 2019 and takes further steps toward implementing burdensome appropriate use criteria.

At first glance, the rule doesn't meet MGMA's definition of administrative simplification.

A fact sheet on the Calendar Year 2019 Medicare Physician Fee Schedule proposed rule is available at:

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-07-12-2.html

CMS will accept comments on the proposal until September 10, 2018.

In Case You Missed It: Recording of Panel Discussion on E/M Coding Reform

On July 12, 2018, CMS proposed historic changes that would increase the amount of time that doctors and other clinicians can spend with their patients by reducing the burden of paperwork that clinicians face when billing Medicare.

CMS has held listening sessions all over the country and heard from thousands of providers and one thing they consistently brought up was how documentation was needlessly burdensome, wasn't improving patient care, and was actually having a negative impact on patient care.

In response, CMS proposed streamlining the documentation requirements for E&M visits, as well as moving to single payment rates.

Watch CMS Administrator Seema Verma, CMS Chief Medical Officer and Director of CCSQ Kate Goodrich, Dr. Donald Rucker, National Coordinator for Health Information Technology, Dr. Anand Shah, CMMI Chief Medical Officer, and Dr. Thomas A. Mason, ONC Chief Medical Officer discuss proposed E/M Coding changes.

Title: CMS Panel Discussion on E/M Coding Reform

Link: https://youtu.be/W2QBTQNxfSY

HIPAA Security Rule Risk Analysis Remains Source of Confusion – Fred Donovan, Health IT Security, June 12, 2018

Widespread confusion in the healthcare industry continues to persist about OCR risk analysis requirements under the HIPAA Security Rule, according to legal experts David Gacioch and Edward Zacharias of McDermott Will & Emery.

Failure to perform an adequate risk analysis continues to be one of the most commonly alleged HIPAA violations, appearing in half of the settlements OCR has announced in the last 12 months and in nearly all the $1 million-plus settlements reached during that time period, they noted.

The HIPAA Security Rule defines a risk analysis as an "accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information held by the covered entity or business associate."

OCR explained that a gap analysis can be used to identify problems with electronic protected health information (ePHI) security, but it is not a substitute for a HIPAA Security Rule risk analysis. A Risk analysis is focused on how your IT infrastructure works and how it protects the ePHI that is created, transmitted, and received in it.

Another source of confusion is the use of the terms risk analysis and risk assessment, which are often used interchangeably but mean different things.

The risk analysis is a specific administrative safeguard requirement under the HIPAA Security Rule to assess potential threats and vulnerabilities to all the ePHI in your system.

A risk assessment is required under the HIPAA Breach Notification Rule to determine whether unauthorized use or disclosure of PHI creates more than a low probability of compromise, which requires reporting the incident to OCR.

9 ELEMENTS OF A HIPAA RISK ANALYSIS

In its guidance, OCR lays out nine elements that a risk analysis must include.

1. Scope of analysis -- Account for potential risks and vulnerabilities to the confidentiality, availability, and integrity of all ePHI that an organization creates, receives, maintains, or transmits in any form and/or location.

2. Data collection -- Identify where the ePHI is stored, received, and maintained by reviewing past and/or existing projects, performing interviews, reviewing documentation, and using other data gathering techniques.

3. Identify and document potential threats and vulnerabilities which, if triggered or exploited by a threat, would create a risk of inappropriate access to or disclosure of ePHI

4. Assess current security measures -- Assess and document the security measures an organization uses to safeguard ePHI.

5. Determine the likelihood of threat occurrence -- Consider the probability of potential risks to ePHI and document all threat and vulnerability combinations.

6. Determine the potential impact of threat occurrence -- Assess the magnitude of the potential impact resulting from a threat triggering or exploiting a specific vulnerability and document all potential impacts.

7. Determine the level of risk -- Assign risk levels for all threat and vulnerability combinations identified during the risk analysis. Document assigned risk levels and a list of corrective actions to be performed to mitigate each risk level.

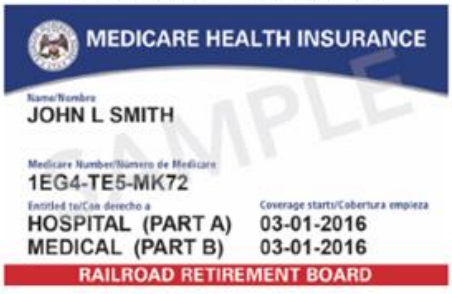
8. Finalize documentation -- Requires the risk analysis to be documented but does not require a specific format.

9. Periodic review and updates to the risk analysis -- Conduct a continuous risk analysis to identify when updates are needed.

The lawyers also warned about some of the penalties that organizations could face if they fail to satisfy OCR in terms of their risk analysis. The penalties could range from $100 per day at the low end, for innocent violations, up to $50,000 or more per day at the high end, for "willful" violations.

New Medicare Cards – please note that the new ID numbers for Medicare and Railroad Medicare no longer contain separate identifiers to distinguish between the two plans.

New Railroad Medicare Card



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