AQREVA
Medical Billing & Consulting

"The undertaking of a new action brings new strength."
-- Richard Evans

Client Memo
February 2020

NEWS Update

Avoid MIPS 7% penalty in 2021

A 7% reduction in Medicare FFS payments in 2021 will occur if eligible providers do not submit their data for the MIPS 2019 performance year by March 31, 2020.

PLEASE DO NOT WAIT UNTIL THE LAST MINUTE

Please note that for small groups (15 or less providers), 2019 was the last year to easily avoid a MIPS penalty by scoring only 30 points.

For those of you who have not yet taken steps to report 2019 MIPS data, it is not too late if you follow the steps outlined below.

1. **Verify your eligibility** using the participation status look-up tool on the Quality Payment Program website. You may not even be a MIPS eligible clinician or you may be part of an APM who will report data for you.

   If you are a partial APM participant, however, you must decide on whether to report MIPS data or not. You will not be penalized if you choose to do nothing.

2. **Identify six quality measures** that apply to at least one patient in your practice.

Example of Easy Measures for Most Specialties:

47 -- Advance Care Plan
110 -- Preventive Care and Screening: Influenza
111 -- Pneumococcal Vaccination Status
130 -- Documentation of Current Medications
226 -- Tobacco Use: Screening and Cessation Intervention
43 -- Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Counseling

3. **Report at least one patient visit** for each quality measure you selected.

4. Report 2 medium or 1 high-weighted improvement activity that was completed for 90 Days.

5. Make sure you can submit your data through your EHR or sign up for a MIPS registry. It is too late to submit your data through your claims.

6. This will give you the 30 points you need to avoid the 7% penalty in 2021.

If you were reporting MIPS measures via claims, your preliminary score is already available on the QPP website: https://qpp.cms.gov You can also attest to Improvement Activities on this site and increase your score.

If you do not have a QPP login you will have to register for one through HARP. Step-by-Step instructions are available by typing in the following on your browser line: https://insight.revolutionehr.com/wp-content/uploads/_2.-Register-for-a-HARP-Account.pdf.

If you are ready to submit your MIPS data, CMS has created a video to assist you with the process: https://www.youtube.com/watch?v=f2dVaBMoEYU&feature=youtu.be

*** Security Risk Assessment Must Be Updated Annually***

Don't forget that an integral part of your MIPS attestation is conducting a security risk assessment of your office and equipment to ensure that your patients' electronic health information is protected.

A tool is now available to assist you with this and can be downloaded from the following site: https://www.healthit.gov/topic/privacy-security-andhipaa/security-risk-assessment-tool

MIPS 2020 Reminders

Check Initial 2020 MIPS Eligibility

CMS has updated the QPP Participation Status Lookup Tool for the MIPS 2020 performance year at: https://qpp.cms.gov/participation-lookup/

Low-Volume Threshold Requirements

To be eligible to participate in MIPS in 2020, you must:

- Bill **more than $90,000** a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule (PFS), **AND**
- Furnish covered professional services to **more than 200** Medicare Part B beneficiaries, **AND**
- Provide **more than 200** covered professional services under the PFS.

Important Things to Note for 2020 MIPS Reporting

- The performance threshold is now 45 points.
- The maximum negative payment adjustment is -9% while the positive payment adjustments can be up to 9%.
- The additional performance threshold for exceptional performance is 85 points.
- The data completeness threshold for the Quality performance category has increased to 70%.
- New specialty measure sets have been added for Chiropractic Medicine, Pulmonology, Endocrinology, Speech Language Pathology, Audiology, Clinical Social Work, and Nutrition/Dietician.
- For the PI category, the Verify Opioid Treatment Agreement Measure is removed and the Query of PDMP measure is optional.

More detailed information regarding the 2020 QPP Final Rule, including APM highlights, are available at: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/737/2020%20QPP%20Final%20Rule%20Fact%20Sheet.pdf

CMS has also finalized the following performance thresholds for the 2021 performance period:

- **The performance threshold is 60 points**
- **The additional performance threshold for exceptional performance will still be 85 points**

Find out whether you are eligible for MIPS today. Prepare now to earn a positive payment adjustment in 2022 for your 2020 performance.

THE PENALTY INCREASES TO 9% IN 2022 IF YOU DO NOT REPORT MIPS DATA FOR 2020.

Note: The 2020 Eligibility Tool Update for Qualifying Alternative Payment Model (APM) participants (QPs)/APMs will be updated at a later time. Additionally, the tool will be updated in late 2020 to indicate final MIPS eligibility.

Most MIPS-Eligible Clinicians Getting a Medicare Pay Bump

According to a blog post by Seema Verma, CMS Administrator, nearly all eligible clinicians participating in MIPS during the 2018 performance year will receive positive payment adjustments or will avoid being penalized in 2020, writes Ken Terry in his January 7, 2020, article for *Medscape Medical News.*

Ms. Verma said that 98% of eligible clinicians who participated in MIPS in 2018 are receiving a "modest" bonus this year compared with 93% last year. Among eligible clinicians in small practices, 84% are receiving a positive payment adjustment, an increase from the 74% who qualified for the increase last year.

Eighty-four percent of MIPS-eligible clinicians received an additional bonus for "exceptional performance," meaning their performance score was equal to or greater than 70 out of 100 points. This is important because, under the law, positive and negative payment adjustments must be budget-neutral, she added.

-- mymipsscore.com

Because few clinicians had negative adjustments, the positive adjustments are very small. To incentivize clinicians to do better, however, Congress provided $500 million during the first 6 years of the law for exceptional performers.

The eligible clinicians with higher scores are getting an extra payment.

In 2018, 183,306 eligible clinicians participated in one of the qualified Alternative Payment Models (APMs) of the Quality Payment Program. In comparison, 99,076 eligible clinicians belonged to qualified APMs in 2017. These clinicians are exempt from MIPS and receive 5% bonus payments for 5

years. Yet only about 17% of all eligible clinicians in QPP joined one of these models in 2018.

Qualified APMs include Bundled Payments for Care Improvement, Comprehensive Primary Care Plus, the Medicare Accountable Care Organization (ACO) Track 1+ Model, the Medicare Shared Savings Program (Tracks 2 and 3 and two other tracks), the Next Generation ACO Model, and the Comprehensive Care for Joint Replacement Payment Model, among other programs.

Managing Secure Direct Messages

Clinicians are developing workarounds to manage patient portal inboxes as secure direct message guidelines remain elusive for patients states Sara Heath in *Patient Engagement.com*, January 6, 2020.

Secure direct messaging and patient portal communication have been a boon for patient-provider relationships but have forced many clinicians to develop a web of workflow fail-safes to help them in managing busy inboxes, according to a new report published in *JAMA Network Open*.

The secure direct messaging function has helped patient-provider relationships blossom, giving patients the ability to contact their providers outside the clinic walls. Using patient portal messages, patients can see easier access to care, may get answers to medical questions without having to make the trek to the clinic, and can obtain refills to prescriptions, experts say.

But there have been some observed downsides to the technology, according to the report authors, who hailed from the Permanente Medical Group, which includes Kaiser Permanente.

In some practices, physicians spend more than half their time on computer activities, with high electronic message volumes associated with burnout symptoms. The trend toward secure portal messaging has created a need for new skills in primary care practice, and traditional medical training has not fully prepared today's physicians with these skills.

Providers find that patients want faster responses to patient portal messages, a timeline many providers said creates added pressure on their already stressful jobs.

Individual primary care providers have developed their own workflows for alleviating some of that stress, including multitasking during the workday between responding to messages and other documenting or clinical duties. Primary care providers also said they'll answer messages at home or enlist the help of medical assistants to respond to some messages.

These strategies suggest a need for better inbox management and patient-provider communication training, the researchers pointed out. "Individual PCPs reported diverse approaches," the researchers noted. "For example, some delegated as much as possible to their MAs, whereas others felt unable to do this."

This poses a difficult balance to strike, the researchers acknowledged. Organizational policies and training for patient-provider communication need to take into account unique provider needs and preferences while also ensuring for a consistent, positive patient experience, they said.

Other experts have touted their own strategies for managing hectic patient portal inboxes. Foremost, medical professionals advise clinicians to set clear expectations with their patients regarding patient portal response times and depth of response. They also recommend providers be upfront with patients about who may be answering the message – whether it will be the provider or a medical assistant.

Coding Updates for Therapy Services

Updates to the list of codes that sometimes or always describe therapy services under Medicare Part B went into effect Jan. 1, 2020, writes Stacy Chaplain (AAPC, November 26, 2019).

Biofeedback Coding

Two new biofeedback training CPT® codes 90912 and 90913 are added and replace 90911.

90912 Biofeedback training, perineal muscles, anorectal or urethral sphincter, including electromyography (EMG) and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient

90913 Each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient (List separately in addition to code for primary procedure)

Cognitive Function Coding

Two new cognitive function CPT® codes 97129 and 97130 were added to replace 97127, which Medicare did not recognize. These new codes will replace HCPCS Level II code G0515, which will be deleted, effective Jan. 1, 2020.

97129 Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes

97130 Each additional 15 minutes (List separately in addition to code for primary procedure)

Additional Therapy Services Updates

For CY 2020, four manual muscle testing codes were deleted: 95831, 95832, 95833, and 95834.

Additionally, 42 HCPCS Level II G-codes related to the discontinued functional reporting of therapy service requirement are deleted for dates of service after Dec. 31, 2019: HCPCS Level II codes G8978 through G8999, G9158 through G9176, and G9186.

Alice Bell provides the following information in her article "Physician Fee Schedule Coding Updates," APTA-PT in Motion, February 1, 2020.

New Dry Needling Codes

Two new codes are now used when a PT delivers dry needling. The code terminology for the procedure is "needle insertion without injection." They are:

20560 — Needle insertion(s) without injection(s); 1 or 2 muscle(s)

20561 — Needle insertion(s) without injection(s); 3 or more muscle(s)

CMS has assigned these codes the status of "non-covered" services under Medicare. This means you will be able to bill a Medicare beneficiary directly for the services.

Muscle Testing

CPT codes 95831 through 95834 for manual muscle testing have been deleted. When a PT performs manual muscle testing during the same visit as an evaluation or reevaluation, it's considered part of the evaluation or reevaluation under codes 97161-97164. When a PT completes formal manual muscle testing and generates a report independent of an evaluation or a reevaluation visit, it's billed using CPT code 97750.

New E-Visit Codes

CMS established three new E/M codes for physicians, physician assistants, and advanced practice nurse practitioners to perform brief, online E/M services: CPT codes 98970, 98971, and 98972.

The following are new digital assessment codes under the CPT-based Healthcare Common Procedure Coding System (HCPCS) for qualified nonphysician health care professionals that perform similar online digital e-visits:

G2061 — Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time of 5-10 minutes

G2062 — Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time

Does Telehealth Pay? – Staff, *Medical Economics,* January 10, 2020

Doctors looking to increase reimbursement might want to consider telehealth. CMS has been slowly pushing telehealth, making it an option for Medicare Advantage plans and ACOs, as long as they are part of risk-sharing contracts. It's also allowed under Medicare Part B for treating substance abuse disorders.

Forty states have passed laws to make it more equitable to providers and patients. Telehealth reimbursement is currently a disjointed system where doctors often struggle to understand who is covered.

In addition, patients will start to expect it as an option, something small practices need to pay attention to.

Most importantly, practices need to think about how telehealth can help them improve care for their patients. This isn't about technology taking over care, but how it can augment care.

Getting Paid for Obesity Counseling

G0447: Face-to-face behavioral counseling for obesity, 15 minutes

This code is currently reimbursed at approximately $25 for patients with a BMI over 30 kg/m2 or greater. According to CMS's National Coverage Determination (NCD) for Intensive Behavioral Therapy, the therapy for obesity consists of the following:

1. Screening for obesity in adults by calculating the patient's BMI;
2. Dietary/nutritional assessment; and
3. Intensive behavioral counseling and therapy to promote sustained weight loss though interventions on diet and exercise.

Additionally, the NCD states that the intensive behavioral intervention for obesity should be consistent with this framework:

ASSESS behavioral health risk(s) and factors affecting choice of behavior change;
ADVISE with clear, specific, and personalized behavior change advice;
AGREE on appropriate treatment goals and methods;
ASSIST the patient in achieving agreed-upon goals;
ARRANGE follow-up contacts in person or by telephone.

Medicare pays G0447 up to 22 times in a 12-month period. Valid ICD-10 codes are Z68.30-Z68.39 and Z68.41- Z68.45. The Medicare coinsurance and Part B deductible are waived for this service.

The patient must be competent and alert at the time of counseling, which may be provided by primary care physicians, advanced practice nurses and physician assistants, instructs Renee Dowling in her January 3, 2020 article for *Medical Economics*.

These services also can be performed by auxiliary personnel when incident-to guidelines are met. For Medicare beneficiaries with obesity, CMS covers:

- One face-to-face visit every week for the first month and one face-to-face visit every other week for months two through six.
- A weight loss reassessment needs to be performed at the six month visit.

Those patients who have lost at least 3 kg during the six months will then be eligible for once a month visits for an additional six months.

Cigna News

Cigna Launches New Telehealth Platform

Cigna is partnering with MDLive to launch a telehealth platform that gives its 12 million members in employee-sponsored health plans access to primary care services, reports Eric Wicklund for *mHealth Intelligence* in his January 13, 2020, article.

MDLIVE, which also has partnerships with Humana and some Blue Cross Blue Shield groups as well as Walgreens, first partnered with Cigna in 2014 to offer urgent care services through telehealth.

The addition of primary care services pushes MDLive and Cigna into a new arena, and one that is growing quickly. Recent surveys are finding that younger generations are bypassing traditional, in-person relationships with primary care providers and looking for those services online.

The new service will include remote patient monitoring through MDLive's Sophie Health Monitoring platform, which integrates AI tools and a chatbot; lab results; referral management and annual health and wellness screenings.

Cigna Patient Reviews Now Available

January 2020

Patient reviews now appearing on myCigna.com

Cigna started asking its customers after their preventive care or specialty office visit if they would recommend the provider to their family and friends. Their responses are now appearing as patient reviews in myCigna.com.

How to see your reviews
Before you can see your reviews for the first time, you will need to:

- Log in to the Cigna for Health Care Professionals website (CignaforHCP.com). If you are not registered for the website, go to CignaforHCP.com > Register Now.
- Under Latest Updates: View your patient reviews, click Learn more.
- Ask your practice's website access manager for access to patient reviews.
- Once you are granted access, see your patient reviews by logging into CignaforHCP.com > Working with Cigna > Patient Reviews.

If you need assistance gaining access to your reviews, please call Cigna at 1.800.853.2713.

MEDICARE NEWS

2020 Medicare Fee Schedule Available

The 2020 Medicare Physician Fee Schedule (MPFS) has been published to the MPFS page under the Fees & News tab on the Noridian website and is posted in convenient Adobe PDF and Microsoft Excel formats.

https://med.noridianmedicare.com/web/jfb/feesnews/fee-schedules/mpfs

Medicare offers several Education and Outreach programs

There are several programs offered by CMS that providers may not know exist on the Noridian Medicare website that serves Jurisdiction F – Medicare Part B.

One of the programs offered is the Ask the Contractor Teleconferences. These are designed to open communication between the provider community and Noridian. These calls allow for timely identification of problems and information sharing in an informal and interactive atmosphere. No Personal Health Information is allowed during these calls.

Noridian representatives from various departments including Appeals, Claims Processing, Electronic Data Interchange Support Services (EDISS), Medical Review (MR), Provider Contact Center (PCC), Provider Enrollment, Provider Outreach and Education (POE) and System Support are available to address questions.

Attendees must register through a free web-based training tool (GoToWebinar) which requires an Internet connection and a toll-free telephone number (provided in the confirmation email). Unless otherwise specified, ACTs are general in nature.

Future dates and times are as follows:

Time: 3-4 p.m. Central Time (CT)
March 18, 2020 – General
https://register.gotowebinar.com/rt/8992370545468266508

July 15, 2020 – Diagnostic Lab and X-rays
https://register.gotowebinar.com/register/5053721982723458828

November 11, 2020 – General
https://register.gotowebinar.com/register/3032907571940487181

Per CMS Internet Only Manual (IOM), clicking on the date will take providers to the registration site. Questions and answers will be published within 30 business days following an ACT.

Ways to Ask Questions and Answers

During the GoToWebinar, under the Menu, Questions section, type a question and various Noridian team representatives will be available to answer.

Up to five days prior, providers may complete the Part B ACT Provider Question Submission form to submit pre-question(s) for the scheduled ACT.

Sample (from ACT November 14, 2019)

Q7. When billing for Advance Care Planning (ACP) codes 99497 or 99498, in a Provider Based Clinic, can time by the medical assistant (MA) or registered nurse (RN), explaining and completing the documents, be counted toward the minimum time to bill?

A7. No. CPT codes 99497 and 99498 are provided by physicians or through a team-based approach provided by physicians, nonphysician practitioners (NPPs) and other staff under the order and medical management of the beneficiary's treating physician. However, only a Qualified Health Professional (QHP); such as a MD, DO or NPP (nurse practitioner, physician assistant or clinical nurse specialist) can discuss ACP. MA's and RN's time is already accounted in the practice expense portion of the payment. For Medicare purposes, it's consistent to be billed by the physicians or NPPs, whose scope of practice and Medicare benefit category, include these services to treat and independently bill Medicare. Therefore, only these practitioners may report CPT codes 99497 or 99498

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.

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