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Client Memo
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"Your attitude, not your aptitude, will determine your altitude."

-- Zig Ziglar

NEWS Updates

Implement Medical Practice Change without Going Broke or Insane

Over the last several years, new regulations have become law affecting how doctors practice medicine, writes Linda Girgis, MD, in the May 30, 2018, edition of *Physicians Practice.*

First came the Meaningful Use program, pushing doctors to purchase and implement EHRs. Then came updates to those rules, threatening doctors with financial penalties not only if they failed to incorporate an EHR into practice, but if it was not used in a meaningful way based on submitted data metrics, as determined by government officials.

Now, many practices and healthcare systems are scrambling to address the recently enacted MACRA laws, also known as Medicare's Quality Payment Program. There is much discussion going on about how to avoid reimbursement reductions.

Tips to incorporate new regulations

- Know the regulations -- Even lawmakers didn't read the bill introducing MACRA they passed into law. We need to know as much as we can because this affects our careers and patients.

- Make it a team sport -- Physicians are busy seeing patients and no one has extra time to see what it all means. Discuss it with your staff and enlist their help.

- Ask others -- State medical societies are a great source of help. They have many resources to commit to the new regulations.

- Make change your new routine -- For example, when implementing Meaningful Use, we were required to report email addresses and language spoken. Since, we knew our patients and knew that they spoke English or another language, we didn't need to record it in the chart. Since it is a required data metric, however, it is now routine to ask every patient their primary language.

- Educate your patients about the regulations -- Healthcare is becoming extremely complicated these days. Some of these new laws make it more complex. Help patients understand these new rules and how it affects them.

- If it's not working, drop it -- For many physicians in small practices, it is much easier to opt out of Medicare rather than implement these Draconian changes to their practice. And there is nothing wrong in doing this. We have to survive too. Just be sure to give patients enough advance notice.

- Speak up -- If you don't agree with the need for the new laws or those being proposed in the halls of Congress, raise your voice.

Whether or not we agree with the rules being manacled to us, when they become law we have no choice but to comply if we want to stay in business. The system seems to be pushing more and more doctors away from self-employment and into larger systems.

It is very important to stand strong against the forces driving us away from private practice. It is only when we succeed that the winds will again change and the force be diverted to other agendas.

-- physicianspractice.com

Significant MIPS Changes Physicians Need To Know -- Kyle Haubrich, JD & Jacob Grimes, JD, *Medical Economics,* May 23, 2018

The 2018 MACRA rule has implemented several new changes to the MIPS program which physicians and clinicians should be aware of in order to obtain the highest possible payment bonus.

MIPS: Quality category

The new rule significantly changes the Quality category, which makes up 50 percent of a physician's total score in MIPS. One change includes additional "topped out measures." In 2018, CMS added the following topped out measures, which means that even if you submit a 100% performance rate on the measure, you can still only earn 7 out of the 10 possible points.

TOPPED OUT MEASURES

1. Perioperative Care: Selection of Prophylactic Antibiotic – First or Second Generation Cephalosporin (Measure 21)

2. Melanoma: Overutilization of Imaging Studies in Melanoma (Measure 224)

3. Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When indicated in ALL patients). (Measure 23)

4. Image Confirmation of Successful Excision of Image Localized Breast Lesion (Measure 262)

5. Optimizing Patient Exposure to Ionizing Radiation: Utilization of a Standardized Nomenclature for Computerized Tomography (CT) Imaging Description. (Measure 359)

6. Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy (Measure 52)

Thus, in order to fully maximize the Quality category, your practice will have to select more measures to make up the difference in points and ensure your Quality measures are not considered "topped out.."

Other changes include the time a physician or clinician must collect data to be in compliance.

MIPS: Cost category

For 2018, the Cost category will now look at all the adjudicated claims submitted in the calendar year for a practice's Medicare patients, which will count for 10% of a physician's overall MIPS score.

Since no additional data needs to be submitted to determine the Cost score, most physicians should focus on the other three MIPS categories.

Virtual groups

In 2018, CMS developed a new way for physicians and clinicians to report their MIPS data -- the "virtual group." This is defined in the rule as, "a combination of two or more tax identification numbers (TINs) assigned to one or more solo practitioners or one or more groups consisting of 10 or fewer eligible clinicians that elect to form a virtual group for a performance period for a year."

To form and join a virtual group, physicians or clinicians must be eligible under MACRA, and at least one member of a group of 10 or less physicians or clinicians must not be exempt from having to comply with MACRA to be eligible to join a virtual group.

The benefits of joining a virtual group allow physicians and clinicians to band together to increase their MIPS scores.

Percentage changes in weighting of final MIPS score

While the Cost (10%) and Quality (50%) categories under MIPS change in 2018, the Advancing Care Information (25%) and Improvement Activities (15%) categories have not.

The new exclusions

Under the new rule, fewer physicians will be required to comply with MIPS. This year, physicians are excluded if they either bill less than $90,000 to Medicare Part B or see 200 or fewer Medicare beneficiaries. Some exclusions remain the same; for example, a physician that is new to Medicare is excluded for that calendar year.

Excluded physicians should note that if their practice group decides to report its MIPS data as a group, the formerly excluded physician may have to comply with MIPS if the group bills more than $90,000 to Medicare Part B or sees more than 200 Medicare beneficiaries.

Do not rely solely on your EHR for MIPS reporting

Many EHR systems are simply not capable of collecting the necessary data to ensure complete MIPS reporting. As a result, physicians and groups may be leaving money on the table or, worse, subjected to negative adjustments as a result of their reliance on EHR systems. To best ensure thorough MIPS reporting, physicians and groups should rely on outside professionals fluent in the collecting and reporting of MIPS data.

Education is power

Knowledge of the 2018 changes is necessary to fully comply with MACRA/MIPS and to ensure you receive the maximum positive adjustment. Rolling the dice on MIPS can lead to major losses of income to you or your practice group. Don't be the doctor paying the doctor down the street for complying with MIPS—be the doctor who is being paid by those who fail to comply.

Using the Patient Portal Can Save Money

Patient portals have become increasingly popular; physicians who use them say that they save time and money and collect payments faster. Yet plenty of physicians are still unenthusiastic about them. Can they be worthwhile for you--or, if you already have a patient portal, can you make it even more useful, asks Sandra Levy in the May 1, 2018, issue of *Medscape Business* of Medicine.

In her article "7 Ways Physicians Can Save Money Using the Patient Portal," Ms. Levy writes that many physicians are saying that a patient portal increases their practice's efficiency because patients use the portal to fill out and update personal health information forms, schedule their own appointments, access test results, request medication refills, send secure messages, receive chronic care alerts, and pay bills.

A fully functional patient portal that is easy to access has benefits. Listed below are some of the advantages:

Patients Can Reach You Without Tying Up the Phones – Portals that offer secure messaging enable practices to use their staff more efficiently.

Increase Your Revenue During Slow Periods - Let patients know they are due for preventive care.

Physicians are able to run reports in their EHR to identify patients who are due for annual preventive care visits at the beginning of each year. From there, they can easily notify patients via the portal, saving paper, postage, and phone calls.

Patients Can Pay Online

Practices that accept payments through the portal can save time and money used on phone calls, printing, and mailing patient statements

Reduce the Number of No-Shows - Patients Can Schedule, Change, or Cancel Appointments

Getting Patients on Board

Thirty percent of patients who visit hospital-owned practices use the portal, a rate that drops to 10% to 15% of patients who visit physician-owned practices, according to the Medical Group Management Association's (MGMA's) 2017 Practice Operations Survey, writes Ms. Levy.

According to an MGMA spokesperson, 35% of patients in primary care practices use the portal, which is the highest percentage compared with other specialties.

> Of the functions of patient portals, MGMA found that accessing test results was the most popular (29%), with bill payments, communicating with providers and medical staff, downloading or transmitting medical records, and scheduling appointments each at 28%.

How can physicians encourage more patients to use the portal?

"The main way is a face-to-face encounter with the patient when they're coming in for visits," says Kathy Moghadas, RN, a healthcare consultant based in Winter Springs, Florida.

"When the staff is doing an update on the history of present illness, they should ask, 'Are you signed up to give information on the patient portal?' This gives an opportunity for the staff person to say, 'Let us sign you up.'"

Physicians should take the lead in teaching patients how to use the portal. MGMA consultant Laurence Kinzler advises physicians that if physicians don't use the portal properly, patients will get turned off.

Kinzler also suggests that practices be "pleasantly aggressive" about notifying patients that the portal exists. Signs and posters can also be displayed in the office.

CMS Seeks Feedback on MIPS

Medicare's deadline for recommendations for new measures for its MIPS program was June 1, 2018. CMS will publish a final annual list of 2019 measures for MIPS-participating clinicians in the Federal Register by November 1, 2018.

CMS is refining MIPS, even as criticism of this payment system builds, writes Kerry Dooley Young in his article published May 31, 2018, in *Medscape Medical News.*

Through its routine MIPS Annual Call for Quality Measures, CMS sought feedback from healthcare professionals, researchers, medical societies, and professional associations. The agency said it is especially interested in adding measures linked to care coordination and cost reduction.

Think 'specificity' when documenting these seven diagnoses - Lisa A. Eramo, *Medical Economics,* May 29, 2018

Diagnosis codes convey the reason for the visit, and they also capture risk--something that many payers increasingly consider when calculating reimbursement. It's important for physicians to ensure that the information they document is as specific and complete as possible, states Terri Thomas, RHIA, clinical documentation specialist in San Leandro, Calif., who spoke during AAPC's HEALTHCON, April 8-11 in Orlando, Fla

"Unspecified diagnosis codes often wreak havoc on cash-flow because many payers simply deny them. Providers need to be as specific and compliant as possible. That's one of the reasons why we moved to ICD-10."

Ms. Thomas discussed these seven diagnoses and provided checklists of what physicians should document to avoid denials:

Anemia
- Any association with chemotherapy, drugs, neoplasms, chronic kidney disease, end-stage renal disease, or other chronic disease, when applicable
- Due to bleeding (including the site), when applicable
- Specificity (acute, chronic, or acute on chronic)
- Type (deficiency, aplastic, pernicious, or postoperative)

Asthma
- Any related tobacco use, dependence, or exposure
- Any chronic signs and symptoms
- Medication noncompliance, when applicable
- Presence of chronic obstructive pulmonary disease or bronchitis, when applicable
- Severity (mild intermittent, mild persistent, moderate persistent, or severe persistent)
- Triggers or environmental risk factors
- With or without acute exacerbation

Bronchitis
- Type (i.e., acute or chronic)
- Infectious agent (i.e., viral, bacterial, or obstructive)
- Associated conditions/contributing factors (e.g., influenza, pneumonia, or emphysema), when applicable
- Tobacco use, abuse, dependence, or exposure, when applicable

Chronic obstructive pulmonary disease
- Body mass index
- Smoking status, including history of smoking, when applicable
- Use of home oxygen, BIPAP, or CPAP, when applicable
- With acute exacerbation, hypoxemia, bronchitis, asthma, emphysema, or upper respiratory infection, when applicable

Congestive heart failure
- History of myocardial infarction, coronary artery bypass graft, or smoking, when applicable
- Medication noncompliance, when applicable
- Presence of heart disease, bradycardia, heart block/type, arrhythmia, or diabetes, when applicable
- Severity (i.e., acute, chronic, or acute on chronic)
- Type (i.e., systolic, diastolic, left, right)
- Use of home oxygen, when applicable
- With hypertension or renal failure, when applicable

Hypertension
- Exposure to environmental tobacco smoke, when applicable
- History of myocardial infarction, coronary artery by-pass graft, or any other cardiac condition, when applicable
- Medication noncompliance when applicable
- Relationship with chronic kidney disease, congestive heart failure, or both, when applicable
- Tobacco dependence, use, or history of tobacco use, when applicable
- Type (i.e., emergency, urgency, or crisis)

Diabetes
- Long-term insulin use, when applicable
- Manifestations and complications (e.g., nephropathy, retinopathy, osteomyelitis, and vascular disease), when applicable
- Medication noncompliance, when applicable
- Presence of secondary diabetes and cause (e.g., due to neoplasm, steroid-induced, or adverse effect of drugs), when applicable
- Relationship between diabetes and cellulitis, when present
- Type (i.e., Type 1 or Type 2)

Update On New Medicare Cards

New Medicare Cards Look-Up Tool

Medicare Beneficiary Identifier (MBI) Look-up Tool Clarification: The Medicare portal MBI look-up tool will only return an MBI if the new Medicare card has been mailed; this avoids potential confusion if the MBI is used before the beneficiary receives their new Medicare card/MBI:

- Medicare is mailing new cards in phases by geographic location.
- Patients should be asked for their new cards when they come in for care.

New Medicare Card Mailing Schedule

Wave	States Included	Card Mailing
New Members	All - Nationwide	Beginning April 2018
1	Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	Beginning May 2018
2	Alaska, American Samoa, California, Guam, Hawaii, Northern Mariana Islands, Oregon	Beginning May 2018
3	Arkansas, Illinois, Indiana, Iowa, Kansas, Minnesota, Nebraska, North Dakota, Oklahoma, South Dakota, Wisconsin	After June 2018
4	Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island, Vermont	After June 2018
5	Alabama, Florida, Georgia, North Carolina, South Carolina	After June 2018
6	Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Texas, Utah, Washington, Wyoming	After June 2018
7	Kentucky, Louisiana, Michigan, Mississippi, Missouri, Ohio, Puerto Rico, Tennessee, Virgin Islands	After June 2018

Here are 3 ways you and your office staff can get MBIs:

1. Ask your Medicare patients
   - Ask your Medicare patients for their new Medicare card when they come in for care. If they haven't received a new card at the completion of their geographic wave, refer them to 1-800-Medicare (1-800-633-42 27).

2. Use the MAC's secure MBI look-up tool
   - Once the new Medicare card with the MBI has been mailed to your patient, you can look up MBIs for your Medicare patients when they don't or can't give them to you. Sign up for the Portal to use the tool. You can use this tool even after the end of the transition period – it doesn't end on December 31, 2019.

3. Check the remittance advice.
   - Starting in October 2018 through the end of the transition period, Medicare will return the MBI on every remittance advice when you submit claims with valid and active Health Insurance Claim Numbers (HICNs).

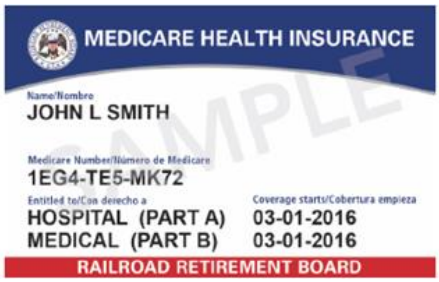
You can start using the MBIs even if the other health care providers and hospitals who also treat your patients haven't. When the transition period ends December 31, 2019, providers must use the MBI for most transactions.

Railroad Medicare Cards

The Railroad Retirement Board (RRB) is also mailing new Medicare cards with the MBI. The RRB logo will be in the upper left corner and "Railroad Retirement Board" at the bottom, but you can't tell from looking at the MBI if your patients are eligible for Medicare because they're Railroad retirees.

You'll be able to identify them by the RRB logo on their card, and we'll return a "Railroad Retirement Medicare Beneficiary" message on the Fee-For-Service (FFS) MBI eligibility transaction response.

New Railroad Medicare Card



Note that the MBI is confidential like the HICN, and it should be protected as Personally Identifiable Information (PII).

The MBI does not change Medicare benefits. Medicare Advantage and Prescription Drug plans will continue to assign and use their own identifiers on their health insurance cards. For patients in these plans, continue to ask for and use the plans' health insurance cards.

Medicaid News

2018 Program Requirements for Medicaid

CMS is renaming the EHR Incentive Programs to the Promoting Interoperability (PI) Programs to continue the agency's focus on improving patients' access to health information and reducing the time and cost required of providers to comply with the programs' requirements.

CMS is also in the process of finalizing updates to the programs through rulemaking.

Medicaid EHR Incentive Program

In 2018, eligible hospitals and eligible professionals (EPs) that attest directly to a state for the state's Medicaid EHR Incentive Program will continue to attest to the measures and objectives as finalized in the 2015 EHR Incentive Programs Final Rule (80 FR 62762 through 62955).

EPs can either attest to the 2018 Modified Stage 2 program requirements or the 2018 Stage 3 Program requirements.

Details for each measure set can be found as follows:

2018 Modified Stage 2 requirements
https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/TableofContents_EH_Medicaid_ModifiedStage2_2018.pdf

2018 Stage 3 requirements
https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/TableofContents_EP_Medicaid_Stage3_2018.pdf

EPCS Legislation Shows Power and Promise – Ken Whittemore, Jr, Surescripts, May 3, 2018.

According to recent research from the IQVIA Institute, the number of opioid prescriptions in the U.S. fell 10.2% in 2017 compared to 2016. At the same time, lawmakers are taking aim at the opioid epidemic by ramping up legislation that mandates Electronic Prescribing for Controlled Substances (EPCS).

A handful of states have already mandated the use of e-prescribing in general or EPCS for opioids and other controlled substances, including Minnesota, New York, Maine and Connecticut, where mandates are currently in effect. The latter three states saw a dramatic uptick in the number of prescribers enabled to use the technology as the effective dates of each respective law approached. Minnesota does not have specific penalties for non-compliance, therefore the rate of increase in prescriber enablement for EPCS has been less dramatic.

Several other states have passed EPCS legislation that will go into effect during the next two years, including Arizona, New Jersey, North Carolina, Rhode Island and Virginia.

There's more good news: the EPCS movement continues to gain momentum. Another 14 states have had legislation introduced, and about half of these bills will likely pass this year.

To see where each state stands in terms of EPCS enablement, access an interactive map, which is updated monthly, at:

https://surescripts.com/enhance-prescribing/e-prescribing/e-prescribing-for-controlled-substances/

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