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Medical Billing & Consulting

To be prepared is half the victory -- Miguel de Cervantes

NEWS Updates

Client Memo October 2018

The Quality Payment Program Year 3 Proposed Rule

According to CMS, the first two years of the Quality Payment Program were implemented gradually to reduce burden, provide flexible participation options, and allow providers to spend less time on regulatory requirements and more time with patients.

Year 3 proposed policies have been recently released and reflect feedback CMS received from many providers. CMS will continue offering free, hands-on technical assistance to help individual clinicians and group practices participate in the Quality Payment Program.

A summary of some of the Year 3 proposals are listed below. Please note that these are proposals only and subject to change in the 2019 Physician Fee Schedule (PFS) Final Rule which should be released later this year.

Quality Payment Program Year 3 Proposals: MIPS

Some of the proposals 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 to the low-volume threshold determination, and giving eligible clinicians who meet one or two elements of the low-volume threshold the choice to participate in MIPS (referred to as the opt-in policy)

Opt-in to participate in MIPS

Starting in Year 3, clinicians or groups would be able to **opt-in to MIPS** if they meet or exceed one or two, but not all, of the low-volume threshold criteria.

- restructuring the Promoting Interoperability performance category, formerly known as Advancing Care Information; and

- creating an option for certain facility-based clinicians to use facility-based Quality and Cost performance measures.

CMS is also proposing further flexibilities for clinicians in small practices, a few of which are:

- 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

- awarding small practices 3 points for quality measures that don't meet the data completeness requirements

- consolidating the low-volume threshold determination periods with the determination period for identifying a small practice.

Bipartisan Budget Act of 2018

Enacted in early 2018, the Bipartisan Budget Act of 2018 provides additional authority to continue the gradual transition in MIPS for three more years. Although the Bipartisan Budget Act of 2018 was enacted after the publication of the Calendar Year (CY) 2018 Quality Payment Program final rule, CMS has already implemented adjustments to the low-volume threshold calculations for Year 2 of the program. In the CY 2019 Physician Fee Schedule proposed rule, CMS wants to continue using this authority to help further reduce clinician burden.

Quality Payment Program Year 3 Proposals: APMs

Changes being proposed include:

- updating the Advanced APM 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;

- increasing flexibility for the All-Payer Combination Option and Other Payer Advanced APMs for non-Medicare payers to participate in the Quality Payment Program as well as streamlining the definition of a MIPS comparable measure in both the Advanced APM criteria and Other Payer Advanced APM criteria;

Value-Based Payment Models May Hit Providers of Sicker Patients

-- Roxanne Nelson, BSN, RN, *Medscape Medical News*, September 21, 2018

Medicare has steadily moved toward value-based and alternative payment models, in which clinicians and hospitals are held accountable for both quality and costs of care. In theory, this makes sense, as the goal of value-based payment models is to provide incentives for delivering high-quality care.

However, inherent limitations of these models as they now stand may incur unintended consequences. According to two new studies published in *JAMA Internal Medicine*, both clinicians and hospitals may be penalized for caring for sicker patients, those with mental health/cognitive impairments, and patients at lower socioeconomic status.

In an editorial accompanying both studies, Julie Bynum, MD, MPH, from the University of Michigan Medical School, Ann Arbor, and Valerie Lewis, PhD, from the University of North Carolina at Chapel Hill, point out that with value-based payment models, there may be benefits to avoiding treating high-risk populations.

This can be an "appealing option for physician organizations, hospitals, or payers concerned that they will need to expend more resources for certain patients than they will receive to care for them," they write.

Known by many names, including adverse selection, cherry picking, cream skimming, and patient dumping, this phenomenon "has been found in a variety of contexts related to quality reporting or pay for performance."

This type of "adverse selection" represents a serious threat to the success of value-based payment models, but the biggest potential harm is to the high-risk patient, who may have limited access to high-quality clinicians, the editorialists note.

Please refer to the *JAMA Internal Medicine,* September 17, 2018, online article for more details on the studies.

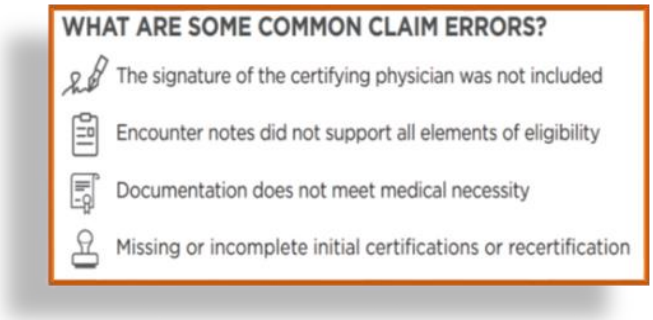
Targeted Probe and Educate (TPE)

CMS created a new audit process designed to help providers eliminate mistakes. CMS's Targeted Probe and Educate (TPE) program is designed to help providers and suppliers reduce claim denials and appeals through one-on-one help.

Targeted **providers with high denial rates or unusual billing practices**

The goal: to help providers quickly improve. Medicare Administrative Contractors (MACs) work with providers to identify errors and correct them. Many common errors are simple – such as a missing physician's signature – and are easily corrected.

Many of the mistakes that are identified can be easily fixed.



What to Expect

- The MACs will chose providers who have high claim error rates or unusual billing practices.
- The MAC will send a notice to the provider informing them that the TPE review has been initiated.
- **ROUND 1:** Shortly thereafter, the MAC will send a request for medical records and other documentation to support 20 to 40 claims.
- The provider has 45 days to collect all the documentation and return it to the MAC.
- The MAC then has 30 days to review the claims and supporting materials. The MAC sends the provider a letter detailing the results of the claim review and claim errors.
- The MAC also offers the provider the opportunity for a one-to-one educational call to review the audit results and discuss the errors and CMS policies related to the services or items under review.
- If the provider is deemed compliant, the provider will not be reviewed again for at least 1 year on the same topic.
- The acceptable claim error rate will be dependent upon the service or item under review.
- **ROUND 2:** If the MAC deems the provider was not compliant in round 1, then a few months later, the MAC will send another request for documentation for an additional 20 to 40 claims and the same process is followed.
- **ROUND 3:** If the provider is not compliant again, the same process occurs for a third and final time.
- *Providers only have 3 rounds to become compliant.*
- If there is a failure to improve after 3 rounds, the provider will be referred to CMS for additional review or other disciplinary actions that may include suspension of Medicare payments, revocation of Medicare billing privileges, or exclusion from the Medicare program.

To learn more about TPE audits, check out the 5 minute video at:

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Targeted-Probe-and-EducateTPE.html#probe

How Agencies Can Win with Targeted Probe & Educate Audits

Although the above article was written in December 2017, Carlo Calma's comments in *Home HealthCare News* still apply today. Excerpts from his article are presented below.

CMS has certainly kept the home health industry on its toes, with 2017 being a banner year for regulations and proposals. Between the now on-hold Home Health Groupings Model (HHGM), and the new Conditions of Participation (CoPs) set to take effect on January 13, 2018, home health providers have been hit with a lot of changes.

In keeping with this trend, CMS expanded its Targeted Probe and Educate (TPE) program to all Medicare Administrative Contractors (MACs). The nationwide expansion of the program is just another hit for the home health industry at large, according to Diane Link, director of clinical services at Pennsylvania-based BlackTree Health Care Consulting.

Unlike previous audits, TPE audits are triggered when an agency either has a high rate of claims being denied, often based on incidences like invalid face-to-face encounters or if therapy utilization is higher than deemed reasonable.

Under the magnifying glass: TPE audits consist of three (3) rounds. Goal is to learn from education and improve results in the next round.

After the third round, if they are still having issues, the MAC will escalate it up to CMS for possible further action which can involve a Zone Program Integrity Contractor (ZPIC) or Unified Program Integrity Contractor (UPIC) audit, or even a 100% pre-pay review.

For some providers, the TPE program offers an opportunity to identify key areas in their claims submission processes, according to Dawn Futris, risk management and infection control manager at Illinois-based NorthShore University HealthSystem Home Health and Hospice.

"A TPE audit allows the opportunity to know where the problem is…and the agency can either take the steps to correct the issues or suffer the consequences," Futris told HHCN.

Agencies really need to be proactive before they submit a claim to make sure that clinical review has been done to ensure that they are compliant with the requirements.

AMA Releases Updated CPT Codes for 2019

The 2019 CPT code set includes 335 code changes, the AMA announced on September 5, 2018. The changes to the code reflect key trends in patient care, writes Marcia Frellick in her September 6, 2018, article for *Medscape Medical News.*

Among important changes, which go into effect January 1, 2019, are additional codes that will help physicians bill for patient population health and care coordination services.

The new codes include:

- three remote monitoring codes that will help physicians account for monitoring patients at home and gathering data for care coordination, according to an AMA press release;
- two new codes addressing nonverbal communication technology to coordinate care between consulting and treating physicians; and
- new and revised codes for skin biopsy, fine needle aspiration biopsy, adaptive behavior analysis, and central nervous system assessments including psychological and neuro-psychological testing.

New CPT category 1 codes go into effect Jan. 1, 2019. The AMA releases the annual code sets 4 months early to ease the transition between code sets. Category 1 codes cover procedures that are consistent with contemporary medical practice and are widely performed.

The AMA has urged CMS to adopt the new codes for remote patient monitoring and internet consulting and designate the related services for payment under federal health programs in 2019.

Medicare's acceptance of the new codes would signal a landmark shift to better support physicians participating in patient population health and care coordination services that can be a significant part of a digital solution for improving the overall quality of medical care.

3 Billing Codes Physicians Should Use

Doctors and practice administrators are always looking for ways to maximize profits. Here are three codes that Michael Enos, CPC, CPMA, finds are often misunderstood, underused, or unknown. Practices that know about these codes, and how to use them, may be able to earn additional reimbursement, he states in his article for *Physicians Practice*, August 28, 2018.

99441-99443: Telephone services

CPT offers codes to report telephone services provided by a physician or other qualified health care professional. These codes can only be reported for an established patient and are not billable if the call results in the patient coming in for a face-to-face service within the next 24 hours (or next available urgent visit).


(stepsfoward.org))

The codes are selected from code range 99441 to 99443 and are based on the time spent: 5-10 minutes, 11-20 minutes, or 21-30 minutes, respectively.

These calls are also not billable if they refer to an E/M service performed within the last seven days.

96160: Health risk assessment


(MedXM)

Providers can bill code 96160 when they perform a health risk assessment with a patient or caregiver or guardian in order to assess the risk of conditions such as mental disorders.

They can also report 96160 when administering a patient-focused health risk assessment. Providers should report 96161 for a caregiver-focused health risk assessment, such as depression inventory, for the benefit of the patient.

99058: Services provided on an emergency basis

What can providers do when they already have a packed schedule and a patient walks in demanding to be seen? What if a scheduled nurse visit is more serious than anticipated, and the provider is called to step in and spend a great deal of time with that patient?

When a patient is seen on an emergency basis in the office and it disrupts other scheduled office services, providers may be able to report add-on code 99058 for additional reimbursement.

CMS Proposes Rule to Reduce Burdensome Healthcare Facility Requirements – Greg Slabodkin, *Health Data Management*, September 18, 2018

On Monday, September 17, 2018, CMS announced a proposed rule designed to trim some healthcare compliance rules.

The agency says it's proposing the steps to remove unnecessary, obsolete and excessively burdensome requirements for healthcare facilities.

Part of the agency's Patients Over Paperwork initiative, the CMS proposal is an attempt to streamline documentation requirements and to modernize Medicare payment policies.

With this proposed rule, CMS takes a major step forward in its efforts to modernize the Medicare program by removing regulations that are outdated and burdensome.

"The changes we're proposing will dramatically reduce the amount of time and resources that healthcare facilities have to spend on CMS-mandated compliance activities that do not improve the quality of care, so that hospitals and healthcare professionals can focus on their primary mission -- treating patients," said CMS Administrator Seema Verna in a written statement.

The rule is divided into three categories: proposals that simplify and streamline processes, proposals that reduce the frequency of activities and revise timelines, as well as proposals that are obsolete, duplicative or that contain unnecessary requirements.

When it comes to ambulatory surgical center (ASC) requirements for comprehensive medical history and physical assessment, CMS is proposing to replace current requirements with requirements that defer, to a certain extent, to ASC policy and the operating physician's clinical judgment to ensure that patients receive the appropriate pre-surgical assessments tailored to the patient and the type of surgery being performed.

At the same time, the agency says it "still would require the operating physician to document any pre-existing medical conditions and appropriate test results, in the medical record, which would have to be considered before, during and after surgery."

Further, CMS has "retained the requirement that all pre-surgical assessments include documentation regarding any allergies to drugs and biologicals, and that the medical history and physical examination, if completed, be placed in the patient's medical record prior to the surgical procedure."

As far as hospital requirements for comprehensive medical history and physical examinations are concerned, the agency is proposing to "allow hospitals the flexibility to establish a medical staff policy describing the circumstances under which such hospitals could utilize a pre-surgery/pre-procedure assessment for an outpatient, instead of a comprehensive medical history and physical examination."

In supporting this proposal, CMS said it believes that the "burden on the hospital, the practitioner and the patient could be greatly reduced by allowing this option."

In order to exercise this option, a hospital would need to document the assessment in a patient's medical record.

Rick Pollack, president and CEO of the American Hospital Association, voiced AHA's support for regulatory relief to enable hospitals and health systems to focus on delivering high-quality care and improving patients' access to services.

"The simple truth is that the regulatory burden hospitals face is substantial and unsustainable, and can be overwhelming," said Pollack.

"CMS's commitment to reduce the regulatory burden is crucially needed as we strive to meet the increasingly complex needs of our patients and accelerate efforts to reduce costs. The AHA and our members look forward to continuing working with CMS to ensure that we have more responsible and reasonable regulations that reflect the realities that doctors and nurses face on the front lines to enable them to provide care in an effective and efficient way," he continued.

The agency's proposed rule also addresses home health agency requirements for providing patients with copies of clinical records.

The proposed rule removes the requirement that Home Health Agencies provide a copy of the clinical record to a patient, upon request, by the next home visit but retains the requirement that the copy of the clinical record must be provided, upon request, within 4 business days.

CMS will accept public comments on its proposed rule until November 19.

New CMS Proposal Would Save Home Health, Hospice $137M Annually -- Robert Holly, *Home HealthCare News*, September 17, 2018

Federal policymakers are again taking aim at costly administrative and paperwork burdens for the home health and hospice industries in order to help providers save tens of millions of dollars annually.

CMS announced its latest proposed rule focused on minimizing burdens on home health agencies, hospice providers, hospitals, skilled nursing facilities and other health care entities. The proposed rule, a response to the Trump administration's "cut the red tape" initiative, would save all health care providers an estimated $1.12 billion a year, according to CMS.

Thanks to provisions targeting patient rights requirements, medication staffing stipulations and deficiency training rules, home health and hospice providers, in particular, would stand to save an estimated $137 million combined.

Hospice providers would likely reap more savings than home health agencies under the newly proposed rule.

"We are committed to putting patients over paperwork, while at the same time increasing the quality of care and ensuring patient safety and bolstering program integrity," CMS Administrator Seema Verma said in a statement.

With this proposed rule, CMS takes a major step forward in its efforts to modernize the Medicare program by removing regulations that are outdated and burdensome.

Burdens for home health agencies

Among suggested changes, the proposed rule would remove the requirement that home health agencies provide a copy of clinical records to patients during the very next home visit following a request.

Instead, agencies would have four business days to provide copies if patients or their families ask for them.

In addition to those changes, CMS's proposed rule also calls for eliminating the requirement that home health aides receive full competency evaluations when supervisors visit in the field and identify deficiencies in caregiving ability.

Currently, home health agencies must conduct -- and aides must complete -- full competency evaluations that assess all aide skills whenever an issue is observed.

In lieu of full competency evaluations, CMS is proposing that agencies need only retrain an aide in the observed deficient skill or skills, with aides likewise completing evaluations that are directly relevant to the issues at hand.

In a change that is more consistent with requirements for other provider types, such as hospices, ambulatory surgery centers and mental health centers, the proposed rule also seeks to scrap the requirement that home health agencies must provide verbal notification of all patient rights. Written notification, though, would still be required.

Those and other burden reductions proposed by CMS would save an estimated $55 million annually, according to the agency.

Hospice cost savings

CMS's proposed rule also included suggested changes to hospice requirements, most notably a change related to the requirement of having an individual with specialty knowledge of hospice medications on staff.

The requirement is no longer necessary for various reasons and should be eliminated, according to CMS.

CMS is also proposing to replace the requirement that hospices provide a copy of medication policies and procedures to patients, families and caregivers with a requirement that hospices provide information regarding the use, storage, and disposal of controlled drugs to the patient, patient representative or family. The proposal calls for that information to be provided in a more user-friendly manner, as determined by each hospice.

The hospice burden reductions proposed by CMS would save the industry an estimated $82 million annually, according to the agency.

Since CMS's Patients Over Paperwork initiative began in 2017, the agency has uncovered 3,040 "mentions of burden," which CMS has categorized as related to 1,146 different issues. CMS has taken action to address 55% of the burden topics raised. CMS projects savings of nearly $5.2 billion and a reduction of 53 million hours through 2021.

CMS Faces Decisions in Shaping Medicare Advantage Home Care Benefits -- Tim Mullaney, *Home HealthCare News*, August 21, 2018

In a major change for the home care industry, Medicare Advantage plans have been granted new flexibility this year, which will allow them to cover non-skilled in-home services for the first time.

Important Medicare Advantage policy changes had been made via the Bipartisan Budget Act of 2018, signed by President Trump on Feb. 9. These changes are the focus of the issue brief from the Bipartisan Policy Center, a nonprofit think tank based in Washington, D.C.

Specifically, the Budget Act gives Medicare Advantage payers more flexibility to offer non-medical health-related services and support to people with multiple chronic conditions starting in 2020.

"This new flexibility for health plans has significant potential to provide access to non-medical health-related benefits, including those that have proved successful in keeping patients in their homes," the issue brief states.

--ubisafe.org

The goal is to short-circuit the "cycle of emergency department visits, hospital admissions, and discharges to home" that patients with multiple chronic conditions often find themselves in, which drives up costs across the health care continuum and compromises quality of life and health outcomes for these individuals.

Going forward, CMS will serve as the lead office for how provisions of this law are implemented. A number of key questions that CMS will have to address were identified.

One major decision point centers on the level of flexibility that Medicare Advantage providers will have in defining what new supplemental benefits they will offer and who is eligible for them.

The new law opens the door to non-medical, health-related services, such as transportation, meals, and home modifications. Health plans may determine that some make economic sense and others do not.

In terms of eligibility, CMS will have to decide whether plans will have latitude in deciding which enrollees qualify for the new supplemental benefits.

One option would be to base eligibility on a person's diagnoses, but insurance providers might object that this would make benefits available to people who might not need them. A more precise way to determine eligibility might be to measure a person's ability to do activities of daily living, such as preparing meals or driving.

Despite these uncertainties about the size and scope of the new Medicare Advantage opportunity, home care companies are already taking steps to work more closely with Medicare Advantage insurers. For instance, major franchise company Senior Helpers recently hired a new executive to help lead its Medicare Advantage-related efforts.

MEDICARE ANNOUNCEMENTS

MIPS Targeted Review Deadline Extended

Eligible clinicians have an extra two weeks to request a targeted review of 2019 MIPS payment adjustment calculations after CMS found errors with the program's scoring logic.

CMS recently announced that it is extending the targeted review deadline for 2017 MIPS performance score. Eligible clinicians now have until October 15, 2018, at 8:00 pm EDT to request a targeted review of their MIPS performance score from CMS. The old deadline was September 30, 2018.

A targeted review allows eligible clinicians, groups, and providers in certain alternative payment models (APMs) to request that CMS review their MIPS payment adjustment factor if they think the payment adjustment is wrong.

The initial round of targeted reviews for the 2017 MIPS performance period uncovered a series of concerns, writes Jacqueline LaPointe, in her article "CMS Finds Errors in 2019 MIPS Payment Adjustment Calculations" for *RevCycle Intelligence*, September 26, 2018. They include:

- the application of the 2017 Advancing Care Information (now Promoting Interoperability) Extreme

and Uncontrollable Circumstances hardship exceptions;

- the awarding of Improvement Activity credit for successful participation in the Improvement Activities Burden Reduction study; and
- adding the All-Cause Readmission measure to the MIPS final score.

CMS will address and correct the identified MIPS scoring logic errors, the announcement noted. The corrections will result in changes to the 2017 MIPS final scores and related 2019 MIPS payment adjustment factors for eligible clinicians who were impacted by the MIPS scoring issues.

Eligible clinicians and groups who were not impacted by the MIPS scoring errors may also see their payment adjustments slightly change, CMS added. The 2017 MIPS performance feedback provided on the Quality Payment Program website was also revised on Sept. 13, 2018.

Targeted reviews can be requested by going to the Quality Payment Program website, logging in using their Enterprise Identity Management (EIDM) credentials, and requesting a targeted review.

Quality Payment Program website: **https://qpp.cms.gov**

Don't Forget the ABN Modifiers!

Having Medicare patients sign an Advance Beneficiary Notice of Non-coverage (ABN) for services that may not be covered by Medicare is often overlooked. An ABN is a notice a provider gives to a Medicare patient if he or she believes that Medicare will not pay for a service.

If the practice does not have a signed ABN on file for the patient and Medicare denies the service, the patient cannot be billed for it and the charge must be written off. If an ABN is signed, however, the patient will be responsible for full payment if Medicare denies the service.

Please note: ABNs are not necessary for services that are specifically and routinely denied as non-covered.

Specific modifiers are required when billing for services or items that require an ABN. If the claim shows that a signed ABN is on file, the patient's EOB will drop the amount of the denied charge to patient responsibility. The modifier is added to the actual service being billed.

ABN forms and instructions can be downloaded from the Medicare website and must be completed correctly in order to be valid. **http://www.cms.gov/BNI/02_ABN.asp**

ABN Modifiers

Modifier	Modifier Description
GA	Used to report a required ABN was issued for a service and is on file. A copy of the ABN does not have to be submitted but must be made available upon request.
GX	Used to report a voluntary ABN was issued for the service.
GY	Used to report than an ABN was not issued because the item or service is statutorily excluded and is not required.
GZ	Used to report that an ABN was not issued for a service and the item or service is expected to be denied as not reasonable and necessary.

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