AQREVA
Medical Billing & Consulting

Client Memo
July 2018

"Nobody cares how much you know, until they know how much you care."

-- Theodore Roosevelt

NEWS Updates

MACRA/MIPS: The Final Scores Cometh

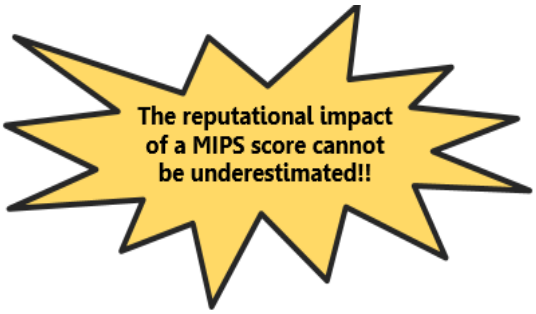
Seem like we've been waiting for this a long, long time. All these MACRA/MIPS mileposts and deadlines have come and gone. The rear-view mirror shows where we've been, but what lies ahead, asks Jim Tate, in the June 29, 2018, issue of *EMR Advocate, Inc.*

Here is what CMS tell us, Mr. Tate writes:

- The data submission period for the 2017 Merit-based Incentive Payment System (MIPS) closed on April 3, 2018.
- Final scores and feedback will be available July 1, 2018 through the Quality Payment Program website. (www.qpp.cms.gov) Clinicians will be able to access preliminary and final feedback with the same Enterprise Identity Management (EIDM) credentials that allowed them to submit and view their data during the submission period.

Eligible clinicians will be able to log in here and see their final MIPS scores for the 2017 reporting period.

This will be an opportunity to view the scores before they will be publicly released later this year. Those scores will be available on the Physician Compare website viewable on provider profile pages as well as a master file that can be downloaded.



That master file, with data on hundreds of thousands of MIPS affected clinicians, will be the data that groups like HealthGrades, RateMDs, and Vitals will use to provide consumer/patient information.

Shortly after the scores are public, Mr. Tate expects numerous websites will appear allowing anyone the opportunity to enter their zip code and type of provider (oncologist, dermatologist, etc.) they need and a Google map with addresses, names, and MIPS scores will pop up.

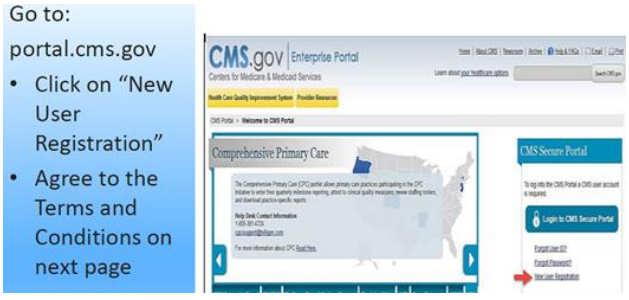
Jim Tate, Founder of MIPS Consulting, President of EMR Advocate, and Partner at Answers Media is recognized as one of the most experienced authorities on Health Information Technology and the MACRA/MIPS program.

Registering for an EIDM Account

Providers who chose to meet the minimum MIPS requirement by reporting Quality measures via the claims submission method will still need to use EIDM credentials to sign into the QPP site and see if they succeeded.

Providers may have used these credentials in the past to login to the CMS Enterprise Portal and/or to submit data to the Physician Quality Reporting System (PQRS).

If providers have forgotten their credentials, or need to register, please go to the CMS Enterprise Portal: https://portal.cms.gov/wps/portal



A step-by-step tutorial can be found at:
https://www.hsag.com/contentassets/57ace903ed5e49ff8a372b96835cbd4f/qnd1eidmqpp508.pdf

Unbilled Services = Lost Revenue

There are times when a provider or staff member performs a readily reimbursable service and documents it, but fails to bill for it.

A few of these services from the article "7 Services PCPs Forget to Bill For" by Betsy Nicoletti (*Medscape Business of Medicine*, June 12, 2018) are presented below.

These services that often do not get billed, even though they should be, include:

Transitional Care Management (TCM)

Two codes, 99495 and 99496, are used to describe the work of caring for a patient who is transitioning from a facility. The work includes:

a. direct contact, such as a phone call, with the patient or caregiver within 2 calendar days of discharge
b. an E/M service
c. medication reconciliation
d. review of the discharge documents, and
e. other non-face-to-face service provided by the clinician or the clinical staff to support the patient's transition of care.

Both the work relative value units (wRVUs) and the payment to the practice are considerably higher than for an established patient visit.

Code	Description	wRVUs	Non-facility Pymt
99495	TCM, 14-day visit, moderate medical decision-making (MDM)	2.11	$166.99
99496	TCM, 7-day visit, high MDM	3.05	$236.45
99214	Office/outpatient visit, established, level 4	1.5	$109.41
99215	Office/outpatient visit, established, level 5	2.11	$147.56

Certification for Home Health Services

There are codes for certification and recertification of a patient for Medicare-covered home health services. These codes pay for the development and revision of the plan, reviewing information that is sent by the home health agency, updating orders, and the responsibility for oversight.

Payment is not for simply signing the form, it is for the development and supervision of the home health services. Medical practices can set up a process for billing these at the time the form is signed by the physician.

Recertification may be billed 60 days after the certification.

Code	Description	wRVUs	Non-facility Pymt
G0180	Physician certification of Medicare-covered home health services	.67	$54.70
G0179	Physician recertification of Medicare-covered home health services	.45	$42.47

Pulmonary Services

There are two pulmonary services that are a large source of lost revenue for medical practices and urgent care centers.

The **first service** is the nebulizer treatment and the medication used in the treatment. When a patient presents with wheezing or shortness of breath, and a nebulizer treatment is done in the office, there should be three charges billed:

1. a charge for the E/M service,
2. a charge for the nebulizer treatment itself, and
3. a charge for the medication used in the nebulizer treatment.

Code	Description	wRVUs	Non-facility Pymt
94640	Airway inhalation treatment	0	$19.07
94664	Demonstration and/or Evaluation patient use of inhaler	0	$17.64
J7613	Albuterol via DME unit dose 1 mg		$.05
J7320	Albuterol and ipratropium bromide via DME		$.15

The **second** service is education by staff about the use of a nebulizer or other home pulmonary treatment.

1. Use 94664 for this service: Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, metered dose inhaler or IPPB device.

2. This is often performed by clinical staff members, incident to the physician's service. It could also be performed by the physician in some instances.

Consults

Many physicians remember that in 2010, Medicare stopped recognizing consultation codes. Medicare Advantage plans followed suit quickly, as did managed Medicaid (AHCCCS) programs.

However, many commercial insurers still recognize and pay for office/outpatient consultations and inpatient consultations. Following Medicare rules on consultations for all payers is a source of lost revenue and lower RVU production.

Any specialty provider may bill a consult, if the requirements for a consultation are met. Document the request for the consult using the requesting clinician's name and the reason for the consult, and make sure that a copy of the report is sent to the requesting clinician.

Many coders and physicians assumed that all commercial payers would follow Medicare and stop reimbursing for the service. While some did, many major national payers still recognize the codes.

Code	Description	wRVUs	Non-facility Pymt
99241	Office Consult Lev 1	.064	$48.23
99242	Office Consult Lev 2	1.34	$90.69
99243	Office Consult Lev 3	1.88	$124.17
99244	Office Consult Lev 4	3.02	$185.71
99245	Office Consult Lev 5	3.77	$226.38
99251	Inpatient Consult 1	1	$49.67
99252	Inpatient Consult 2	1.5	$75.94
99253	Inpatient Consult 3	2.27	$116.97
99254	Inpatient Consult 4	3.29	$169.87
99255	Inpatient Consult 5	4	$204.42

Collecting revenue for medical services is hard work but don't compound the problem by not billing for services performed and documented in the office, Ms. Nicoletti concludes.

Hospitalist Specialty Code C6: 1 Year After Implementation – Jennifer L Fink, *Medscape Hospital Medicine*, May 24, 2018

It's been a year since hospitalist physicians were first allowed to bill CMS using their own unique specialty code. The C6 code, introduced in April 2017, enables hospital medicine physicians to differentiate their services from those of internal medicine physicians and general practitioners.

Providers who are already enrolled with CMS can simply update their existing specialty code electronically, using the PECOS system.

> "A lot of us happily converted. We can get clean data and actually get to know what kind of work we're doing and how we're doing compared with others in the field of hospital medicine."

Previously, hospital medicine physicians' work had been lumped together with the work of office-based internal medicine physicians and general practitioners. That practice was problematic, however, because hospitalists order far more procedures and tests for their patients than primary care providers in office-based settings.

When hospitalist-specific data are available, hospital medicine physicians can finally compare their practice with their peers. That information will not only provide a broad picture of what hospitalists do, but will also make it easier to embark on meaningful quality improvement projects.

Initially, there were some fears that the C6 code might affect reimbursement. One year later, some hospital medicine providers say there's been no impact, while others note positive financial effects.

> "We're not gaining additional reimbursement by being a hospitalist—which I think was the hope of some providers—but there's also not a negative impact if providers continue to self-identify as internal medicine rather than use the C6 code."

The existence of the C6 code also allows at least some hospital medicine physicians to bill for higher-paying initial consults rather than subsequent visits.

Patients may now receive bills from both their primary care physician and hospital medicine physician, whereas previously only one provider could bill for services.

ICD-10 Code Changes Have Been Released for 2019

The CDC released the fiscal year 2019 ICD-10-CM code changes on June 11, 2018.

One can see that the volume of changes is slowing down which many Health Information Management coding professionals are glad to see, reports Gloryanne Bryant, HIA, CDIP, CCS, CCDS, ICD 10 Monitor, June 12, 2018

The FY 2019 ICD-10-CM codes are available in both PDF (Adobe) and XML file formats and can be found at:

ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Publications/ICD10CM/2019

Total number of new code changes is 473 with 279 new codes, 143 revised codes and 51 deactivated codes.

A lot of the changes provide more specificity with deleted codes being replaced by multiple new codes specifying not just laterality but location as well.

Listed below are some examples of the new codes that were added:

Chapter 2 Neoplasm

- Add C43.111 Malignant melanoma of right upper eyelid, including canthus
- Add C43.112 Malignant melanoma of right lower eyelid, including canthus
- Add C43.121 Malignant melanoma of left upper eyelid, including canthus
- Add C43.122 Malignant melanoma of left lower eyelid, including canthus

Chapter 7 Diseases of the Eye and Adnexa

- Add H01.00A Unspecified blepharitis right eye, upper and lower eyelids
- Add H01.00B Unspecified blepharitis left eye, upper and lower eyelids

Chapter 11 Diseases of the Digestive System

- Add K35.890 Other acute appendicitis without perforation or gangrene
  K35.891 Other acute appendicitis without perforation, with gangrene

New ICD-11 Codes Released

The World Health Organization (WHO) today released the 11th edition of the International Classification of Diseases (ICD-11) after more than 10 years in the making, announced Megan Brooks in her June 18, 2018, article "WHO Releases New ICD-11" for *Medscape Medical News.*

For the first time, the new ICD-11 is fully electronic, making it easier to use and less prone to errors, the WHO noted at a press briefing announcing the launch. Thirty-one countries were involved in field testing ICD-11. It contains 55,000 codes vs 14,400 in ICD-10.

ICD-11 will be presented at the World Health Assembly in May 2019 for adoption by member states, and it will come into effect on January 1, 2022. Releasing it now will allow countries to plan how to use the new version, prepare translations, and train health professionals all over the country.

U.S. adoption of the new codes is not expected until after 2022, writes Laurie Johnson in her own article "ICD-11: Hurry Up and Wait," (*ICD 10 Monitor*, June 26, 2018). A lot of excitement was generated when WHO announced that ICD-11 was being released. But there is a long way to go before the finalization of ICD-11, added Ms. Johnson.

The next milestone is for the World Health Assembly to accept the proposed version, and that organization does not meet until May 2019. The WHO effective date for ICD-11 is Jan. 1, 2022, so the U.S will not be able to implement any earlier than that.

The major changes for ICD-11 include:

1. There are 30 chapters rather than 21.
2. Each category will feature four characters rather than three; for example, 1A00.00
3. The alphanumeric codes have a letter in the second position and a number in the third position. A number will always be in the third position.
4. The range of codes is 1A00.00 to ZZ9Z.ZZ.

Some interesting changes include the addition of Internet Gaming Disorder as a mental health disorder. In the U.S., the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) lists this condition as meriting further study. Transgender Identification is listed as gender incongruence in the chapter titled "Conditions Related to Sexual Health."

It is exciting to see ICD-11 in "print," but it is also important to understand that actual implementation and readiness is still several years away.

Billing Properly For Your Practice's NPPs –

Avery Hurt, *Modern Medicine*, May 7, 2018

According to a 2017 survey by MGMA, wise use of non-physician practitioners (NPPs), such as nurse practitioners and physician assistants, can increase practice revenue.

Physicians who are suffering from burnout often find that sharing the load with these professionals increases the amount of face-to-face time physicians have with the patients they see, removing one of the most common causes of burnout.

However, if you want NPPs to provide more benefit than cost to your practice, you must know how to bill properly for these professionals.

Incident To

Services provided by an NPP can be billed under his or her own NPI number. With Medicare, there will be a 15 percent reduction in reimbursement, and with most commercial payers the reduction is about the same.

However, in most cases you can bill "incident to." This means that you bill for NPPs services under the physician's NPI -- but you have to meet certain requirements.

- The physician must initiate the patient's care and any changes in care plan.
- The physician has to be present in the office suite and immediately available during the time the care is given.
- The physician must actively participate in and manage the patient's course of treatment.

Though a physician does have to be available at the time of care and must manage the care, the supervising physician can be any doctor in the group. It does not have to be the one who initiated and manages the patient's care.

"Incident to" is Medicare language. Typically you're fine with most payers if you bill NPPs according to Medicare's incident-to rules.

The rules can vary from payer to payer and even plan to plan with a given payer. It can be confusing -- and time-consuming -- to master the ins and outs of properly billing for NPPs, but if you can get it right, there are many benefits to using these supplementary professionals in your practice.

Leverage Annual Wellness Visits To Improve Value-Based Performance

Medicare Annual Wellness Visits (AWVs) offer practices a way to improve the health of their patients, increase revenue, and improve quality scores in value-based reimbursement programs.

Recent analysis of Medicare claims data showed nearly half of AWVs were performed by just 10 percent of the doctors who provide them. Overall, a national study by the AMA found that under 20 percent of eligible Medicare patients received AWVs in 2016.

Practices able to deliver AWVs in an effective manner to most of their eligible patients could see a substantial return on investment. Moreover, these visits would generate follow-up visits for preventive services that patients might not otherwise seek from their physicians.

-- Image from Study.com

An AWV is not an office visit that requires a physical exam by the provider. The patient is screened with multiple questions related to their wellness by a nurse.

AWVs offer additional benefits~

- ❖ Screening tests and other preventive services arising from those visits can help physicians raise their quality scores in MIPS.
- ❖ For ACOs that participates in the Medicare Shared Savings Program (MSSP), AWVs can help ACOs improve their scores on 13 MSSP quality metrics.

According to CMS, an AWV (G0438/G0439) and an E/M service (99212-99215) can all be billed on the same date, **as long as there is separate documentation supporting each of these services**.

According to the latest Physician Fee Schedule, Medicare currently pays $161-$227 for initial AWVs and $108-$152 for subsequent AWVs, depending on practice location.

The bottom line ~

In the Medicare population, prevention is often overshadowed by chronic issues and acute concerns. The AWV is an opportunity for both physicians and patients to make preventive care a priority. But it is significantly underutilized.

-- Excerpted from article written by Alex Tse, MD, *Medical Economics*, June 25, 2018

Medicare and Medicaid News

The AHCCCS attestation deadline for the 2017 EHR Incentive Program has been extended to August 31,

** Providers in other states should check with their own state agencies for updates.

ALERT: MIPS Reporting Criteria Changes

CMS has recently released MIPS 2018 measures. Providers are urged to check the Quality Payment Program website (www.qpp.cms.gov) for any changes in Quality and Promoting Interoperability reporting requirements. If reporting Quality measures via claims or a registry, please note that the Tobacco Use Screening and Cessation measure now has three objectives that need to be reported.

1. All patients who were screened for tobacco use one or more times within 24 months.
2. Patients who received tobacco cessation intervention.
3. Patients who were screened at least once within 24 months AND who received tobacco cessation intervention.

Please contact the Quality Payment Help desk for assistance: 1-866-288-8292.

MIPS eligible clinicians or groups can request that CMS review the calculation of their 2019 MIPS payment adjustment factor via Targeted Review

If clinicians believe an error has been made in their 2019 MIPS payment adjustment calculation, they can request a targeted review **until September 30, 2018**. The following are examples of circumstances in which you may wish to request a targeted review:

- Errors or data quality issues on the measures and activities you submitted
- Eligibility issues (e.g., you fall below the low-volume threshold and should not have received a payment adjustment)
- Not being automatically reweighted even though you qualify for automatic reweighting due to the 2017 extreme and uncontrollable circumstances policy.

You can access your MIPS final score and performance feedback and request a targeted review by:

1. Going to the Quality Payment Program website
2. Logging in using your EIDM credentials *(Please refer to page 1 of this newsletter for instructions on obtaining an EIDM login.)*

For more information about how to request a targeted review, please copy the link below to review the fact sheet and instructions:

https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2017-Targeted-review-fact-sheet.pdf

If you have questions about your performance feedback or MIPS final score, please contact the Quality Payment Program by:

- Phone: 1-866-288-8292/TTY: 1-877-715-6222 or
- Email: QPP@cms.hhs.gov

New Medicare Card Mailing Update – Wave 3 Begins, Wave 1 Ends

CMS started mailing new Medicare cards to people with Medicare who live in Wave 3 states: Arkansas, Illinois, Indiana, Iowa, Kansas, Minnesota, Nebraska, North Dakota, Oklahoma, South Dakota and Wisconsin.

CMS will continue to mail new cards to people who live in Wave 2 states and territories.

New cards will be mailed to all other states, including Arizona, after June 2018. Arizona is included in Wave 6.

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 directly or call 1.800.568.4311.

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