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Medical Billing & Consulting

"Laughter is an instant vacation." – Milton Berle

Client Memo
April 2019

NEWS Updates

Understanding and Addressing MIPS Topped-Out Measures

Many providers attesting for the 2018 MIPS program are finding that some of their quality measures have been designated as "topped-out measures."

Jackie Rogers explains what this means in her June 8, 2018, article for *Medical Economics*. "Topped-out measures" are specific quality measures in which "meaningful distinctions and improvement in performance can no longer be made," she writes.

For example, process measures (which make up half of all measures) would be topped-out if the median performance is 95% or higher - or 5 % or lower if it is scored inversely - both of which would be deemed too easily attainable.

Topped-out measures may make it difficult for practices to receive the maximum number of points under the QPP, but by identifying measures as topped-out, CMS is incentivizing practices to choose other measures where considerable performance improvement is more likely.

Looking ahead, CMS will continue to identify and top out measures that do not offer MIPS-eligible clinicians significant improvement opportunities. Once identified, measures will be phased out over a four-year timeline consisting of capping the measure to a lower maximum score, followed by the measure's removal entirely.

However, some topped-out measures may remain in the program for longer than four years as CMS considers the maintenance of measures that contribute important aspects of patient safety and reliability.

Current benchmarks can help determine if a quality measure is topped-out. An example of a commonly reported topped out measure is **Documentation of Current Medications** (Quality Measure #130), which is topped-out for all methods of reporting but does not yet have capped scoring.

Variance in scoring is so limited that one performance mistake could lose you several points, depending on the method of reporting. That leaves practices no leeway in workflow errors, as just one patient missed could keep them from maintaining perfect performance.

Due to topped-out measures' scoring limitations, successful practices should carefully consider and select measures that show improvement in performance. For example, **Controlling High Blood Pressure** (Quality Measure # 236) is a high-priority measure practices can select and work with their patients to improve over time.

Measures that continue to show meaningful improvement in performance by practices will likely have a longer time span in the MIPS program.

Additionally, practices do not need to look for the easiest measure to meet or achieve a "perfect" score as other practices could potentially be doing the same (which then creates a high benchmark that may demonstrate little variance and lead to further top outs).

Challenging Medical Necessity Denials to Increase Your Reimbursement: Key Considerations for Providers – Bridget Gordon, *Health Law Perspectives,* February 2019

Recently, many of our clients have found that more and more of their in-network, contracted claims which they have billed to the various payers are being denied, in whole or in part, for an alleged lack of medical necessity.

This article provides some considerations to be made when dealing with payers who have denied claims based on medical necessity grounds.

Examine Your Contract - Definition of Medical Necessity

Providers should examine their contracts with the payer at issue. First, determine how the terms "Medical Necessity" or "Medically Necessary Services" (or the equivalent) have been defined in your contract. Ensuring that the services in question comply with that definition will be critical to succeeding in any challenge to the payer's denial of the claim.

This means that during the contract negotiation and/or drafting stage, providers should seek to include expansive definitions of medical necessity and avoid allowing payers to insert specific guidelines that are more limited or not readily used by physicians and or other providers who actually make treatment decisions.

For instance, many payers will attempt to insert language defining "Medical Necessity" by the Milliman Care Guidelines (MCG), a set of guidelines that physicians and other providers do not consider (nor are they supposed to consider) when making medical decisions based on their professional judgment.

Timeframes and Processes for Challenging Denial

Providers should also examine their contracts to determine how long they have to challenge the payer's denial and what processes they must follow to challenge the denial, including those that must be completed before litigation or arbitration can proceed.

Such a deadline can often be located in a section of the contract which deals with arbitration or litigation or in a provision titled, "Statute of Limitations."

Determining when a claim arose can become a hotly contested issue between the parties, and taking a conservative approach, such as the date of the patient in question's discharge from the provider, will protect the provider from arguments that his claims are contractually stale.

Filing Suit or Pursuing Arbitration -- Gathering Evidence

Providers should ensure that they have as robust a medical record as possible and that they have collected the appropriate documentation from all of the patient in question's treating providers for the denied or down coded services in question.

Collecting records for other related stays for the same patient (either before or after the denied dates of service) may also be helpful to emphasize the overall status and condition of the patient during the denied dates in question.

Providers should also consider exactly what type of medical necessity denial the payer has asserted. The provider may also want to gather peer-reviewed scholarly and scientific articles, FDA findings, Medicare guidelines, and other supporting materials for the services provided.

In the alternative, this task can be left to the medical necessity expert selected by the provider.

Selecting an Expert

Medical necessity disputes frequently become what is known as a "battle of the experts," in which each party will put forth an expert to explain why the healthcare services provided were or were not medically necessary. Typically, payers will utilize an in-house medical director or nurse as their expert.

Providers should consider what type of medical necessity claim denials they are challenging, in order to select an appropriately knowledgeable expert.

Often, the denied claims will range through a varied assortment of medical ailments and medical specialties. A physician with broad-experience, such as an internal medicine physician or general practitioner, will likely be able to serve as the expert on many of the claims at issue due to their broad based knowledge.

However, for highly specialized claims, providers should consider engaging a more specialized expert to opine on the services.

Chronic Conditions Account for $8.3B in Avoidable ED Visits – Jessica Kent, *Health IT Analytics*, February 18, 2019

Patients with chronic conditions accounted for a significant number of potentially preventable ED visits, indicating a need for more effective primary care.

> Emergency department (ED) visits for people with at least one chronic condition contributed to nearly 60 percent of all annual visits in 2017 and $8.3 billion in spending, says a report from Premier, a leading healthcare improvement company.

Of these visits, over 4.3 million were potentially preventable, suggesting that these patients need access to higher-quality primary care.

To avoid preventable ED visits and subsequent hospital admissions, it is critical that patients with chronic conditions receive proactive primary care.

Premier analyzed nearly 24 million ED visits at 750 hospitals among patients with asthma, COPD, hypertension, heart failure, diabetes, and behavioral health issues. Researchers found that nearly 60 percent of all annual visits were for people with at least one of these conditions, of which more than 4.3 million were potentially avoidable.

Behavioral health issues accounted for approximately 24 percent of all ED visits in Premier's analysis. This is mainly due to national shortages of mental health professionals and affordable psychiatric care, the report said.

Hypertension accounted for 17 percent of all ED visits, due to a lack of lifestyle modification counseling, Premier said.

"Lifestyle modifications have been found to be effective in managing hypertension, yet only about 35 percent of patients with hypertension receive counseling for diet and 26 percent for exercise, and only 10 percent continue to follow advice concerning lifestyle modifications," the report stated.

Medication non-adherence can also be a problem for hypertension patients, researchers said, noting that about half of patients stop drug treatment after one year.

Diabetes accounted for approximately 9 percent of all ED visits. These instances primarily occurred because patients were unable to fill insulin prescriptions, were not taking insulin as prescribed, and making poor lifestyle choices, including diet and exercise.

The results indicate that patients with chronic conditions may benefit from improved primary care services, which will involve significant changes in care delivery.

What is CPT Code 99483?

Providers can be reimbursed for providing care planning services to patients with cognitive impairment, including Alzheimer's disease. This code has been effective January 1, 2018, and replaces the temporary code G0505 that was used prior to then.

All beneficiaries who are cognitively impaired are eligible to receive the services under the code. This includes those who have been diagnosed with Alzheimer's, other dementias, or mild cognitive impairment. But, it also includes those individuals without a clinical diagnosis who, in the judgment of the clinician, are cognitively impaired.

Service elements of CPT® code 99483
Cognition-focused evaluation, including a pertinent history and examination of the patient
Medical decision making of moderate or high complexity (defined by the E/M guidelines)
Functional assessment (for example, Basic and Instrumental Activities of Daily Living), including decision-making capacity
Use of standardized instruments to stage dementia
Medication reconciliation and review for high-risk medications, if applicable
Evaluation for neuropsychiatric and behavioral symptoms, including depression and including use of standardized instruments
Evaluation of safety (for example, home safety), including motor vehicle operation, if applicable
Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports and the willingness of caregiver to take on caregiving tasks
Development, updating or revision, or review of an Advance Care Plan
Creation of a care plan, including initial plans to address any neuropsychiatric symptoms and referral to community resources as needed (for example, adult day programs and support groups); the care plan must be shared with the patient and/or caregiver at the time of initial education and support

Caregiver Identification must be included.

99483 requires the presence of a caregiver to provide information and help implement the care plan. The caregiver must be identified and an assessment of that caregiver's knowledge, needs, and ability to provide care must be documented.

Caregivers may also be included throughout each of the required service elements of 99483, including the creation of a detailed care plan for the person with cognitive impairment.

How often can care planning be provided?

Clinicians can provide and bill for care planning services under 99483 **once every 180 days**. Experts have noted that care planning for individuals with dementia is an ongoing process and that a formal update to a care plan should occur at least once per year.

Are there any restrictions in using other billing codes at the same time as 99483?

99483 cannot be used along with the following codes: 90785,90791, 90792, 96103, 96120, 96127, 99201-99215,99241-99245, 99324-99337, 99341-99350, 99366-99368, 99497, 99498, and 96161.

Reimbursement

Reimbursement rates can vary slightly based on the setting in which the service is provided and geographic location. For example, the reimbursement rate for 99483 billed by a physician in a non-facility setting would be approximately $260 for jurisdiction F, which includes Arizona, Montana, North and South Dakota.

How to avoid denials when reporting 99483:

- Know the appropriate use of this code;
- Report only once every 180 days;
- Don't bill with services that are not covered if done on the same dare of service.

Get Over the Pitfalls of Out-of-Network Surprise, Balance Billing

Matt Dallmann explores the issue of balance billing in his April 2019 article for *Health Business Monthly.*

Most non-participating providers learn that out-of-network reimbursement can be higher than in-network reimbursement.

The two drawbacks to remaining out of network — higher patient out-of-pocket and exclusion from participating provider listings — may be remedied by waiving patient deductibles/co-insurance and assuring referring entities that insurance reimbursements would be accepted as payment in full.

Because this practice creates an unfair market advantage and increased cost, commercial carriers have retaliated with audits and legal action. Perhaps the biggest concern is billing patients their portion of the out-of-network charge.

Generally, the patient is supposed to be billed the entire difference between the total billed amount and the insurance reimbursement amount. For example, if the charge is $100 and the patient has a 20% co-insurance, but you have no intention of billing the patient $20, the actual charge is $80 (and should be reported, as such).

If the charge is $150, but the insurance carrier considers only $100 payable, the patient should be charged both the $20 co-insurance and the $50 difference between the billed and allowed amounts. Some carriers will list only the deductible and co-insurance as patient responsibility on the explanation of benefits; but to remain compliant, the provider must bill the entire amount not covered by insurance.

Many out-of-network providers have argued that they do not have a contract with a given insurance carrier, so they should not be obligated to balance bill or adhere to the patient's benefits. Recent legal decisions (Horizon Blue Cross Blue Shield of New Jersey v. East Brunswick Surgery Center) suggest that providers may be liable for aiding/facilitating the patient in breaching the member contract with the insurance carrier.

This is referred to as "tortious interference," and it is considered fraudulent.

It is difficult for commercial insurance carriers to prove that a medical practice engages in fee forgiveness. As long as the provider makes a good faith effort to bill the patient by sending at least three statements, the practice remains compliant with the out-of-network balance billing requirements.

If a payer suspects a practice of fee forgiveness, they likely will request a claims audit for medical necessity. Along with the medical records, they will ask for billing records, and they may flag the group's tax identification number to stop reimbursement altogether.

The payers also may send letters to the provider's patients, inquiring about financial agreements made between the provider and patient.

Due to all the claims processing obstacles and balance billing concerns, some out-of-network providers bill as much as possible, with the hope of getting something in return.

One problem with this approach is that patients get caught in the crossfire and end up with large and unexpected balance bills.

One problem with this approach is that patients get caught in the crossfire and end up with large and unexpected balance bills.

These surprise bills have become so common that legislators have begun enacting laws against them at the state level. These laws are largely meant for out-of-network labs and emergency room providers, where patients almost never meet the physicians or laboratory technicians.

The aforementioned state laws prevent out-of-network providers from holding patients responsible for charges not covered by their insurance plan. Full transparency with published fees and written acknowledgement must be obtained for a provider to hold a patient legally responsible for the charges in excess of the out-of-network insurance reimbursement.

Even as the patient responsibility is being alleviated by some state laws, non-participating providers can still capitalize on reimbursement through pricing negotiations.

Implement financial hardship agreements: an out-of-network practice may enter into a written financial hardship agreement with a patient, if applicable, to avoid balance billing. If audited, payers may ask for financial proof of the hardship via the patient's tax return and reasonable justification for using that specific out-of-network provider.

Offer full transparency: Ideally, patients should sign an Out-of-Network Consent Form with published fees and the practice's financing policies. Since it is difficult to know in advance what the patient responsibility might be, you should be able to quote a 'ball park" figure or price range.

With more hurdles set by commercial carriers, out-of-network groups require tight billing/practice management. Full financial transparency aids in making the office workflow more effective.

The essential idea is, as an out-of-network provider, you provide a concierge service with shorter waiting room times, better access to physicians, and quality care.

The financial side of the patient experience should match the high level of service on the clinical side.

Updating Your Fee Schedules. It's Important to the Health of Your Clinic – Editorial Staff, *Outsource Receivables*, January 16, 2019

Each year, Medicare updates their payment schedules for medical services. Typically, this is the lowest rate a doctor can expect to be reimbursed by any insurance provider. As the lowest denominator for which fees are paid, setting your schedules to collect an appropriate amount from Medicare is the right place to start.

Medicare Fees Schedule Publication

Published on November 1st the prior year, new Medicare schedules take effect January 1st. For example, The CY 2019 Medicare Physician Fee Schedule Final Rule was placed on display at the Federal Register on November 1, 2018. This final rule updates payment policies, payment rates, and other provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after Jan. 1, 2019.

Making yearly updates to your charge fee schedule is one of the most important things a doctor can do to ensure the collection of an appropriate amount for services.

Billing Appropriately

Most physician fee schedules bill for more than their allowables. There are several important reasons for this. Different payers pay at different amounts for any given service. Because there are so many variations in reimbursements, it's important for your office to streamline billing and expected payments. Additionally, it is against the law to bill any other insurer less than what is billed to Medicare for the same service.

How to Set Fees

When using a percentage of what Medicare allows, a good rule of thumb is to charge 150% of the Medicare allowance.

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Important Note: Because billers do not know what you have paid for your vaccines, please make sure to notify them as soon as possible if your costs have increased. This way your fee schedule can be updated and the vaccine billed out appropriately.

SENTINEL

Sentinel is a digital health company using remote monitoring to tackle the hypertension epidemic. Its mission is to ease physicians' workloads and to deliver better care to people with hypertension and other chronic diseases.

Sentinel seamlessly integrates with your clinic to help you achieve the triple aim of:

Improving the patient experience of care

Improving the health of populations

Reducing the per-capita cost of care

Sentinel increases your clinic's revenues, at no additional cost, while helping you achieve better outcomes for your patients.

As of January 1, 2019 , Sentinel provides access to clinics for 3 new CPT codes for Remote Physiologic Monitoring equipment, setup, and monitoring services:

- CPT code 99453: Initial setup.
  - Pays approximately $21.
- CPT code 99454: Device/transmission fee.
  - Pays approximately $69 per month.
- CPT code 99457: Monitoring and treatment.
  - Pays approximately $53 per month for 20 minutes of time spent viewing data and communicating with patients.

Sentinel will partner with your clinic to meet the requirements for all 3 codes above.

For more information, please contact:
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Medicare News

CMS Improving Nursing Home Compare in April 2019 – Changes offer greater support to consumers looking to compare nursing homes

On March 5, 2019, CMS announced updates coming in April to Nursing Home Compare and the Five-Star Quality Rating System.

The Nursing Home Compare website and Five-Star Quality Rating System were created to help consumers, their families, and caregivers compare nursing homes and identify areas they may want to ask about when looking at nursing home care.

The April 2019 changes include revisions to the inspection process, enhancement of new staffing information, and implementation of new quality measures.

MIPS Facility-based Preview -- For the 2019 performance year, MIPS includes the option to use facility-based measurement for the Quality and Cost performance categories for MIPS eligible clinicians, groups, and virtual groups who are determined to be facility-based.

To determine if a provider is facility-based, CMS will look at Medicare Part B claims billed between October 1, 2017 and September 30, 2018 (including a 30-day claims run out).

A provider is considered facility-based if he or she is:

1. A MIPS eligible clinician type and;
2. Billed at least 75 percent of covered professional services in a hospital setting;
3. Billed at least one service in an inpatient hospital or emergency room; and
4. Can be attributed to a facility with a Hospital Value-based Purchasing (VBP) score

How do I know if I am facility-based -- This information is available on the QPP Participation Status lookup tool.

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