AQREVA Medical Billing & Consulting

Client Memo
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"New Year's most glorious light is sweet hope!"

-- Mehmet Murat Ildan

NEWS Update

What the New Fee Schedule Means for 2020 – *Medical Economics*, December 10, 2019

The staff at *Medical Economics* declares that Medicare's 2020 Physician Fee Schedule is a win for primary care doctors. Under the rule, doctors in the coming years will see higher reimbursements for E/M related services as well as simplified requirements for billing and coding these services.

"Historic simplifications to billing requirements mean that clinicians will be able to focus on recording the information that's most important to keeping a patient healthy," Alex Azar, secretary of the U.S. Department of Health and Human Services, said in a statement. "As we move toward a system that pays more and more providers for outcomes rather than procedures, we look forward to freeing clinicians from even more of these burdens."

--codemap.com

Beginning Jan. 1, 2020, CMS will increase the PFS conversion factor -- part of the formula used to translate RVUs into actual payments -- from $36.04 to $36.09.

Beginning January 1, 2021, CMS will increase payments for office and outpatient E/M visits and provide enhanced payments for visits with patients with greater needs and multiple medical conditions.

CMS says the higher reimbursements are a result of its decision to use the AMA Relative Value Scale Update Committees' recommended values for office and outpatient E/M codes for 2021 and a new add-on CPT code for prolonged service time.

E/M changes include reducing from five to four the number of levels for office/outpatient E/M visits for new patients.

2020 CPT Code Changes – Free Tool

In 2020, there are 394 CPT code changes (248 new, 71 deleted, 75 revisions). To assist providers in navigating all the changes, the "2020 CPT Additions, Revisions and Deletions Summary Worksheet" can be downloaded at no cost. This free downloadable Excel tool, offered by *Healthcare Training Leader,* summarizes and breaks down each of the new, deleted and revised codes by section.

To access your free ***2020 CPT Additions, Revisions and Deletions Summary Worksheet***, simply complete this online form. There is no cost to you whatsoever, and your free tool will be available for download immediately from:

https://healthcare.trainingleader.com/2020-cpt-codechanges-free-tool/?utm_source=QF_Buyers&utm_campaign=85a7e92770-MC-8U20CS_T2121927-100 01397&utm_medium=email&utm_term=0_c90ccd945a-85a7e92770-80850649&mc_cid=85a7e92770&m c_eid=80188e8adc

The first tab in the workbook is a summary of all changes; subsequent tabs have code changes by CPT sections. All but three of the CPT sections have changes. The chapters below have the most impactful changes.

- **Evaluation and Management**: 6 new codes, 1 revision and 1 deleted code. Be sure to start using codes for services you already perform including digital communication tools such as patient portals, e-visits and self-measured blood pressure monitoring.

  Examples of some of the referenced changes include:

  99421-99423 -- New codes for online digital E/M services for established patients for up to 7 days

  99446-99452 -- Telephone/Internet/EHR Consultations revision: Consults of less than 5 minutes should not be reported.

  99473 – Self measured blood pressure using a device validated for clinical accuracy

- **Surgery:** 38 new codes, 37 revised, and 17 deleted. Some top changes to watch for include new repair code guidelines, cardiology code changes, new codes for dry needling, and lumbar puncture guidance bundles.

- **Medicine:** 47 new codes, 21 deleted codes and 10 revised codes. The majority deal with long awaited enhancement of codes for long-term EEG monitoring – 23 new codes (95700-95726) and a rehaul of health and behavior assessment and intervention services.

- **Category II:** 5 new codes, 3 revised codes and 1 new code.

- **Category III:** 51 new codes, 1 revised code and 11 deleted codes

Please refer to the worksheet for more information and to review the actual codes that have been added, revised, or deleted.

Challenges Facing Physicians in 2020

It has never been such a challenging time to be a physician. Physicians, whether they own their own practice or are employed by a hospital or larger health system, must navigate a host of obstacles each and every day.

Each December, *Medical Economics* presents its list of the top challenges facing physicians going into the next year. This year the staff focused not only on the challenges, but also offered practical tips physicians can start using right away to make practicing medicine easier.

Some of these challenges are outlined below.

Challenge: Administrative burdens

Physicians say administrative hassles and regulatory requirements are their biggest challenge, with the need for prior authorizations being a common complaint. Here are some ways to ease that burden:

- Be prepared with forms for procedures that most commonly require a Prior Auth.
- Document in the patient's chart why he or she needs the procedure or medication.
- Follow recommended treatment guidelines to increase approval chances.
- Do a cost-benefit analysis for how many prior auths were required by payors and consider dropping any whose reimbursement does not justify the time.

Challenge: Getting paid

Treating patients and managing a practice are challenging enough. For today's physicians, simply getting paid is often a struggle.

Accurate documentation and coding are necessary to avoid denials and ensure proper reimbursement levels.

Challenge: Increased competition

Will the quest for patient convenience kill the traditional medical practice? Patients are now demanding the same conveniences from doctors that they find at restaurants and retailers. An increasing number of options are out there for patients to choose from. With more urgent care centers and retail clinics available, private practices have to cater more to patient demands.

Consider making the following changes to your practice:

- Easy, online appointment-setting
- Streamlined paperwork – allow patients to fill out forms online prior to visits
- Minimized wait times
- Updated waiting rooms with free Wi-Fi, coffee and water
- Increased availability with evening and weekend appointments
- Quick responses to questions posted via email or an EHR portal

Challenge: EHR usability and interoperability

EHRs remain a serious challenge for physicians, and that shows no signs of changing in 2020. While physicians are often powerless to do anything about their current EHR, experts say to take whatever training is available for their systems to make sure all available shortcuts are understood.

Challenge: Avoiding a lawsuit

The threat of a medical malpractice lawsuit is a common concern among physicians and half of all physicians will face a suit at some point in their career.

Four way to protect yourself are:

1. Document everything. Focus on accuracy and completeness. Remember: if it wasn't documented, it wasn't done.
2. Review medications. Do this even if someone else reviews them as it's a common area for mistakes.
3. Follow up on tests. Set alarms for test orders and if you don't see the results in a week, find out what happened.

Challenge: Cybersecurity

Your practice is a target for hackers whether you want to believe it or not. The threat will continue to grow in 2020 as hackers covet the rich personal data contained in medical records.

To help protect your practice from cybercriminals:

- Establish policies against opening emails and attachments from unknown sources and continuously remind staff about those policies.
- Ensure all software has the latest upgrades and security patches.
- Hire a cybersecurity firm to test your defenses.
- Enforce passcodes, automatic logoffs, and mobile device access limits.
- Review and update data recovery plans to ensure access to backup files in the event of a cyberattack.

Challenge: Negotiating better payer contracts

Good contracts can be the difference between a practice's survival and its demise.

To negotiate better contracts:

- Focus on payers that pay below the Medicare fee schedule amount as they provide the most potential for gain.
- Create a value proposition based on volume of patients seen, extended office hours to reduce ED visits, and practice location(s).
- Ask for a cost-of-doing-business increase at a minimum, citing specific examples of how your costs have increased.

Medicare Home Health Changes

Family physicians who order home health services for their patients should be aware of upcoming changes to Medicare payments for those services, announced *AAFP.org* News Staff on December 10, 2019.

Specifically, the home health unit of payment will change from the current 60 days to 30 days, an adjustment intended to ensure that patients' care needs are being actively monitored and met, effective January 1, 2020.

These changes won't directly impact physicians' payment, but physicians would do well to stay engaged.

According to blog author Kent More, the *AAFP's* Senior Strategist for Physician Payments, the new payment methodology may affect how physicians order home health services for their Medicare patients.

Moore explains that under the Patient-Driven Groupings Model, "the principal diagnosis code on the home health claim will assign the home health period of care to a clinical group that explains the primary reason the patient is receiving home health services."

He adds that some diagnoses are "vague, unspecified or not allowed to be reported as a principal diagnosis by ICD-10 coding guidelines that will not be assigned into a clinical group."

It's likely that such claims will be returned to the home health agency supplying the services; in turn, the agency will contact the ordering physician for more definitive diagnosis coding.

"USE THE MOST SPECIFIC DIAGNOSIS YOU CAN WHEN ORDERING HOME HEALTH FOR YOUR MEDICARE PATIENTS."

For its part, CMS recently provided guidance in two special editions of its Medicare Learning Network publication MLN Matters.

In a Nov. 22 article, (www.cms.gov), titled "Overview of the Patient-Driven Groupings Model," CMS reminds physicians that with the implementation of the new Home Health Prospective Payment System case-mix adjustment methodology comes a high level of need for accurate diagnosis reporting and physician documentation.

"UNDER THE MEDICARE HOME HEALTH BENEFIT, THE PATIENT MUST BE UNDER THE CARE OF A PHYSICIAN AND MUST BE RECEIVING HOME HEALTH SERVICES UNDER A PLAN OF CARE ESTABLISHED AND PERIODICALLY REVIEWED BY A PHYSICIAN."

It notes that with the change to a 30-day unit of payment, home health agencies may have more frequent contact with the certifying physician to communicate any changes in the patient's condition to ensure that the home health payment is adjusted to account for those changes.

A second MLN Matters article, (www.cms.gov) provides additional information on implementation of the PDGM, including the case-mix variables representing the clinical characteristics that affect resource use.

CMS Boosts Transitional Care Management Pay, Removes Edits

When helping patients successfully transition from the hospital, SNF, or rehab, providers can capture non face-to-face care coordination services with Transitional Care Management codes. To encourage you to use these codes more often, CMS is making them more lucrative and less burdensome, writes Emily Miller for *Healthcare Practice Advisory,* November 27, 2019.

The CMS 2020 Physician Fee Schedule final rule boosts Transitional Care Management (TCM) fees and allows concurrent billing with several previously unallowed CPT codes.

Expect More Pay for TCM Services

TCM services were adopted for the management of transitions from acute care or certain outpatient stays to a community setting. These services include a face-to-face visit, once per patient within 30 days post-discharge.

CMS increased the payment for the two Transitional Care Management CPT codes, effective Jan. 1, 2020:

99495 (Moderate): Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; medical decision making of at least moderate complexity during the service period; face-to-face visit, within 14 calendar days of discharge. **Increased from 2.11 to 2.36 work RVUs.**

99496 (Complex): Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; medical decision making of high complexity during the service period; face-to-face visit, within 7 calendar days of discharge. **Increased from 3.05 to 3.10 work RVUs.**

The 2020 Physician Fee Schedule also reduced some billing restrictions. Originally, CMS had found 57 codes duplicative with TCM services.

Many of these codes were either bundled, noncovered by Medicare, or invalid for Medicare payment purposes. 14 of the payable codes have now been opened as separately payable along medically necessary TCM services.

Along with medically necessary TCM services, per CMS, you may now also bill the following codes:

Bill TCM with Additional Services

Prolonged Services without Direct Patient Contact

99358 – Prolonged E/M service before and/or after direct patient care; first hour; non-face-to-face time spent by a physician or other qualified healthcare professional on a given date providing prolonged service

99359 – Prolonged E/M service before and/or after direct patient care; each additional 30 minutes beyond the first hour of prolonged services

Rationale: "For example, CPT code 99358 would allow the physician or other qualified healthcare professional extra time to review records and manage patient support services after the face-to-face visit required as part of TCM services," states CMS.

Note: CPT 2020 guidelines still indicate this bundle is not allowed.

Home and Outpatient International Normalized Ratio (INR) Monitoring Services

93792 – Patient/caregiver training for initiation of home INR monitoring

93793 – Anticoagulant management for a patient taking warfarin; includes review and interpretation of a new home, office, or lab INR test result, patient instructions, dosage adjustment and scheduling of additional test(s)

Note: CPT 2020 guidelines still indicate this bundle is not allowed.

End-Stage Renal Disease Services (patients who are 20+ years)

90960 – ESRD related services monthly with 4 or more face-to-face visits per month; for patients 20 years and older

90961 – ESRD related services monthly with 2-3 face-to-face visits per month; for patients 20 years and older

90962 – ESRD related services with 1 face-to-face visit per month; for patients 20 years and older

90966 – ESRD related services for home dialysis per full month; for patients 20 years and older

90970 – ESRD related services for dialysis less than a full month of service; per day; for patient 20 years and older

Note: CPT 2020 guidelines still indicate this bundle is not allowed.

Analysis of Data

99091 – Collection and interpretation of physiologic data

Care Plan Oversight Services

G0181 – Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities within a calendar month; 30+ minutes

G0182 – Physician supervision of a patient receiving Medicare-covered hospice services (patient not present) requiring complex and multidisciplinary care modalities; within a calendar month; 30+ minutes

Report Chronic Care Management Codes Plus TCM

Chronic Care Management (CCM) services already include certain Transitional Care Management services when performed during the same month, including following up with patients after discharge from inpatient and some outpatient visits, so billing TCM services at the same time as chronic care management hasn't been allowed.

CHANGE: EFFECTIVE JAN. 1, 2020, YOU WILL BE ABLE TO BILL CHRONIC CARE MANAGEMENT CONCURRENTLY WITH TRANSITIONAL CARE MANAGEMENT SERVICES

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.

NEW: G2058 Medicare only add-on code to 99490 – used to report the initial 20 minutes and can be reported up to twice per calendar month.

99491 – Chronic care management services, provided personally by a physician or other qualified healthcare professional, at least 30 minutes of time, per calendar month.

Complex Chronic Care Management Services

99487 – Complex Chronic Care with 60 minutes of clinical staff time per calendar month

99489 – Complex Chronic Care; additional 30 minutes of clinical staff time per month

Note: CPT 2020 guidelines still indicate this bundle is not allowed.

Codes for Principal Care Management Services – Kent Moore, Amy Mullins, et al, *AAFP.org,* December 12, 2019.

CMS created new coding for Principal Care Management (PCM) services for patients with only a single serious and high-risk chronic condition.

CMS expects most of these services will be billed by specialists managing patients with a single chronic condition so complex that it cannot be managed as effectively in the primary care setting. But nothing prohibits primary care physicians from reporting PCM services when they provide them. If the patient only has one complex chronic condition overseen by the primary care physician, then the primary care physician would be able to bill for PCM services.

Like CCM, PCM requires an initiating visit and documentation of the patient's verbal consent in the medical record. Physicians and qualified healthcare professionals billing for PCM must also document ongoing communication and care coordination between all of the patient's other physicians and qualified healthcare professionals.

For 2020, CMS will make separate payment for PCM via two new codes:

G2064 for at least 30 minutes per month of services provided by a physician or other qualified healthcare professional; and

G2065 for at least 30 minutes per month of services performed by clinical staff under the supervision of a physician or other qualified healthcare professional.

MEDICARE NEWS

MIPS 2019 Data Submission Period is Open

MIPS Eligible Clinicians Can Start Submitting Data for 2019 through March 31, 2020.

CMS has opened the data submission period for MIPS eligible clinicians who participated in the 2019 performance period of the Quality Payment Program. Data can be submitted and updated from 10:00 a.m. EST on January 2, 2020 until 8:00 p.m. EDT on March 31, 2020.

Please note, the data submission period through the CMS Web Interface for ACOs and pre-registered groups and virtual groups also opens on January 2, 2020 and closes on March 31, 2020.

Quality measures reported via Medicare Part B claims have been submitted throughout the 2019 performance period. Sign in to https://qpp.cms.gov for your preliminary feedback on Part B claims measure data processed to date. CMS will update this feedback at the end of the submission period with claims processed by your Medicare Administrative Contractor within the 60 day run out period.

New Rebuttal Process for Medicare Providers

CMS has developed a new rebuttal process for providers whose Medicare enrollments have been deactivated. This new process began on December 31, 2019, and gives providers the right to file a rebuttal to challenge their deactivation.

Only enrollments that are deactivated for the following reasons can be challenged through the new rebuttal process:

- Deactivation because the provider or supplier did not submit Medicare claims for twelve consecutive calendar months.
- Deactivation because the provider or supplier did not report a change of information within 90 calendar days of when the change occurred or within 30 days if it is an ownership change.
- Deactivation because they did not respond to a revalidation request letter or to a request for corrections on a revalidation application.
- Deactivation because the provider is in an approved status but doesn't have any practice location or active reassignment for 90 calendar days.

All rebuttals must be submitted within 20 calendar days from the date of the deactivation notice. These requests can be mailed, emailed, or faxed to Noridian. Any rebuttal submitted after the 20 calendar days will be dismissed.

Rebuttals need to be signed by the individual provider, an authorized or delegated official on file or a legal representative. If the rebuttal submission is signed by an attorney, the attorney must also submit proof that they have the authority to represent the provider/supplier.

AQREVA would like to wish everyone a Happy, Healthy, and Prosperous 2020!!

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