AQREVA
Medical Billing & Consulting

"Write it on your heart that every day is the best day in the year" – Ralph Waldo Emerson

Client Memo
January 2019

NEWS Updates

- Solutions for What's Ruining Medicine for Doctors (Page 2)
- Maximizing Revenue for Nursing Home Services (Page 4)
- MIPS Requirements for 2019 (Page 5)
- Use HARP to Access the MIPS Reporting Portal (Page 6)
- ICD-10 Look Up Tool (Page 8)
- New Center for Physician Rights (Page 8)

Healthcare IT Trends For 2019

The push to digitize healthcare has been going on for at least 10 years. That's when the push began for hospitals and physicians to implement electronic health records. Now, providers are looking for ways to achieve measureable results with the systems they have in place.

Health Data Management has compiled a variety of predictions from various sources. 6 of the 12 trends expected to dominate healthcare IT in the New Year are excerpted below from Fred Bazzoli's article "12 Trends that will Dominate Healthcare IT in 2019," December 19, 2018.

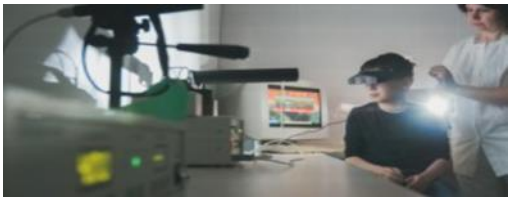
Using IT to help achieve patient engagement and experience

Patient experience management encompasses the range of interactions that patients have with the healthcare system, including their care from health plans, and from doctors, nurses and staff in hospitals, physician practices and other healthcare facilities.

Healthcare organizations will invest in care delivery models to meet patients where they are, through portals, medical apps and remote patient monitoring. Patients will also want to exert control over their data and will insist on the ability to easily share it.

Rising efforts to achieve digital health

New uses for existing and emerging technologies will give consumers and providers more options for delivering care. Digital technology will be packaged with an ROI.



Savvy healthcare organizations are moving beyond the hype of digital technologies and focusing on measurable outcomes. Big technology companies -- Apple, Google, Amazon and others -- will aim to have a voice in applying technology to reinvent healthcare.

Accelerating use of AI and data visualization

Developers increasingly see the potential to apply artificial intelligence to the patient information that's been collected through various electronic records systems. The long-term goal is to assist clinicians with decision support, reduce financial risk, establish population health initiatives for chronic disease management, and more.

The most substantial real-world AI applications will be in image processing through early stage machine learning for areas like radiology and dermatological lesions.

Importance of population health management

A variety of information technologies will be used to segment populations and treat their specific illnesses. Data will transform how providers make decisions. The growing implementation of technology developed for healthcare is creating the opportunity to use clinical data in more

sophisticated ways, enabling clinicians to make better decisions and deliver better care.

Pressing on toward interoperability

Increased interoperability will propel value-based care. Patient demand for data sharing and improved interoperability will have the added side-effect of propelling industry-wide momentum towards value-based care in 2019. The lack of interoperability has historically stifled its growth.

Pushing to achieve EHR optimization

With records systems now widely implemented, IT developers are striving to enable the technology to be more interactive and responsive to clinician needs, which is expected to have a huge impact on how care is delivered.

New platforms and infrastructure innovations will be made to allow hospitals to finally get a handle on messy, unstructured data in order to take advantage of new AI advances. This will help automate more clerical busy work for doctors, including documentation and repetitive tasks related to clinical care and billing. And the role that EHRs play in physician burnout will renew the push to improve the user interface with records systems.

Growing the role for virtual care

As part of the effort to deliver care in the least expensive, most effective setting, developers will continue to push care to a virtual environment via telemedicine or in the home, through the use of remote patient monitoring devices.

Reimbursement initiatives underway in both arenas are likely to increase the use of the technologies and more savvy patients will want the same utility for health-care that they experience everywhere else in life: getting what they want and need, when they want it. Telehealth, mobility and millennials will upend the who and where of care delivery. From urgent care to "Dr. Google," the state of care delivery is swiftly being disrupted.

What's Ruining Medicine – Solutions to Nine Issues Causing Doctors Problems

-- *Medical Economics* Staff, *Medical Economics*, December 25, 2018

At the end of every year, *Medical Economics* publishes a list of the top challenges facing physicians. This list is generated by surveying their physician readers.

For this year's list, the staff decided to recast the question. Instead of asking what challenges physicians face, they wanted to hone in on what issues annoy and frustrate doctors and get in the way of what's truly important: Treating patients and running practices.

The goal is not to dwell on the negative aspects of working as a physician. Instead, the staff at *Medical Economics* wanted to show readers that they share common challenges when dealing with the vexing issues facing primary care in today's complex health-care environment.

What's ruining medicine for physicians?

1	44%	Paperwork and Administrative Burdens
2	41%	Difficulty Using EHRs
3	26%	Government Regulations
4	24%	Prior Authorizations
5	19%	Replacing Primary Care Physicians with NPs/PAs
6	18%	No Negotiating Leverage with Payers
7	15%	Rising Practice Staff and Overhead Costs
8	15%	Imbalance in Primary Care vs. Specialist Reimbursements
9	12%	MOC Costs and Requirements

Details on a few of the above issues are excerpted below and include practical solutions that physicians can start using in their practices today.

1 Paperwork and administrative burdens

It's no surprise that physicians chose paperwork and administrative burdens as the top issue ruining medicine. Much of this burden is a result of changes in the last several years, notably the advent of value-based care.

Ways to overcome the challenge:

Have patients pay cash for medications -- Patients whose insurance companies require prior authorization will take this route because it will simplify the process.

There is no magic solution for eliminating paperwork or administrative burdens. But there are some ways physicians can ease the burden on themselves and their patients.

Rely on Technology -- The future of health-care operations and clinical delivery will improve thanks to enhancements to technology that will decrease paperwork and administrative burdens, such as increased machine learning and artificial intelligence in day-to-day care delivery.

4 Prior authorizations

Physicians hate prior authorizations. They find the process insulting, as they argue they know what's best for each individual patient under their care, and have the medical training and expertise to back up their clinical decisions.

Prior authorizations also disrupt a practice's workflow by creating additional work for staff and physicians to get a treatment or test approved. Physicians are pessimistic that there's anything they can do, either individually or collectively, to make prior authorizations go away.

Still, there are strategies doctors can put in place to better manage prior authorizations:

Focus staff efforts -- Find a staff member that can focus on prior authorizations. This person can attempt to monitor formulary changes, track prior authorization requests to detect patterns and eliminate inefficiencies.

Get patients involved -- There's nothing wrong with having patients assist with the prior authorization effort. Asking patients to call their insurance company to inquire about prescriptions and tests is one way to make patients a part of the process.

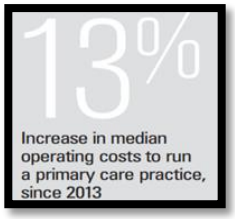
Play hardball (when possible) -- Do you have a payer contract that's given you a lot of problems? Consider not re-upping with that payer; however, this is not a decision to make lightly, as it affects patients under your care.

Advocate -- Physicians often are leery about getting involved in politics. But it is one way to bring about change. David O. Barbe, MD, MHA, the former president of the AMA, told *Medical Economics* earlier this year that physicians can work through their state medical societies and other membership organizations to fight for change.

"These membership organizations exist to serve their members and patients, and they want to hear from practicing physicians about obstacles they face in providing high-quality care," Barbe said.

7 Rising staff and overhead costs

Every business grapples with rising employee and overhead costs, but these increases are particularly distressing for physician practices. Since 2013, the median operating costs for primary care practices rose by 13 %, according to a 2018 Medical Group Management Association (MGMA) report



"What I think has made it more acute and painful for physician practices is that earnings have remained fairly flat," says Susanne Madden, president and CEO of The Verden Group, a practice-management consulting fim in Nyack, N.Y.

To combat these rising business costs, practices must balance reducing expenses with driving revenue growth.

Here are four strategies that can help practices succeed in the face of financial constraints.

FIND THE BEST VENDOR CONTRACTS -- Get the best prices for medical and office supplies, medications, vaccines, and other overhead services by taking advantage of discount contracts.

EXPAND PRACTICE OFFERINGS -- Ancillary services can improve the bottom line but often require considerable upfront investment. If a practice is not financially ready to add an ancillary service, Madden recommends renting out practice space to complementary specialties and/or offering educational sessions on pertinent topics, such as mental health or nutrition, that patients can attend for a modest fee. These offerings require minimal investment while providing value for patients and a revenue boost for the practice.

INVEST IN STAFF -- Administrative and clinical staff members play a pivotal role in the success or failure of a practice, and employing non-physician providers leads to increased revenue despite greater expenses, according to the 2018 MGMA report. It pays to hire and retain skilled and engaged employees, even if that means offering them competitive wages and benefits. You want to make sure you can attract the good ones, Madden says.

SOLICIT PATIENT FEEDBACK -- Don't rely on trial and error to pinpoint which areas of the practice are functioning well and which need improvement, as decisions based on incorrect assumptions can be expensive to rectify.

Asking patients what they want from the practice is key to improving patient satisfaction, which increases the likelihood of retaining current patients and acquiring new ones without any additional marketing costs.

Maximizing Revenue For Nursing Home Services

It's probably difficult for most internists to imagine: Seeing patients when it's convenient for the physician, largely avoiding high-deductible health plans, and ensuring a steady income with few interruptions, writes Lisa Eramo in excerpts from her article "7 Tips to Maximize Revenue for Nursing Home Services," for *Medical Economics.com*, December 28, 2018.

For Connecticut-based internist Jeffrey Kagan, MD, this dream is a reality thanks to the fact that he spends 20 percent of his time seeing patients in nursing homes.

Other physicians say nursing home services can be lucrative but not without challenges. Although physicians can't control some of the payment barriers they face, there are certainly steps they can take to make nursing home services more lucrative, says Vanessa Moldovan, CPC, CPMA, senior billing specialist at Medic Management Group LLC, a healthcare consulting company in Akron, Ohio.

Some of these steps include:

Do your homework before seeing patients in the nursing home.

To avoid denials, physicians, and any non-physician providers they employ to treat patients in the nursing home, must be credentialed with every nursing facility in which they render services, says Michele Rodgers, certified medical manager at Healthstone Primary Care Partners.

To minimize denials, determining whether the provider is contracted with the patient's insurance company should take place as soon as possible. For patients with Medicare, it should take place before the first mandated visit, which Medicare states must occur within 48 hours of admission to the nursing facility.

If the physician isn't contracted with the patient's payer, the services will likely be subject to the patient's out-of-network benefits and the patient could owe a significant co-insurance. When patients have this information in advance, they may be more likely to follow through with payment or go to another nursing home that has an arrangement with a physician who's in the patient's network.

Know what codes to report

Report a CPT code from the **99304-99306** code range for the initial nursing home visit. For all other medically necessary visits, report a CPT code from the **99307-99310** code range. This includes the federally-mandated visits for Medicare patients that occur every 30 days for the first 90 days after admission to the facility and at least once every 60 days thereafter.

It can get tricky when a patient with Medicare or a commercial plan leaves the nursing facility and returns a short time later: Physicians must determine whether the return to the nursing facility is considered an initial visit or subsequent.

Medicaid requirements may differ from state to state. For example, Connecticut Medicaid requires nursing homes to hold the bed for 14 days. If a patient with Medicaid is readmitted to the nursing home during that time, the physician must report a subsequent services code. If it's after 14 days, the physician can report an initial services code. Physicians should check their states' requirements.

Report CPT codes **99315 or 99316** for nursing facility discharge services, depending on the time spent performing these services.

Report CPT code **99318** for the annual nursing facility assessment.

Double-check the place of service (POS) code

Many physicians incorrectly use POS code **11 (office)** rather than POS code **31** (**skilled nursing facility**) or **32 (nursing facility**).

Append modifiers, when necessary

To be paid appropriately for providing nursing home services to Medicare patients receiving **hospice care**, physicians must append one of the following modifiers: **GV** (when a provider performs a service related to the problem for which a patient was admitted into hospice) or **GW** (when the service is not related to the hospice patient's terminal condition). If providers don't usually treat patients on hospice, they may not be aware of these modifiers.

Distinguish between nursing and assisted living facilities

The CPT manual describes assisted living facilities as those that provide room, board, and other personal assistance services, generally on a long-term basis. These facilities do not include a medical component. When physicians render services in an assisted living facility, they should report a CPT code from the **99324-99328** code range for new patients and the **99334-99337** code range for established patients, with POS code 13.

Don't forget prolonged services

Bill CPT codes **99358-99359** (prolonged services without direct patient contact) for time spent on the phone with nurses, family, or other physicians. Note that these **codes must be reported in addition to an E/M code**, and they require at least an additional 60 minutes of services beyond what's typically associated with the E/M code. Physicians can also report CPT codes **99354-99355** for prolonged services with direct patient contact.

2019 MIPS Requirements

Below is a recap of what to expect for 2019

Policy	Year 3 - 2019
MIPS Eligibility	Expanded to include Physical therapist • Occupational therapist • Qualified speech-language pathologist • Qualified audiologist • Clinical psychologist • Registered dietitian or nutrition professionals
Low Volume Threshold	To be excluded from MIPS, clinicians or groups need to meet one or more of the following three criterion: 1. Have ≤ $90K in Part B allowed charges for covered professional services; 2. Provide care to ≤ 200 Part B enrolled beneficiaries; OR 3. Provide ≤ 200 covered professional services under the Physician Fee Schedule (PFS)
Opt-In	Clinicians or groups can opt-in to MIPS, if they meet or exceed at least one, but not all three, of the low-volume threshold criteria. • A virtual group election in Year 3 is considered a low-volume threshold opt-in for any prospective member of the virtual group
Determination Period	The MIPS determination period includes two 12-month segments: o **First 12-month segment:** Oct. 1, 2017 to Sept. 30, 2018 (including a 30-day claims run out) **Second 12-month segment**: Oct. 1, 2018 to Sept. 30, 2019 (does not include a 30-day claims run out).
Performance Period	**Quality**: 12-months **Cost**: 12-months **Improvement Activities:** continuous 90-days **Promoting Interoperability**: continuous 90-days Quality
Performance Threshold	Performance Threshold is set at 30 points. • Additional performance threshold set at 75 points for exceptional performance. • As required by statute, the maximum negative payment adjustment is -7%. • A positive payment adjustment generally can be up to 7% (but the upward payment adjustment factor is multiplied by a scaling factor to achieve budget neutrality, which could result in an adjustment above or below 7%). • The additional payment adjustment for exceptional performance will be applied in the same way as in year 2 for final scores at or above the additional performance threshold.
Final Score	Quality: 45% Cost: 15% PI: 25% IA: 15% If a MIPS eligible clinician is scored on fewer than two performance categ-ories, a final score equal to the perfor-mance threshold will be assigned and the MIPS eligible clinician will receive an adjustment of 0%
Complex Patient Bonus	Retaining the 5 point bonus added to the MIPS Final Score for clinicians who treat medically complex patients.

Quality Performance Category

Policy	Year 3 - 2019
Weight	Weight for final score: 45% The Quality performance category may be reweighted if there are no applicable and available measures or due to extreme and uncontrollable circumstances.

Policy	Year 3 - 2019
Submission Mechanism (Individual)	**Individual eligible clinicians** can: submit data using **multiple** collection types (MIPS CQM, eCQM, QCDR measures, and for small practices, Medicare Part B claims measures) If the same measure is submitted via multiple collection types, the one with the greatest number of measure achievement points will be selected for scoring.
Submission Mechanism Groups	Groups and Virtual Groups can use multiple collection types: MIPS CQM, eCQM, QCDR measures, CMS Web Interface measures for large practices, and Medicare Part B claims measures for small practices If the same measure is submitted via multiple collection types, the one with the greatest number of measure achievement points will be selected for scoring **EXCEPTION**: CMS Web Interface measures cannot be scored with other collection types other than the CMS approved survey vendor measure for CAHPS for MIPS and/or administrative claims measures.
Claims Submission	Medicare Part B claims measures can only be submitted by clinicians in a small practice (15 or fewer eligible clinicians), whether participating individually or as a group.
Data Completeness	Claims: 60% of Medicare Part B patients for the performance period. • QCDR/Registry/EHR: 60% of clinician's or group's patients across all payers for the performance period. • CMS Web Interface: Sampling requirements for Medicare Part B patients. • CAHPS for MIPS Survey: Sampling requirements for Medicare part B *For groups that submit 5 or fewer quality measures and do not meet the CAHPS for MIPS sampling requirements, the quality denominator will be reduced by 10 and the measure will receive zero points.*
Bonus Points	2 points for outcome, patient experience 1 point for other high priority measures which need to meet the data completeness and case minimum requirements along with having a performance rate of greater than 0. Capped bonus points at 10% of the denominator of total Quality performance category. Discontinue high priority measure bonus points for CMS Web Interface Reporters. Definition of a high priority measure revised to include opioid-related measures.

Policy	Year 3 - 2019
Bonus Points End-to-End Electronic Reporting	1 point for each measure submitted using end-to-end electronic reporting. • Capped at 10% of the denominator of total Quality performance category points.
Small Practice Bonus	The small practice bonus will now be added to the Quality performance category, rather than in the MIPS final score calculation 6 bonus points are added to the numerator of the Quality performance category for MIPS eligible clinicians in small practices who submit data on at least 1 quality measure.

Cost Performance Category

- Weight for final score: 15%
- Two measures: Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) remain the same for 2019
- 8 new episode based measures added to the Cost performance category.
- Case minimum of 10 for procedural episodes and 20 for acute inpatient medical condition episodes.

Facility-Based Quality and Cost Performance Categories

- The measure set for the fiscal year Hospital Value-Based Purchasing (VBP) program that begins during the applicable MIPS performance period will be used for facility-based clinicians.
- MIPS eligible clinician furnishes 75% or more of their covered professional services in inpatient hospital (POS 21), on-campus outpatient hospital (POS 22), or an emergency room (POS 23), based on claims for a period prior to the performance period.
- The clinician can be attributed to a facility with a Hospital VBP Program score for the applicable period.
- A facility-based group is one in which 75% or more of the MIPS eligible clinician NPIs billing under the group's TIN are eligible for facility-based measurement as individuals.
- A facility-based clinician is attributed to the hospital at which they provide services to the most Medicare patients.
- If there is an equal number of Medicare beneficiaries treated at more than one facility, the value-based purchasing score for the highest scoring facility is used.
- Facility-based measurement is automatically applied to MIPS eligible clinicians and groups who are eligible for facility-based measurement and who have a higher combined Quality and Cost score.

Promoting Interoperability Performance Category Measures

Policy	Year 3 - 2019
Weight	Weight for final score: 25%
Reweighting of PI Category	Reweighting of the Promoting Interoperability performance category remains the same as Year 2: o Nurse practitioners, physician assistants, physical therapists, occupational therapists, clinical psychologies, speech-language pathologies, audiologists, and clinical nurse specialists or certified registered nurse anesthetists. o Significant hardship (e.g. lack of internet, extreme and uncontrollable circumstances, small practice) o Hospital-based clinicians o Eligible clinicians using decertified EHR technology
Certification	Must use 2015 Edition CEHRT
Scoring	**Eliminating base, performance, and bonus scores** Each measure will be scored based on the MIPS eligible clinician's performance for that measure based on the submission of a numerator or denominator, or a "yes or no" submission, where applicable. Finalizing Security Risk Analysis measure as a required measure without points. The scores for each of the individual measures will be added together to calculate the score of up to 100 possible points. If exclusions are claimed, the points for measures will be reallocated to other measures.
Objectives & Measures	One set of objectives and measures based on the 2015 Edition CEHRT. Four objectives: 1. e-Prescribing, 2. Health Information Exchange, 3. Provider to Patient Exchange, and 4. Public Health and Clinical Data Exchange. Clinicians are required to report certain measures from each of the four objectives, unless an exclusion is claimed. **Two new measures added for the e-Prescribing objective**: 1. Query of Prescription Drug Monitoring Program (PDMP) and 2. Verify Opioid Treatment Agreement as optional with bonus points available

Improvement Activities Performance Category

- Weight for final score: 15%
- Modifications include the addition of one new criterion in the public health category.

The MIPS Data Submission Portal Opens on January 2, 2019

The MIPS Data Submission Portal is now open. Please review the CMS Guide for Obtaining an HCQIS Access Roles and Profile (HARP), formerly known as an Enterprise Identity Management (EIDM) Account, for Quality Payment Program (QPP) submissions.

EIDM Changing to HARP

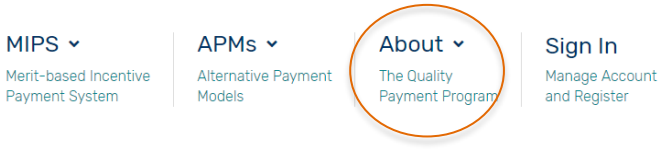
CMS is transitioning the system used to request access to the QPP website from the Enterprise Identity Data Management System (EIDM) to the HCQIS Access Roles and Profile System (HARP). All users will report quality data and view their MIPS feedback directly through the QPP website.

If you already have an EIDM account with a role for QPP, you'll automatically be transitioned to HARP. You'll use your existing EIDM user ID and password to sign in to the QPP website.

MIPS Top Tips of the Month
Tip #1
With the change of EIDM to HARP, we highly recommend you login to the QPP portal as soon as possible.
Tip #2
Get ready to submit! The QPP Data Submission Portal is set to open on January 2, 2019!
Tip #3
Don't forget to prepare for 2019's QPP requirements.
HSAG is here to answer your questions by calling 1.844.472.4227

For more information including detailed instructions on how to register for HARP, please go to the Quality Payment Program website: https://qpp.cms.gov

The User Guide is located under the "About" heading on the QPP home page. Click on the Resource Library option. The 2018 QPP Access User Guide will be under the General Resources section,



The new 2019 diagnosis codes contain 473 changes (279 new, 51 deleted, and 143 revised codes going live). The good news is that you don't have to dig through these hundreds of code changes alone.

Available immediately, you can download the 2019 ICD-10-CM Additions, Revisions and Deletions Summary Worksheets at no cost. This Excel tool summarizes and breaks down each of the 473 new, deleted and revised codes by ICD-10-CM manual chapter. This means you'll be able to easily find the changes in your manual for additional information, if necessary.

Inside the workbook, the code changes are color coded and set up with filters to make implementing them easier and faster than ever before (and if you've already updated your system, it can be a great accuracy double check).

To access the free download, copy the link below to your browser:

https://codingleader.com/pages/free-tool-2019-icd-10-cm?utm_source=LEAD-ICD10_T3121828A_eng-10000484&utm_medium=AAPC2013&utm_campaign=DMS&utm_term=smagalnick@drs-az.com&utm_content= stage_3_mhi_master

New Center for Physician Rights Helps Protect, Guide Doctors

– Pauline Anderson, *Medscape Medical News*, November 9, 2018

Physicians who believe they have been subjected to unfair treatment and/or discipline by a state medical board, physician health program (PHP), or other regulatory body now have a place to turn for information, advice, and support.

With the official launch of the Center for Physician Rights, these physicians have a one-stop access point for assistance. For instance, physicians can get a free "curbside" consultation, which will provide them with feedback and guidance.

The CPR will be a critical" resource for physicians, who, when they become involved in an investigation, are often induced to relinquish their basic rights, believing that they have nothing to hide and that these organizations exist to protect them.

According to their website, T**he Center for Physician Rights** offers:

- Free confidential case review;
- Case consultation and coaching;
- Serve as a central authoritative informational and consultative resource;
- Pursue organizational and legislative change

Go to https://www.physicianrights.net for more information.

We are working hard to keep you on the edge of healthcare. Help us fulfill our strong commitment to maintain our level of service excellence by providing us with your feedback. Please feel free to contact your Account Representative directly or call 1.800.568.4311.

For more information about any of these articles, we invite you to contact your Account Representative directly or call 1.800.568.4311.

www.aqreva.com