AQREVA
Medical Billing & Consulting

"An ounce of prevention is worth a pound of cure."
– Benjamin Franklin

Client Memo
June 2019

NEWS Update

Remote Patient Monitoring

CMS introduced three new codes for Remote Patient Monitoring services in 2019, allowing reimbursements of approximately $116 per month. Furthermore, through chronic care management and a range of other codes, there are opportunities for further reimbursement under CMS, writes Christopher McCann in the May 1, 2019, issue of *Current Health.*

Chronic Care Remote Physiologic Monitoring

In the 2019 physician fee schedule, CMS finalized three new codes for RPM. These are:

CPT	Description	Fee
99453	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; setup and patient education on the use of equipment	**$19.46** Facility and Non-Facility
99454	Remote monitoring of physiologic parameter(s) (weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days	**$64.15** Facility and Non-Facility
99457	Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff, physician, other qualified healthcare professional time in a calendar month requiring interactive communication with the patient or caregiver during the month	**$32.44** Facility **$51.54** Non-Facility

In summary, this means that providers using RPM platforms, such as that by Current Health, can receive reimbursement for their services.

$19.46 is available under 99453 for initial set up and patient education, while a further monthly amount of $115.69, via 99454 and 99457, is available to cover the cost of the solution and at least 20 minutes of clinical time.

Can these codes be billed incident to? Yes. CMS announced on March 14, 2019, that RPM could be billed as "incident to" the billing practitioners services. This crucial change allows RPM services to be delivered by auxiliary personnel but, unlike in CCM described below, those auxiliary personnel must still be under the direct supervision of the physician. In practice, this means the physician must be in the same building at the same time as the auxiliary staff delivering the RPM service, though they do not have to be in the same room.

Are there geographic restrictions? No. RPM is not considered a telehealth service. Therefore there are no geographical or originating site restrictions

Can the patient be at home? Yes.

Do we need consent? Yes. The patient must give consent.

Is there a copayment? Yes. As a Medicare Part B service, there is a 20% copayment.

Does there need to be face-to-face interaction? Only if the patient is new or has not been seen by their provider for greater than one year. In that case, the provider must conduct a face-to-face visit with the patient.

Chronic Care Management

CCM also provides a route for additional reimbursement for providers. **This can be billed along with the aforementioned RPM codes**.

CMS breaks CCM down into non-complex CCM and complex CCM.

Non-Complex CCM

CPT	Description	Fee
99490	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month, with the following required elements: Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; Chronic conditions place the patient at significant risk of death, acute exacerbation, decompensation, or functional decline; Comprehensive care plan established, implemented, revised, or monitored.	**$32.44** Facility **$42.17** Non-Facility

Complex CCM

CPT	Description	Fee
99487	Complex chronic care management services, with the following required elements: Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline; Establishment or substantial revision of a comprehensive care plan; Moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month.	**$92.98** Facility **$52.98** Non-Facility
99489	Each additional 30 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month. This is listed separately in addition to the primary code.	**$46.49** Facility **$26.67** Non-Facility

99489 must be reported in conjunction with 99487. 99487 provides reimbursement for the initial 60 minutes of clinical time, while 99489 provides reimbursement for each additional 30 minutes of clinical time.

Note that a patient is either non-complex CCM or complex CCM; never both in a given service period.

Can this be billed in conjunction with the Chronic Care Remote Physiologic Monitoring described above? Yes. 99457 can be billed in conjunction with 99490 or 99487 but the time spent delivering these services cannot be counted towards the required time for both RPM and CCM codes for a single month. No double counting is allowed. That means that billing 99457 and 99490 would require 40 minutes of clinical time

Can these codes be billed incident to? Yes. And unlike in the RPM codes described above, CMS only requires general supervision. This means the billing practitioner does not need to be in the same building at the same time as the delivery of the service.

Does there need to be face-to-face interaction? Only if the patient is new or has not been seen by their provider for greater than one year. In that case, the provider must conduct a face-to-face visit with the patient. This visit would be reimbursable under E/M visits (CPT 99212 through 99215).

Do we need consent? Yes. The patient must give consent.

G0506 (Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services) is also available and can be reported once per CCM billing practitioner per CCM initiation and provides $63.43 reimbursement.

Virtual Check-Ins (G2012)

G2012 provides one other opportunity for reimbursement. G2012 provides reimbursement of $14.78 for a brief, virtual check-in between the patient and their physician or other qualified healthcare professionals where the patient isn't sure if symptoms require an office visit.

Billing is only possible where the check-in does not lead to an office visit and where there was not a related E/M visit in the preceding 7 days.

There is no frequency limitation on this code.

HIPAA is Clear: Breaches Must be Reported 60 Days After Discovery

While the healthcare sector continues to be heavily targeted by hackers, many providers are still behind in conformance to the best practice security policies in HIPAA and the NIST Cybersecurity Framework, states Jessica Davis in the May 1, 2019, issue of *Health IT Security.com*.

In fact, she writes, the most recent CynergisTek report found that HIPAA conformance among healthcare organizations declined by 2 percent in the last year. And many healthcare providers are still performing well below what's needed to address risk.

The findings potentially shed light on a recent trend seen in the healthcare sector: breached organizations notifying patients well after the HIPAA-mandated 60 days.

"It is better to get notice out timely than to worry about having full knowledge and details of the breach."

To shed light on the best practice breach notification policies outlined in HIPAA, *HealthITSecurity.com* asked renowned healthcare attorney with Clark Hill Strasburger, Corinne Smith, to explain how providers can remain compliant under HIPAA.

Under HIPAA, a breach is determined "discovered" by a covered entity on the first day a breach is known, or would have been known, by the covered entity by exercising "reasonable diligence," Smith explained.

Once a breach is discovered, Smith stressed that notice to the impacted individual must be provided within 60 calendar days of the initial breach discovery. If more than 500 patients are involved, notice must also be provided to OCR and media outlets.

To help remain in compliance, health providers "must incentivize employees" to report discovered breaches "without penalty or fear of retaliation." Smith said that delayed investigations are often caused by failure to communicate security incidents to the right leaders.

In addition to HIPAA, healthcare providers that fail to timely report breaches are also at risk of state-based penalties. State laws may also require providers to report breaches in less than 60 days.

Lastly, breach providers put themselves at risk of lawsuits when they mishandle reporting.

Why The Value of a HIPAA Risk Analysis Continues to Rise – Matthew Fisher, *Health Data Management*, May 24, 2019

The HHS Office for Civil Rights (OCR) announced another monetary penalty and settlement for the failure of an entity to fully or competently comply with HIPAA requirements.

The new settlement, impacting Medical Informatics Engineering, arose after the discovery of unauthorized access to its servers. Turning to the findings from OCR's investigation only two deficiencies were cited.

The two deficiencies were impermissibly disclosing PHI and not conducting an accurate and thorough risk analysis.

With the focus on the risk analysis, which is a common thread throughout all of the OCR's settlements, it is a good time to provide a refresher on why the risk analysis is important.

The Security Rule identifies the following requirement: "Conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information held by the covered entity or business associate." 45 C.F.R. § 164.

An accurate and thorough assessment requires assessing all aspects of an organization and its operations. All types of assets and systems should be identified, vetted, reviewed and more. Practically, no piece of an organization should be excluded from consideration.

The next piece is to assess potential risks and vulnerabilities. Once the results of the risk analysis are compiled and finalized, the identification of risks and vulnerabilities will determine how to implement the remaining elements of the Security Rule.

The next question is how frequently a risk analysis should occur. From one perspective, it can and should be done on a rolling basis because vulnerabilities and threats are constantly shifting. From that perspective, a full comprehensive risk analysis should occur on an annual basis.

The analysis not only helps to implement strong security policies, but demonstrates a commitment to securing the sensitive data entrusted to the organization

Avoid Pass-Through Billing

Martin Merritt, JD, explains what pass-through billing is in his May 3, 2019, article for *Modern Medicine Network*. The CEO of Palo Pinto General Hospital in Texas pled guilty to a scheme that defrauded commercial carriers by use of what is termed pass-through billing. Physician practices need to be aware of the risks posed by these schemes.

Pass-through billing arrangements are typically pitched to clinics as a way to increase revenue, without increasing overhead. A contractor proposes to provide equipment and a technician to perform some ancillary service, whether it be a CLIA laboratory, sonogram testing, or some other well-patient test using the latest gadget or device.

All the provider needs to do is order the test, let the contractor do the work on a machine you don't own using personnel employed by the contract, and then your clinic is expected to bill for the service using your clinic NPI number. When the claim is paid, you both split the money. The contractor is paid as a 1099 independent contractor.

There are multiple reasons this is illegal and fraudulent.

1. Pass-through billing is illegal, because the contractor, not your clinic, performed the service. In the above Palo Pinto Hospital case, the hospital paid an outside CLIA lab to perform tests, but billed the insurance as though the tests were performed by the hospital.

2. Pass-through billing is fraudulent, because the actual cost of the service is the amount paid to the contractor, not the marked-up price listed on the HCFA 1500 claim form.

3. Pass-through billing violates Stark Law and the Anti-Kickback Statute. In Medicare, Medicaid and federal payer cases, the service will not meet the "ancillary services exception" or safe harbor. This is because the services were not performed by the clinic as part of its own in-office ancillary services, but instead by an independent contractor, yet the services were billed as if the clinic had performed the test.

4. Pass-through billing is unethical. The AMA takes the position that pass-through billing is unethical as set forth in Opinion 8.0321. Physicians are not allowed to mark-up the costs of ancillary services performed by others.

5. Pass-through billing violates your PPO contract.

Pass-through billing is never a good idea. The trouble lies in the fact that certain exceptions and safe harbors for equipment leases, in-office ancillary services, and group practice exceptions appear similar. If you have any doubt, ask for the help of an experienced healthcare attorney.

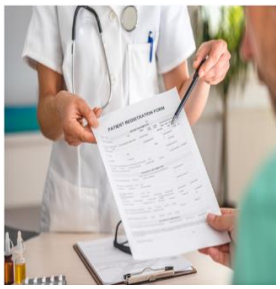
Is it time to reform your forms?

Exchanging health information is a two-way street. On one side, physicians aim to gather pertinent information from patients. On the other side, patients are looking for clear directions from practitioners.

Unfamiliar terminology, confusing multiple-choice questions, or insensitively worded documents can adversely impact a patient's comprehension of—and subsequent compliance with—their doctor's written instructions.

Even something as basic as a lab requisition or online booking form can cause confusion.

If you haven't revised the documents you share with patients for a while, perhaps now is the time to review and update them. Here are a few suggestions to help you get started.



Patient intake forms -- The intake form is usually the first touchpoint patients have with your practice. It's vital to keep this document simultaneously simple and comprehensive.

One thing you may need to refresh is the language used for gathering vital statistics.

Are there appropriate gender classifications? The traditional male/female choice is no longer adequate in today's diverse society.

Remember to ask for the names and numbers of two contacts, just in case an urgent or confusing situation arises and you need to reach someone STAT.

It's helpful to include details about your booking and cancellation policies, hours of operation, and contact information on the patient intake form.

Lab test and Radiology Forms -- Take a look at the lab, radiology, and other external forms you use on a daily basis. View these forms from a patient's point of view to see if there are any confusing or vague instructions.

Procedure explanation forms -- Patients need to know exactly what to do in advance of and following all medical procedures. The most efficient and reliable way to ensure this is to provide them with simple, detailed, step-by-step instructions.

-- Sue Jacques, *Physicians Practice*, April 24, 2019

Consult Codes and BCBS

Effective for claims received on or after July 1, 2019, consultation codes 99241–99245 and 99251–99255 will no longer be eligible for reimbursement. Blue Cross Blue Shield of Arizona is following the standard set by CMS in not recognizing these CPT® codes.

Please bill all professional consultation services with the appropriate E/M code from the 99201–99215 range. Select the E/M code that best describes the place of service and consultation complexity, and indicates whether the patient is new or already established with the provider.

Starting July 1, 2019, BCBS will return claims with consultation codes 99241–99245 and 99251–99255.

For additional information, see our new Consultation Services Pricing Guideline in the secure provider portal at "azblue.com/providers > Provider Resources > Guidelines > Claim Pricing > Consultation Services Pricing Guideline."

If you have questions, please contact your network contract specialist or call the claims customer service number on the back of the member ID card.

Providers are encouraged to check with their state's BCBS plan for updates.

Quality Payment Program (QPP) News

Opt-In Versus Voluntary Reporting

The opt-in policy is new for 2019 and allows an eligible clinician who meets at least one (1) of the three (3) low-volume threshold criteria to submit data to CMS and possibly earn a positive payment adjustment.

It is important to note that if an eligible provider chooses to opt-in, that choice will be irrevocable during the remainder of the performance year. If he or she fails to submit data to CMS or earn the minimum number of required points to remain neutral, the provider will receive a negative payment adjustment.

If a provider does not meet any of the three low-volume threshold criteria, but would still like to submit, he or she can voluntarily submit data. The data will be scored by CMS, but the provider would not be eligible to receive a positive or negative payment adjustment.

Webinar: "How to Succeed in the Promoting Interoperability Category for Solo and Small Group Practices"

The above webinar is being offered for interested providers on the following dates and times.

Tuesday, June 18, 2019 at 11:00 am – 12:00 PM EST

To register, copy and paste the following link into your browser:

https://events-na1.adobeconnect.com/content/connect/c1/2354040968/en/events/event/shared/default_templatesimple/event_landing.html?connect-session=na1breezoz zu2k2oicyeawf9&sco-id=3101462423&_charset_=utf-8

Thursday, June 20, 2019 at 3:30 pm – 4:30 pm, EST

To register, copy and paste the following link into your browser:

https://events-na1.adobeconnect.com/content/connect/c1/2354040968/en/events/event/shared/default_template_simple/event_landing.html?connect-session=na1breezozzu2k2oicyeawf9&sco-id=3101534713&_charset_=utf-8

Payment Adjustment Determination for MIPS

Final Score for 2019	Payment Adjustment 2021
>75 Points	-- Positive adjustment greater than 0% -- Eligible for exceptional performance bonus, minimum of additional 5%
30.01-74.99 Points	-- Positive adjustment greater than 0% -- Not eligible for exceptional performance bonus
30 Points	-- Neutral payment adjustment
7.51-29.99 Points	-- Negative payment adjustment between -7% and 0%
0-7.5 Points	-- Negative payment adjustment of -7%

HSAG

MEDICARE & MEDICAID NEWS

CMS Finalizes Rule to Protect Medicaid Provider Payments

The final rule ensures Medicaid providers receive complete payments as required by law.

CMS released the Medicaid Provider Reassignment Regulation final rule removing a state's ability to divert portions of Medicaid provider payments to third parties outside of the scope of what the statute allows.

This final rule is intended to ensure that providers receive their complete payment, and that any circumstance where a state redirects part of a provider's payment is clearly allowed under the law.

Section 1902(a)(32) of the Social Security Act generally prohibits states from making payments for Medicaid services to anyone but the provider.

Home Health PDGM Revisions

Revisions were announced by CMS on May 24, 2019.

One change is that episode is also now a period of care. HHAs should note the following instructions in the revised Medicare Claims Processing Manual, Chapter 10, Section 40.2:

- HH PPS claims must report a 0023 revenue code line on which the first four positions of the HIPPS code match the code submitted on the RAP. This HIPPS code is used to match the claim to the corresponding RAP that was previously paid. After this match is completed, grouping to determine the HIPPS code used for final payment of the period of care will occur in Medicare systems. At that time, the submitted HIPPS code on the claim will be replaced with the system-calculated code.

- Principal Diagnosis Code o ***For claim "From" dates before January 1, 2020***, the ICD code and principle diagnosis reported must match the primary diagnosis code reported on the OASIS form item M1020 (Primary Diagnosis).
    - ***For claim "From" dates on or after January 1, 2020***, the ICD code and principle diagnosis used for payment grouping will be claim coding rather than the OASIS item. As a result, the claim and OASIS diagnosis codes will no longer be expected to match in all cases.
    - Typically, the codes will match between the first claim in an admission and the start of care (Reason for Assessment –RFA 01) assessment and claims corresponding to recertification (RFA 04) assessments. Second 30-day claims in any 60-day period will not necessarily match the OASIS assessment. When diagnosis codes change between one 30-day claim and the next, there is no requirement for the HHA to complete another follow-up (RFA 05) assessment to ensure that diagnosis coding on the claim matches to the assessment.

- Other Diagnosis Codes
    - For claim "From" dates before January 1, 2020, the other diagnoses and ICD codes reported on the claim must match the additional diagnoses reported on the OASIS, form item M1022 (Other Diagnoses).
    - For claim "From" dates on or after January 1, 2020, claim and OASIS diagnosis codes may vary as described under Principal Diagnosis.

Information regarding this change is available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2019Downloads/R4312CP.pdf.

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 or call 1.800.568.4311.

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