AQREVA
Medical Billing & Consulting

Client Memo
May 2018

"Aim for the moon. If you miss, you may hit a star."
-- W. Clement Stone

NEWS Updates

Meaningful Use Overhaul

As part of a new proposed rule released April 24, 2018, CMS announced that it was overhauling and streamlining the EHR Incentive Programs for hospitals as well as for the Advancing Care Information performance category of MIPS, which is one track of the Quality Payment Program.

The proposed policies released on April 24th begins the implementation of core pieces of the government-wide MyHealthEData initiative through several steps to strengthen interoperability or the sharing of healthcare data between providers.

Specifically, CMS is proposing to overhaul the Medicare and Medicaid EHR Incentive Programs (also known as the "Meaningful Use" program) to:

- make the program more flexible and less burdensome,
- emphasize measures that require the exchange of health information between providers and patients, and
- incentivize providers to make it easier for patients to obtain their medical records electronically.

To better reflect this new focus, CMS is re-naming the Meaningful Use program "Promoting Interoperability," effective immediately.

Meaningful Use now called "Promoting Interoperability."

Please note that this rebranding does not merge or combine the EHR Incentive Programs and MIPS.

In addition, the proposed rule reiterates the requirement for providers to use the 2015 Edition of certified electronic health record technology in 2019 as part of demonstrating meaningful use since this updated technology includes the use of application programming interfaces (APIs), which have the potential to improve the flow of information between providers and patients. Additionally, CMS is proposing a variety of other changes to reduce the number of hours providers spend on paperwork.

MIPS Preliminary Scores Now Available

The deadline for submitting 2017 MIPS data has passed and results are being tabulated. Providers can view their preliminary results by signing into the Quality Payment Program website www.qpp.cms.gov with their EIDM login credentials.

If you've forgotten your EIDM credentials, go to the CMS Enterprise Portal to reset your user ID or password: https://portal.cms.gov.

If you need to register for a login in order to view your results, a step-by-step tutorial can be found at: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/Enterprise-Identity-Data-Management-EIDM-User-Guide.pdf

If you have questions about your MIPS performance feedback preliminary data, please contact the Quality Payment Program by:

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

The Importance of MIPS Data

In his April 9, 2018, article *"MIPS Data: The Finish Line is Crossed,"* Jim Tate warns providers of the importance their MIPS scores will have once published.

Mr. Tate writes that providers who submitted data through the Quality Payment Program can sign in now and view preliminary feedback. Just keep in mind this is not the final MIPS score or feedback. CMS states that a final MIPS score will be available for providers to view on July 1, 2018.

Prior to that date changes could occur due to the following situations:

- Special Status Scoring Considerations (ex. Hospital-based Clinicians),
- Claims Measures to include the 60-day run out period,
- Advancing Care Information Hardship Application status, or
- Creation of performance period benchmarks for Quality measures that didn't have a historical benchmark.

The upcoming July 1st date will allow providers to get a preliminary peek at their MIPS report cards before they **become public later this year on the CMS Physician Compare website.**

Those with high scores will be in good shape in terms of Medicare Part B reimbursement and professional reputation. Those with low scores will have to prepare responses along the lines of: "This is not reflective of quality", "This is not fair", etc.

Beyond the reimbursement adjustments, the ranking of providers based on quality will have a colossal impact on reputation.

This entire process has been about the public release of a numeric provider scoring system that is easy to comprehend. Valid or not, the score is simple and not based on a "star ranking" or anything that can be difficult to understand or misconstrued.

0 – 100 is a plain as it can be.

Ready or not, the final exams have been completed and the report cards are coming.

2017 MIPS data will be available for public reporting for clinicians and groups in late 2018

What Is Physician Compare?

The Physician Compare website was designed by CMS to help consumers make informed choices about the health care they receive through Medicare and to incentivize clinicians to maximize their performance.

The Physician Compare website can be found at: https://www.medicare.gov/physiciancompare

MIPS Reporting Requirements for 2018

QUALITY	Submit at least six measures to report for the 12-month performance period (January 1 thru December 31, 2018). (Please note that groups who register to submit data through the CMS Web Interface must submit data for all 15 measures in the CMS Web Interface.) Of the 6 quality measures, one must be an outcome measure OR a high priority measure if an outcome measure is not available. 50% of MIPS score
COST	New for 2018. Cost score will be determined by a Clinician's performance in the Medicare Spending per Beneficiary (MSPB) and total per capita cost measures in 2018. No data submission requirement (other than claims submission) 10% of MIPS score
IMPROVEMENT ACTIVITIES	Report a combination of Improvement Activity measures (up to 4 measures) to equal a total of 40 points for at least 90 days. Groups with less than 15 participants in a rural or health professional shortage area may attest to 2 improvement activities. 15% of MIPS score
PROMOTING INTEROPERABILITY (formerly Acvancing Care Information) ***	NAME CHANGED from Advancing Care Information to Promoting Interoperability to support the secure exchange of health infomation and the use of certified EHR technology. Report on all Base measures as determined by your version of CEHRT for a 90 day period. Choose from 7 Performance measures and submit enough data to reach the 100-point threshold. Points can be reassigned to the Quality category for certain clinicians. 25% of MIPS score

The minimum amount of points needed to avoid the 5% penalty in 2020 is 15 points. To achieve 15 points either report all required Improvement Activities; meet Promoting Interoperability base measures and submit 1 medium-weight Improvement Activity or 1 Quality measure; or submit 6 quality measures.

South Dakota is the 49th State to Pass Data Breach Notification Law – Elizabeth Snell, *HealthIT Security*, March 29, 2018

South Dakota became the 49th state to have a data breach notification law when South Dakota Governor Dennis Daugaard signed SB 62 into law on March 21, 2018. The law will go into effect on July 1, 2018.

The bill includes health information in its definition of personal information as well. Individuals would need to be notified should that data be compromised in a data breach.

Additionally, organizations that suffer a data breach will need to provide notification should the incident involve individuals' first name or first initial and last name, in combination with any of the following elements:

- Social Security number
- Driver's license number or other government issued unique identification number
- An account, credit card, or debit card number in combination with any required security code, access code, password, routing number, PIN, or any additional information that would permit access to a person's financial account
- An identification number assigned to a person by the person's employer in combination with any required security code, access code, password, or biometric data generated from measurements or analysis of human body characteristics for authentication purposes

The attorney general will need to be notified of breaches involving more than 250 South Dakota residents.

"A disclosure…shall be made not later than sixty days from the discovery or notification of the breach of system security, unless a longer period of time is required due to the legitimate needs of law enforcement," the bipartisan bill reads.

The South Dakota Attorney General can prosecute an organization should they fail to disclose a breach. The civil penalty could be "not more than ten thousand dollars per day per violation."

Please note:
Per the NCSL (National Conference of State Legislatures) website, as of March 29, 2018, all 50 states, the District of Columbia, Guam, Puerto Rico and the Virgin Islands have enacted legislation requiring private or governmental entities to notify individuals of security breaches of information involving personally identifiable information.

Coding Mental and Behavioral Health Issues

Achieving accurate and comprehensive coding of such issues is an imperative, states Rhonda Buckholtz, CPC, CPMA, in her April 24, 2018, article for *ICD-10 Monitor.*

Mental disorders contribute to over 65 million physician visits and over 5 million emergency department (as a primary diagnosis) visits annually, according to the Medicare Expenditure Panel Survey (MEPS). These are significant expenditures, and the increases in the need for care have demanded that primary care physicians expand practices to include this specialty.

Recently, HIPAA regulations have provided guidance for providers for patients in danger of harming themselves or others, instructing them to use their expertise and professional judgement when a patient has demonstrated this risk of danger.

According to the HIPAA Helps Caregiving Instructions from the Office of Civil Rights (OCR), a health or mental health professional may always share mental health information with a patient's personal representative, if they have one. They may also contact anyone who is reasonably able to lessen the risk of harm when they believe that a patient presents a serious and imminent threat to the health or safety of a person (including themselves) or the public.

This includes notifying a spouse, caregivers, 911, or even law enforcement.

The recent headlines regarding the nation's heroin and opioid abuse epidemic also pertain directly to healthcare. Many states are creating new laws to monitor the issue. If this is that much on their radar, then coding and reporting becomes a major focus as well.

"The opioid epidemic has affected both the business side of medicine and the clinical," outgoing AAPC National Advisory President Jaci Kipreos recently said. "For these patients to receive the help they desperately need, the first step is awareness. Then there must be new diagnosis codes to accurately identify the situation and then we must remove the stigma of the diagnosis."

Documentation for mental disorders needs to include the type of the condition, the status, what it was caused by or due to, any complications or manifestations, and any co-morbid conditions as well.

Mental disorders are treated in all specialties, to some degree. It is important that all providers know how to document these disorders so that the most appropriate codes can be assigned.

Improper Billing and Testing Will Get Physicians in Trouble – Rachel Rose, JD, MBS, *Physicians Practice*, April 6, 2018

Two recent cases underscore the importance of making sure the provider listed on the claims submission performed the services and providing tests that are reasonable and necessary.

Two settlements in April highlight the notion that the U.S. government has a low tolerance for providers who defraud its programs such as Medicare, Medicaid, TRICARE, and the Federal Employee Health Benefits Program (FEHB).

In the first case, the owner and operator of a physical therapy business in Honolulu, Garrett Okubo submitted claims for physical therapy services between January 2011 and October 2017 for payment from Medicare, Medicaid, TRICARE, and the Hawaii Medical Service Association according to the DOJ.

Okubo, in violation of 18 USC § 1347, executed a scheme by "falsely stating that Okubo himself had personally provided the physical therapy services to his patients, when in reality the services were provided by Okubo's unlicensed staff members, including at times when Okubo was traveling on the U.S. mainland or in a foreign country."

Although Okubo is not a physician, the issues raised in his case, which resulted in both monetary penalties and jail time, parallel those of improper billing of non-physician providers (NPPs) such as physician assistants, nurse practitioners, and clinical nurse specialists.

In general Title 42 must be consulted regarding the scope of the reimbursement. If a nurse practitioner, for example, is billing under their own Medicare provider number, then the reimbursement by Medicare is 85 percent of the Medicare Physician Fee Schedule. It is also imperative to read the respective state law in order to ascertain the scope of practice, licensure requirements and level of supervision.

On April 19, Biotheranostics, Inc. agreed to pay $2 million to resolve allegations that it both submitted and caused to be submitted Breast Cancer Index (BCI) tests for Medicare reimbursement. These tests were not "reasonable and necessary" and, therefore, failed to meet the medical necessity standard.

The Medicare statute expressly states that laboratory tests may be reimbursed by Medicare only if they are "reasonable and necessary for the diagnosis or treatment of a patient' illness or injury."

The take-aways for physicians from these two cases are as follows:

- Make sure that NPPs are billing in the appropriate manner in conjunction with state and federal law and that the definition of "supervision" in a respective state is understood;
- The person's name on the claim's submission form needs to be the one performing the service and indicated in the medical records;
- Ensure that the diagnostic tests or treatment being ordered are substantiated by medical necessity; and
- Failing to be compliant can and often does result in False Claims Act cases, which can carry both civil and criminal penalties.

(Sonoran News, July 27, 2016)

CMS gives Medicare Advantage Plans a Raise

CMS finalized a rule at the beginning of April giving Medicare Advantage plans a 3.4% pay hike in 2019. That's well above the 1.84% bump the agency initially proposed and higher that the 2.95% increase for 2018, writes Virgil Dickson in *ModernHealthCare,* published April 2, 2018.

CMS is also moving forward with plans to increase the use of encounter data to determine risk scores for plans. As a result of the finalized rule, 75% of Medicare Advantage risk scores will be based on traditional fee-for-service data, and 25% based on encounter data. That differs from 2018, when the agency used a risk score blend of 85% fee-for-service data and 15% encounter data.

CMS also finalized a policy to prevent Medicare beneficiaries who are deemed at risk for opioid misuse or abuse from obtaining prescription drugs from multiple doctors or pharmacies. Instead, they'll be locked into one pharmacy or prescriber for Medicare Part D benefits.

Medicare Advantage enrollment is projected to grow by 9% to 20.4 million in 2018. CMS estimated that more than one-third of all Medicare enrollees, or 34%, will be in a Medicare Advantage plan in 2018.

New Medicare Card: You Can Help Your Patients

CMS is mailing new Medicare cards with new Medicare numbers to people newly enrolling in Medicare. People who already have Medicare coverage will receive their cards on a flow basis.

CMS is conducting a major education campaign about the new card, and providers can help:

- **Your Medicare patients will not get new cards if their addresses are not correct. If the address you have on file is different than the Medicare address you get in electronic eligibility transaction responses, ask your patient to correct their address through Social Security.**
- **Play the one minute "New Medicare Cards are coming!" video in your waiting room so patients know when and how they will receive the new card (also available in opened caption and 1080p formats). The video is on youtube at:**

  https://www.youtube.com/watch?v=DusRmgzQnLY
- **Display a poster in your office.**
- **Give your patients tear-off sheets or flyers.**

Register and order these free color products available in multiple languages, or print on 8.5"x11" paper:

- Poster, 11"x17" (Product #12009-P)
- Pad of 50 tear-off sheets, 4"x 5.25" (Product #12006)
- Flyer, 8.5"x11" (Product #12002)

Please go to:
https://productordering.cms.hhs.gov

New Medicare Cards: Challenges and Opportunities -- Duane C. Abbey, PhD, CFP, *ICD10 Monitor,* April 3, 2018

CMS started issuing the new Medicare cards with the MBI (Medicare Beneficiary Identifier) number on April 1, 2018. The Social Security Number based HICN, or Health Insurance Claim Number, is being replaced by an eleven-alphanumeric number. The process of issuing the new cards should be completed by the end of 2019.

Starting January 1, 2020 only the new MBI (Medicare Beneficiary Identification) number will be recognized.

There will be some exceptions allowed and will include:

Appeals -- can be filed using either the HICN or the MBI.

Adjustments -- the HICN can be used indefinitely for some systems (Drug Data Processing, Risk Adjustment Processing, and Encounter Data) and for all records, not just adjustments

Reports -- the HICN should be used on the following reports until further notice:

- Incoming to CMS - quality reporting, Disproportionate Share Hospital data requests, etc.
- Outgoing from CMS - Provider Statistical & Reimbursement Reports, Accountable Care Organization reports, etc.

For Medicare beneficiaries, the question is whether or not they will even know that new cards are coming, and then, once they receive the new cards, what action to take or not take. The concern is that with the elderly population there will be confusion concerning the new cards. There is also concern that fraudulent activities will take place surrounding the issuance and receipt of the new cards.

The most direct way to obtain the new MBI number is to ask the Medicare beneficiary when he or she comes in to see the provider. If the beneficiary doesn't yet have his/her new card, then this can be used as an educational opportunity to inform the Medicare beneficiary that a new card will be arriving in the mail.

The second approach involves the use of a secure portal through your Medicare Administrative Contractor (MAC). Starting in June 2018, the portal approach is planned to be available. With a basic amount of information (e.g., name, HIC number, address, etc.) you should be able to look up the MBI number if it has been assigned.

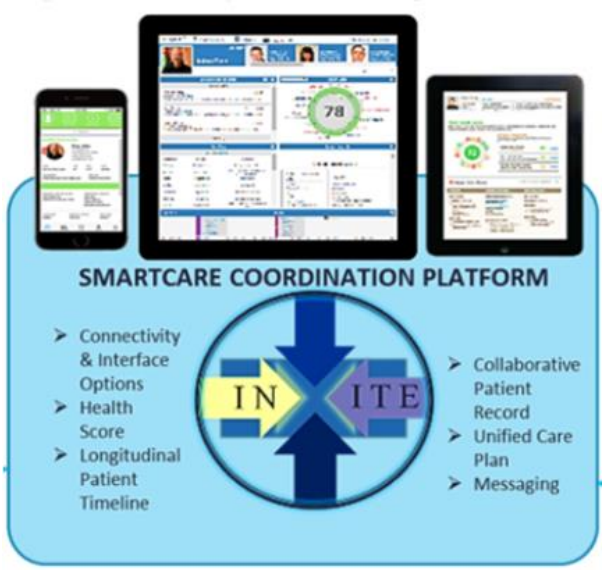
The Most Advanced Platform for Supporting Value-Based Care

The InXite SmartCare Coordination System is designed to complement existing systems and improve how a care group (several providers and organizations) can communicate, share, collaborate and coordinate care on behalf of a patient.

By using the InXite SmartCare Coordination System a patient's providers will have the ability to subscribe and publish to a patient's comprehensive integrated health record, coordinate patient care plans, manage key performance indicators, monitor the patient's progress and have the ability to measure improved care outcomes through advanced analytics and reporting.

InXite Health Systems provides patients and everybody who cares for them the tools and services they all need to better collaborate and improve health outcomes:

Technology – Care-coordination platform, specialized apps and custom plugins
Chronic Care Management- Serving patients with two or more chronic illnesses
Care Coordination Services – Healthcare coordination management
Consulting – Implementing value-based care models



Providers can receive monthly reimbursements for non face-to-face management of chronically ill patients.
To schedule a demo, please visit InXite's website at: www.inxitehealth.com.

CMS Releases 2018 MIPS Eligibility Tool

The updated CMS MIPS Participation Lookup Tool can now be used to check your 2018 eligibility for participating in MIPS. Please go to the Quality Payment Program website www.qpp.cms.gov and enter your NPI number. You will be told whether you need to participate during the 2018 performance year.

To reduce the burden on small practices, CMS also changed the eligibility threshold for 2018. Clinicians and groups are now excluded from MIPS if they:

- Billed $90,000 or less in Medicare Part B allowed charges for covered professional services under the Physician Fee Schedule (PFS)

OR

- Furnished covered professional services under the PFS to 200 or fewer Medicare Part B -enrolled beneficiaries.

Note: The 2018 Participation Lookup Tool Update for Alternative Payment Model (APM) participants will be updated at a later time.

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