AQREVA
Medical Billing & Consulting

Client Memo
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"Once a new technology rolls over you, if you're not part of the steamroller, you're part of the road." -- Steward Brand

NEWS Updates

Changes to E&M Coding & Fee Schedule

After more than 20 years, CMS is proposing to make major changes to the E&M coding and payment structure. The provisions are part of the recently released 2019 Physician Fee Schedule proposed rule which will affect most providers and all specialties.

CMS is redefining the 1995 and 1997 guidelines for E&M coding in 2019. The payment structure for new and established patient office visits will be changed to a single specific RVU.

The proposal offers $93 for established office visit codes and $135 for new patient visits.

CPT Code	2018 Non-Facility Payment Rate	Proposed 2018 Non-Facility Payment Rate
99201	$45	$44
99202	$76	$135
99203	$110	
99204	$167	
99205	$211	
99211	$22	$24
99212	$45	$93
99213	$74	
99214	$109	
99215	$148	

CMS also wants to simplify E&M coding by letting providers choose the office visit code based upon the most important component of the visit:

- medical decision making (MDM), or
- face time spent with the patient, without the existing requirement that the visit be counseling-dominated.

Other provisions of the 2019 Proposed Physician Fee Schedule Rule include:

- New add-on G-codes to increase the payment for those providers who see sicker patients with more complex conditions;
- A new G-code to cover prolonged services,
- Office visits billed on the same day as a procedure with modifier 25 would be paid 50% less;
- No need for providers to personally document patient histories.

Please note that the final rule may be different from the summaries provided above.

The proposed rule can be found at: https://www.federalregister.gov/documents/2018/07/27/2018-14985/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions

Thoughts On CMS's Dramatic Proposal For E/M Guidelines - Lucien W. Roberts, III, *Physicians Practice,* Aug 8, 2018

I have long been a critic of the complexity and subjectivity of the current guidelines. However, I think these changes will be both a good thing and a challenge to physicians, particularly those who derive much of their income from office visits.

CMS has proposed to bundle both established patient visit codes 99212 through 99215 into a single code and new patient visit codes 99202 through 99205 into a single code. The lowest established and new patient visit codes, 99211 and 99201, would remain, but given the small frequency with which they are used, the biggest impact to physicians will be from providing care under the bundled codes

Here are my five impressions of the proposed rule that, if passed, would take effect Jan. 1, 2019.

The winners and losers

Physicians who frequently code level 4 and 5 services will see a decrease in E/M reimbursement, as the proposal sets future service payment at less than the current reimbursement rate for level 4 services. Conversely, physicians who code the majority of their services as level 3 will see their E/M reimbursement go up since the services will be paid at more than the current reimbursement for level 3 services.

Objectivity at last

Coding E/M services is subjective and confusing. Fewer than 6 in 10 physicians would code an office visit at the same level. And yet, Medicare and other payers have penalized physicians for over-coding using Recovery Audit Contractors, chart audits, and other tools. Those days of selecting the wrong code and thus being accused of fraud should go away under the proposed plan.

No more note bloat

The new codes will require minimum documentation, enough to meet what is needed today for a level 2 visit, and that's it. Physicians can focus on what has changed rather than redocumenting what has not. All of the note bloat that adds nothing to patient care—and is glossed over by anyone receiving your note, anyway—will be marginalized.

Since the advent of click-and-count documentation in EHRs, the use of level 4 and 5 codes has nearly doubled. They account for almost half of all E/M services today and have been trending steadily upwards for nearly 20 years.

Care will improve

Providers can now focus on their patients and on documenting what really matters: the care provided and the care plan. Documentation will be better and, I think, easier. Notes received from other doctors will be similarly streamlined and—dare I say—cogent.

Like the Lorax, I have spent years advocating for changes that seemed obvious to me but oblivious to those in power. CMS is at long last moving in the right direction. There will be losers, this being a zero-sum game, but these proposed changes are good for all of us and our patients. I believe that, and overall, I am pleased with CMS's proposal.

Lucien W. Roberts, III, MHA, FACMPE, is the administrator of Gastrointestinal Specialists, Inc., a 25-provider practice in Central Virginia.

CMS Proposes 50 Percent Reduction in Claims Submitted with Modifier 25

CMS has proposed modifications to the reimbursement model for the outpatient/office E&M code sets, as well as the anticipated documentation relaxation accompanying the proposal, writes Shannon DeConda in the August 28th, 2018 article for *ICD 10 Monitor.*

These two portions of the proposed changes are getting much publicity, but what seems to be getting missed with all of the E&M hype is the proposed reimbursement changes to services billed with a Modifier 25.

CMS's proposed change in this area would impact not the documentation requirements, but rather the reimbursement model associated with Modifier 25. Currently, if a claim is received by CMS that includes an E&M service with a Modifier 25 and a procedure, both the E&M and the procedure are reimbursed at 100 percent of the allowed amount.

CMS proposes to reduce the reimbursement for the service with the lower value by 50%.

Why is CMS proposing this change? It has provided two reasons:

- Multiple payment reduction: CMS is comparing an E&M with a procedure to a surgical encounter in which multiple payment reductions are applicable.
- Efficiencies: CMS feels that there are "efficiencies" associated with an E&M encounter and procedure on the same visit that the multiple payment rule should be applied to these instances.

Based on the current rules associated with the proper use of Modifier 25, I am not really sure how either of these reasons are valid.

Modifier 25 is used when a procedure (with a 0-10-day global period) is performed on the same day as an E&M encounter. If the patient presents to the office for a problem, regardless of whether the provider has seen the patient or treated the problem before, if the provider decides that the patient would benefit from a procedure, then the E&M service is not additionally reimbursed.

Modifier 25 appended to the E&M code indicates that there was more to the encounter other than the standard decision-making for the procedure rendered.

Consider the financial implication this will have on your practice, and consider posting your comments for CMS consideration.

MIPS UPDATE

2017 MIPS Performance Feedback and Payment Adjustment Update

CMS originally displayed a single payment adjustment amount, which included an additional adjustment for exceptional performance available to MIPS eligible clinicians and groups with a final score of 70 or greater.

Based on feedback from various clinicians and groups, CMS has updated the system so that your MIPS payment adjustment, and if applicable, your additional adjustment for exceptional performance, are now displayed separately.

Quality Payment Program Exception Applications Now Available on QPP Website

The 2018 Quality Payment Program MIPS Exception Applications for either the Promoting Interoperability (PI) performance category or Extreme and Uncontrollable Circumstances are now available on the Quality Payment Program website https://www. qpp.cms.gov

Promoting Interoperability Hardship Exceptions

If you're participating in MIPS during the 2018 performance year as an individual, group, or virtual group—or participating in a MIPS Alternative Payment Model (APM)—you can submit a Quality Payment Program Hardship Exception Application for the Promoting Interoperability performance category (aka meaningful use), citing one of the following specified reasons for review and approval:

- MIPS-eligible clinicians in small practices (new for 2018),
- MIPS-eligible clinicians using decertified EHR technology (new for 2018),
- Insufficient Internet connectivity,
- Extreme and uncontrollable circumstances, or
- Lack of control over the availability of certified electronic health record technology (CEHRT)

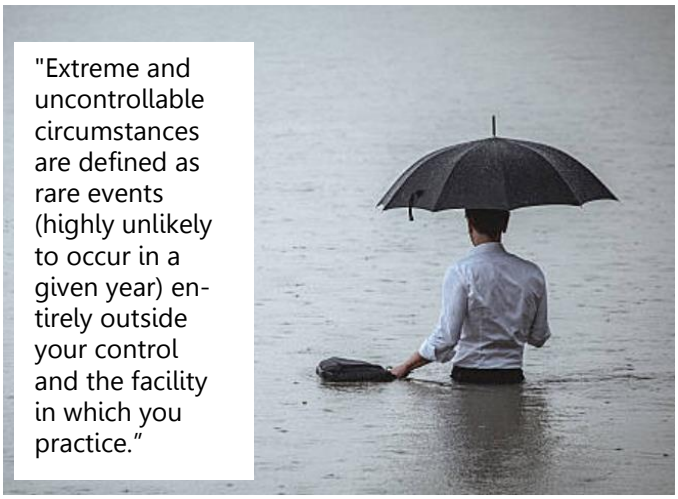
An approved QPP Hardship Exception will:

- Reweight your PI performance category score to 0 percent of the final score
- Reallocate the 25 percent weighting of the PI performance category to the Quality performance category

Please note that simply not using CEHRT does not qualify you for reweighting of your PI performance category.

You must submit a hardship exception application by December 31, 2018 for CMS to reweight the PI performance category to 0 percent.

Extreme and Uncontrollable Circumstances



MIPS eligible clinicians who are impacted by extreme and uncontrollable circumstances may submit a request for reweighting of the Quality, Cost, and Improvement Activities performance categories.

The application for extreme and uncontrollable circumstances must be submitted by December 31, 2018 for the 2018 MIPS performance year.

For More Information:

- Review the 2018 Exceptions FAQ Sheet https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2018-Exceptions-FAQs.pdf
- Contact the Quality Payment Program at QPP@cms.hhs.gov or 1-866-288-8292/TTY: 1-877-715-6222.
- Email: QPP@cms.hhs.gov
- Visit the Quality Payment Program Website https://www.qpp.cms.com

2015 Edition Certified EHR's Mandatory per CMS

CMS is standing firm with its mandate that all providers must use 2015 Edition Certified EHRs in 2019. This version opens APIs, a key ingredient in the effort to achieve full interoperability in healthcare, CMS Administrator Seema Verma announced on Monday, August 6, 2018. An API is a new approach to content management with many advantages over the 'old' way.

Physicians to Expect Greater Competition for Bonuses in 2019 -- Terry Fletcher BS, CPC, *ICD 10 Monitor,* August 14, 2018

Revisions in the QPP proposed rule, tucked into the 2019 Physician Fee Schedule, will make for heightened competition and expectations among physicians participating in MIPS as CMS continues to link performance to patient outcomes.

In looking towards 2019, physicians need to make sure they are not only informed and implementing measures on the performance standards to receive their bonuses, but are also mindful of the penalties they can incur with non-compliance.

In the 2018 QPP final rule, CMS predicted that 74 percent of MIPS-eligible clinicians will earn a score of 70 or greater for the 2018 performance year. This bolsters the expectation that the performance threshold for 2019 will be much higher than for 2018, thereby significantly raising the level of competition for earning incentives and avoiding penalties.

Remember, this is a program that anticipates winners and losers, so you want to be on the winning side, or your monetary penalties for non-participation and/or non-compliance will find their way into the pockets of the proactive physicians, as CMS likes to label "the winners" of their MIPS program.

Waiving Patient Copays or Deductibles

Tom Ambury's comments on the WebPT blog *"Legal Compliance: One More Reason to Collect Patient Deductibles and Copays,"* from July 24, 2017, are just as relevant now as they were a year ago. He has warned that routinely waiving copays and deductibles for patients with a federally funded insurance like Medicare can be a violation of the Federal Anti-Kickback Statute.

For commercial insurances like BlueCross BlueShield, Aetna, and Cigna, Mr. Ambury warns that there are potential legal ramifications for providers who routinely waive copays and deductibles.

Commercial insurance providers have contracts to provide health insurance to employers and employees and now, under the Affordable Care Act, to individuals as well. They must charge a premium for that health insurance, which the employer, employee, and\/or individual must pay.

Because this contract is a legally binding agreement with an employer or individual, if a provider comes along and decides to unilaterally waive patient deductibles and copays, then the provider is reducing the covered person's contractual financial obligation.

If an in-network provider routinely waives deductibles and copays, not only does it interfere with the employer's and/or individual's contractual obligations, it potentially violates the provider's own agreement with the insurance company.

What to Do Instead

- ✓ Adopt the policy of making every reasonable effort to collect all deductibles and copays—unless the patient can demonstrate a financial hardship.
- ✓ Establish a procedure patients must use to demonstrate a financial hardship, and document it. Also, make sure the patient signs an acknowledgment that he or she has a financial hardship.
- ✓ Even if a patient can demonstrate a financial hardship, you don't necessarily have to waive it in full. In other words, you're free to negotiate. Ask the patient, "What can you afford to pay each visit?"

(Tom Ambury has been a physical therapist for 23 years and developed the PT Compliance Group.)

What's the Problem?

Frank Carsonie, JD, and Nathan Sargent, JD, of Benesch, Friedlander, Coplan & Aronoff LLP, Columbus, OH, warn providers of the legal ramification of waiving copays and deductibles in their article "What's the Problem? Providers' Waivier of Patient Copays or Deductibles" for *Anesthesia Business Consultants*, Spring of 2018. Excerpts from their article are presented below.

Plans and healthcare providers establish rates and fee schedules for covered healthcare services by contract. Despite the existence of such contractual arrangements, both in-network and out-of-network health-care providers sometimes waive patient copays, co-insurance and deductibles and they do so for different reasons and under varying circumstances.

HEALTHCARE PROVIDERS WHO GRANT WAIVERS SHOULD KNOW THAT THERE ARE SERIOUS HEALTHCARE FRAUD AND ABUSE IMPLICATIONS UNDER FEDERAL AND STATE LAW

What Laws Apply to Patient Copay or Deductible Waivers?

At the federal level, healthcare provider waivers implicate civil monetary penalties under the Social Security Act as well as the Federal Anti-Kickback Statute.

- **Section 1128A(a)(5) of the Social Security Act**: any person (including an organization, agency or other entity) that offers, or transfers, remuneration to an individual eligible for Medicare or Medicaid benefits, and such person knows or should know the remuneration is likely to influence an individual to order or receive a covered Medicare or Medicaid service from a particular healthcare provider, is subject to a civil monetary penalty (**the CMP Law**).

- **Federal Anti-Kickback Statute**: any person (an entity or individual) that knowingly and willfully pays or offers to pay any remuneration, directly or indirectly, overtly or covertly, in cash or in kind, to any person to induce such person to purchase, lease, order or arrange for any good, service or item for which payment may be made, in whole or in part, by a federal healthcare program, such as Medicare and Medicaid.

Like the civil monetary penalties, a violation of the Anti-Kickback Statute may result in exclusion from participation in Medicare and Medicaid and the imposition of civil monetary penalties in an amount equal to treble damages plus $50,000 per violation.

States often have their own healthcare fraud and abuse laws. Some states even have statutes and regulations that govern the specific practice of healthcare provider waivers.

Others address the issue in provider disciplinary rules and standards of professionalism, expressly prohibiting a licensed practitioner from waiving patient insurance obligations except under certain circumstances

What's Permitted Under Civil Monetary Penalties

As it relates to the CMP Law, "remuneration" is specifically defined to include the waiver of coinsurance, copay and deductible amounts (or any part thereof). However, a waiver does not become remuneration subject to the CMP Law prohibitions if:

- The waiver is not offered as part of any advertisement or solicitation; and
- The healthcare provider does not routinely waive or reduce coinsurance, copay or deductible amounts; and
- The healthcare provider (a) waives or reduces the coinsurance, copay or deductible amounts after determining, in good faith, that the individual is in financial need or (b) fails to collect after making reasonable collection efforts.

Irrespective of when a waiver is granted, there are serious ramifications that must be duly considered. If you have questions about any past, current or proposed waiver practices, you should consult experienced healthcare regulatory counsel.

Four Reasons to Integrate EHR and Practice Management Software

You have EHR software, and you have practice management software. But they aren't on speaking terms. They don't even speak the same language, and this language barrier may be doing more harm to your practice than you realize, writes Avery Hurt in *Physicians Practice*, July 9, 2018.

Simply integrating these two systems can fix a lot of problems. If you've been hesitating to take the plunge, here are a few reasons why you shouldn't wait.

You'll save time

"Integrating medical records and practice management software cuts out a lot of duplicate effort," says Laurie Morgan, a San Francisco-based senior consultant and partner with medical consulting firm Capko & Morgan. If your programs are not integrated, the billing staff has to re-key what providers have written or logged somewhere else.

When the systems are combined, the clinician keys in the information and the codes and other information flow through to billing. You only input the data one time. It greatly speeds up the process.

You'll save money

"Practices often underestimate the costliness of redoing work," says Morgan. Paper super bills can be hard to read, and that means stopping the process to ask questions or redoing work more often.

Saving time is not the only way integration can save you money, however. Integrating EHR and practice management systems can increase revenue because having the data all in one system makes it easier to pull claims to submit to payers. If it's easier to submit claims, you get them in faster. It's also easier for integrated systems to identify and correct improperly coded procedures.a

You'll make fewer mistakes

Putting in data only once reduces errors as well. Each time someone rekeys data, there is another chance for mistakes to creep in. Consolidating patient data increases the accuracy of reports generated and makes for a seamless transition of data between the practice management system and the EHR system. This will increase the accuracy of healthcare data on all fronts.

You have a lower risk of privacy breaches

One unexpected benefit of integration is that the systems can help keep your data safe. An integrated system is easier to maintain and keep secure than multiple systems. It's a low-risk, cost-effective way to make your practice more efficient and more profitable.

Top Skilled Nursing Trends of 2018 – Alex Spanko, *Skilled Nursing News*, January 1, 2018

It's time for us to dive into our predictions for the top skilled nursing trends of the coming 12 months. Some key headwinds, such as questions over Medicaid reimbursements, declining occupancy, and new regulations — including the final round of the requirements of participation roll-out in November 2018 — will continue to plague the industry next year and likely many more to come.

Here are the top trends we see taking hold over the coming 12 months.

The rise of regionalism, or: So long, nationwide chains

Skilled Nursing News tackled the subject of mid-sized SNFs in one of our first longer-form features, in which multiple mergers-and-acquisitions experts predicted the rise of smaller, regional operators and holding corporations.

As the year progressed, their predictions looked more and more prescient. Large, national chains like Genesis (NYSE: GEN) and HCR ManorCare faced strains from both regulators and lenders. Long-term care is an intensely localized business, with residents not wanting to stray far from home and family supports, and operators vying for referrals from a small group of area hospitals.

Plus, despite stringent federal oversight, the nursing-home regulatory landscape often varies on a state-by-state basis. Nationwide chains might find it more difficult to keep up, or rein in rogue branches that happen to be violating laws that don't apply to other facilities in the same ownership group.

As a result, smaller, regional operators are often better equipped to thrive in the space, with a more intimate knowledge of the factors that are so crucial to SNF success: the demands and desires of accountable care organizations (ACOs), discharge coordinator preferences at individual hospitals, and even local health department inspection schedules.

'Small house' adaptations will rule in SNF design

-- mcnhealthcare.com

With younger boomers harboring bad memories of visiting their elders in cold, institutional nursing homes, even the humblest of SNF operators has taken steps to make their properties skew more towards "hotel" and less "Nurse Ratched."

With the oldest physical plants in the senior-housing game, skilled nursing providers face gigantic renovation bills if they want to convert their facilities to something like the "small house" model: a style that focuses on separate, manageable living areas for smaller groups of seniors with communal kitchens and shared spaces.

Medicare and Medicaid in the crosshairs

New tax cuts will shrink government revenue and lead to growth in the budget deficit by as much as $1 trillion, according to some estimates. Entitlement reform is one way to shrink spending and prevent such a ballooning deficit.

Some are skeptical that Congress can accomplish Medicare and Medicaid reform in an election year, but 2018 could still begin with a cut to SNF reimbursements. It's widely expected that SNF payments will be reduced to help offset the costs of repealing Medicare therapy caps.

So, the next 12 months could challenge skilled nursing margins, further complicating the picture for some major providers that are already strapped after a tough 2017.

SNFs get more niches

The era of the neighborhood nursing home, where grandma and grandpa go to receive extended long-term care, continues to wane. But if SNF providers think that the answer is to devote more beds to Medicare-reimbursed short-term rehab, they should think again. Managed care plans and Affordable Care Act policies are putting pressure on length of stay for these patients, and diverting as many patients as possible to receive care at home.

Rather, expect to see more SNFs specialize in the type of care they provide to meet specific needs in their markets. Matros, for one, is a believer in this model. Back in 2015, Sabra paid $234 million for four SNFs focused on particular types of complex care, including ventilator and dialysis services.

Insurance deals drive transformation

2017 ended with a flurry of blockbuster M&A activity, including insurer Humana acquiring a stake in the home health, hospice, and community-care operations of Kindred Healthcare (NYSE: KND) for $4.1 billion.

The deal comes as Kindred is completing its exit from skilled nursing, but it shows how post-acute care has become a top priority for the nation's largest insurers. Humana believes that by more closely managing this part of the continuum, it can better manage costs and outcomes for its beneficiaries.

Look for this to ratchet up the pressure on SNFs to win increasingly scarce referrals, as big payors become more aggressive and efficient at identifying which patients can receive care at home.

It appears that a senior's home is a greater competitor of SNFs than ever before. However, SNF providers staunchly assert that the home is not the best setting in all circumstances. In 2018, it's a safe bet that they will press this case with more and better data

Telemedicine takes off

For years, skilled nursing providers have been excited about telemedicine, saying that virtual visits with physicians and other clinicians could improve care quality while decreasing the stress and costs of transporting residents. With Congress making moves to loosen some obstacles to adoption, and evidence piling up as to the benefits of telemedicine, 2018 could be a turning point for the technology.

Don't expect emergency prep to go away

CMS already made sure that 2017 would be the year of emergency preparations, with a sweeping new rule taking effect November. Then the hurricanes came, bringing with them destruction and truly horrifying tales from nursing homes — most prominently the deaths of 14 residents of a Hollywood, Fla. SNF after it lost power.

Members of the U.S. Congress introduced legislation that would bring about stricter emergency rules for SNFs — while also forcing local utilities to prioritize skilled nursing facilities in disasters.

OIG Special Agents Sound Off on Hospice Fraud, CMS Rules – Robert Holly, *Home Health Care News*, August 12, 2018

In one example of hospice fraud, a provider was caught billing for 17 days of general inpatient care for a 70-year-old Medicare beneficiary, though a caregiver had never even visited him.

In another case, an owner of a hospice was found to be using recruiters to solicit and enroll beneficiaries for hospice care when they were not eligible in the first place.

These are just a few of the many instances of billing fraud happening throughout the hospice industry, collectively costing the government hundreds of millions of dollars each year, according to the U.S. Department of Health and Human Services' Office of Inspector General (OIG).

Providers should know that OIG is on the lookout for illicit marketing maneuvers and unlawful physician kickback arrangements. They should equally note that OIG is trying to get CMS to crack down on the problems.

Hospice services are growing in popularity among Medicare beneficiaries nearing the critical and highly emotional stages of end of life.

In 2016, Medicare paid hospice providers nearly $17 billion. A decade earlier, that total was about $9.2 billion. More money is on the way for hospices, too, as CMS announced in its final rule that it is increasing payments by about $340 million for fiscal year 2019.

Besides improper billing, though, OIG has repeatedly found throughout the past decade that hospices do not always provide necessary services, sometimes even skimping on care over weekends or disregarding patients' care plans.

All providers are required to provide distinct levels of care depending on patient needs, ranging from routine and continuous home care services to inpatient respite care and general inpatient care.

To help hold hospices accountable, OIG can conduct audits and national inspections, also known as evaluations. The agency also gets involved in False Claims Act legal battles and launches its own investigations.

OIG identifies hospices for follow-up investigations in a handful of ways that include:

- following up on tips filed via Health and Human Services' fraud hotline,
- using data analysis to analyze claims,
- monitoring whistleblower lawsuits and
- pursuing special agents' independent leads.

In the report issued last month, OIG compiled 15 recommendations to CMS on how the Medicare hospice program could be improved from a vulnerability perspective. In a response letter from Administrator Seema Verma, CMS disagreed with more than half of those recommendations.

Recommendations included furthering refining Hospice Compare to provide more transparent information for beneficiaries and their families. Specifically, OIG would like CMS to include claims-based and deficiency data from surveys as well as implement stricter rules for how, when and where hospice providers can market to beneficiaries.

Skilled Nursing Growth Continues to Lag – Marty Stempniak, *McKnight's Long-Term Care News*, August 24, 2018

Skilled nursing continues to have the weakest inventory growth out of long-term care property types, with independent living leading the pack.

That's according to a new analysis of primary housing markets by the National Investment Center for Seniors Housing & Care, based on the most recent market cycle peak reached in the fourth quarter of 2014.

Over that time period, the nursing care segment had the weakest overall inventory at -0.4%, a 2 percentage-point decline in occupancy. Its average annualized asking rent growth rate sat at about 2.7%, Lana Peck, senior principal for NIC, noted in a blog post this week.

Meanwhile, by comparison, the memory care segment had the highest inventory growth, 33.6% (explained in part by the relatively small inventory base), and the largest decline in occupancy, 5.1 percentage points, to 82.7%. Average annualized asking rent growth for the period, at 2.5%, was the lowest of any segment, Peck said.

The independent living segment, housing seniors who require the lowest level of care, saw 5.7% inventory growth. Occupancy only decreased by 0.3 percentage points, from 91% to 90.7%, for the segment. That allowed average annualized asking rent rates to increase faster (3.2%) than in the other types of senior care.

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