DOCTORS' RESOURCE SPECIALISTS

"Someone is sitting in the shade today because someone planted a tree a long time ago." -- Warren Buffett

Client Memo
December 2018

NEWS Updates

FINAL RULE FOR 2019 REVEALED

On November 1, 2018, CMS announced the final rule which updates Medicare regulations for 2019. The rule includes updates to payment policies and rates and quality provisions for services furnished under the Medicare Physician Fee Schedule on or after January 1, 2019.

CMS announced a number of final rules that will have an impact on documentation, coding, and payments in these key areas:

- 2019 Medicare Physician Fee Schedule (MPFS);
- Quality Payment Program (QPP);
- Home Health Prospective Payment System (PPS)

According to CMS Administrator, Seema Verma, the E&M documentation framework hasn't been updated in more than 20 years. These rules also contain provisions not only for 2019 but for subsequent years.

The Physician PPS will remain the same until 2021

For 2019 and 2020, CMS will continue the current coding and payments structure for E&M office and outpatient visits. Starting in 2021, however, the following changes will be implemented:

- For E&M office and outpatient visit levels 2 through 4 for established and new patients, a single rate will be paid.
- The payment rate for a level 5 visit will be retained.
- Add-on codes for visit levels 2 through 4 describing the additional resources needed for the care of patients during the visit will be available.
- Providers will be able to choose between documenting visit levels 2 through 5 using medical decision-making or time as well as the current 1995 or 1997 E&M documentation guidelines.

Retaining a separate payment policy for Level 5 E&M services and delaying the E&M coding changes until 2021 are welcome provisions of the final rule. Providers, however, remain wary of the new payment structure.

Healthcare organizations, although still concerned about the revisions, are more supportive of the changes presented in the final rule than they were with those originally proposed.

The AMA, for example, issued a statement supporting the following E&M modifications:

- Changing the required documentation of the patient's history to focus only on the interval history since the previous visit.
- Eliminating the requirement for physicians to re-document information that has already been documented in the patient's record by practice staff or by the patient.
- Removing the need to justify providing a home visit instead of an office visit.
- Declining to move forward on a proposal to reduce payment for office visits when performed on the same day as another service.

Changes to coding and payment for telehealth and communication technologies include:

- Two new codes for physician services furnished using communication technology:
  1. G2012 - Brief communication technology-based service, e.g. virtual check-in; and
  2. G2010 - Remote evaluation of recorded video and/or images submitted by an established patient

- The addition of supplemental codes to the list of telehealth services:
  1. G0513 for prolonged preventive services; first 30 minutes
  2. G0514 for each additional 30 minutes
  3. Above code(s) listed separately in addition to the code for the preventive service.

Quality Payment Program – Year 3

Per CMS, the priority for year 3 policies was to continue the framework established by the Patients over Paperwork Initiative to reduce clinician burden by:

- Implementing the Meaningful Measures Initiative, which is a framework that applies a series of cross-cutting criteria to identify and utilize the most meaningful measures with the least amount of burden and greatest impact on patient outcomes;
- Promoting advances in interoperability; and
- Establishing an automatic extreme and uncontrollable circumstances policy for MIPS eligible clinicians.

MIPS Highlights - Year 3 policies adopted for MIPS 2019 include:

- MIPS eligible clinicians expanded to include new clinician types:
  - physical therapists
  - occupational therapists
  - speech-language pathologists
  - audiologists
  - clinical psychologists
  - registered dietitians or nutrition professionals

- Opt-in policy for those clinicians meeting one or two elements of the low-volume threshold which has been expanded to include a 3rd element:

Low-Volume Threshold Criteria for Year 3

1. Dollar Amount ($90,000)
2. Number of Beneficiaries (200)
3. Number of Covered Professional Services (200)

- Retaining and increasing some bonus points;

Assistance for small practices continues in 2019:

- Bonus increases to 6 points;
- 3 points awarded for submitting quality measures that do not meet the data completeness requirements;
- Submitting quality measures via Medicare Part B claims;
- An application-based reweighting option provided for the Promoting Interoperability performance category;
- Virtual group participation still an option;
- No-cost, customized assistance offered.

- Option to use facility-based Quality and Cost performance measures for certain facility-based clinicians, allowing them to borrow from the Hospital's value based payment program which most of them are involved with on the hospital reporting side;
- Adding new episode-based measures to the Cost category;
- Simplifying the scoring process for Promoting Interoperability performance category;
- Overhauling the Promoting Interoperability (aka Meaningful Use) performance category to support greater EHR interoperability and patient access.

PERFORMING INTEROPERABILITY CHANGES

Objectives	Measures	Pts
e-Prescribing	- e-Prescribing	10 pts
	- Query PDMP	5 bonus pts
	- Verify Opioid Treatment Agreement	5 bonus pts
Health Information Exchange	- Electronically sending health information	20 pts
	- Electronically receiving and incorporating health information	20 pts
Provider to Patient Exchange	- Provide patients electronic access to their Health Information	40 pts
Public Health and Clinical Data Exchange	- Immunization Registry Reporting	10 points
	- Electronic Case Reporting	
	- Public Health Registry Reporting	
	- Clinical Data Registry Reporting	
	- Syndromic Surveillance Reporting	

APM Highlights - Finalized policies for Year 3 include:

- Updating the Advanced APM CEHRT threshold so that an Advanced APM must require that at least 75% of eligible clinicians in each APM Entity use CEHRT, and for Other Payer Advanced APM, as of January 1, 2020, the number of eligible clinicians participating in the other payer arrangement who are using CEHRT must be 75%.
- Extending the 8% revenue-based nominal amount standard for Advanced APMs and Other Payer Advanced APMs through performance year 2024.
- Streamlining the definition of a MIPS comparable measure in both the Advanced APM criteria and Other Payer Advanced APM
- Updating the MIPS APM measure sets that apply for purposes of the APM scoring standard.

For more information, visit the Quality Payment Program website at: https://qpp.cms.gov

Home Health PPS

CMS finalized 2019 and 2020 payment and policy changes for Home Health Agencies and Home Infusion Therapy Suppliers, with the focus on patients and their needs.

In accordance with the Bipartisan Budget Act of 2018, the final rule changes the unit of payment from 60-day episodes of care to 30-day periods of care, to be implemented in a budget-neutral manner on Jan. 1, 2020.

The Bipartisan Budget Act of 2018 also mandates that Medicare stop using the number of therapy visits provided to determine home health payments for 2020.

The implementation of the Patient-Driven Groupings Model, or PDGM, for home health periods of care beginning on or after January 1, 2020, is also being finalized.

The PDGM removes the current incentive to overprovide therapy, and instead, is designed to reflect CMS's focus on relying more heavily on clinical characteristics and other patient information to allow payments to more closely reflect patients' needs.

Pros and Cons of Opting Out of Medicare

Excerpts below from Leigh Page's November 13, 2018, article for *Medscape Medical News* discuss the rewards and risks from closing your doors to, or limiting the number of, Medicare patients in your practice.

Some physicians have found ways to either reduce the number of Medicare patients in their overall panel or cut them out completely. Before you go a similar route, here are some rewards and risks to consider, states Ms. Page.

Pro: Escape All of Those Medicare Requirements

Most physicians who opt out of Medicare do so because of the requirements that the federal program imposes on them.

Medicare requirements include everything from reporting on MIPS to a variety of other regulations, such as having to hire interpreters for patients without any financial support from Medicare or not being allowed to balance bill Medicare patients without a signed ABN on file.

Pro: Avoid Oppressive Investigations

Participating Medicare physicians face audits that are the toughest in the business. Private payers are basically looking for improper payments; they just want their money back. The government, however, wants to add fines and fraud charges.

In addition, Medicare auditors can levy punitive damages up to $11,000 per claim.

Pro: Dump Low Medicare Reimbursements

Another reason to opt out of Medicare is low reimbursement rates. Medicare typically pays 13%-25% less than private payers and has been almost stagnant for many years.

On the plus side, however, the Medicare payment process is often better than that of private insurance. Medicare has lower denial rates, does not require prior authorization, has a more transparent fee schedule, and pays more quickly than private insurers. Medicare's mandate is to pay providers within 14 days.

Other Alternatives

One popular alternative to opting out is to stop accepting new Medicare patients. Not accepting new Medicare patients still means you're in the Medicare program and still subject to Medicare rules and regulations.

Another alternative to opting out is to become a non-participating (nonpar) physician in Medicare. Under this designation, doctors can decide on a case-by-case basis whether they want to bill Medicare as a participating or as a nonpar physician.

As nonpar doctors, they agree to accept 95% of the usual Medicare reimbursement. They are allowed to "balance bill" the patient, which is not allowed in regular Medicare. Nonpar physicians, however, are still affected by all of Medicare's regulations.

Con: Your Medicare Patients May Walk Away

One of the biggest hurdles of opting out is convincing your Medicare patients to give up Medicare coverage and pay you out-of-pocket.

Lawrence Huntoon, MD, a neurologist in Derby, New York, who edits the *Journal of the Association of American Physicians and Surgeons*, and who opted out of Medicare 14 years ago says that in many cases, opted-out physicians retain almost all of their Medicare patients.

Michael La Penna, a practice management consultant in Grand Rapids, Michigan, however tells doctors contemplating the change that they should expect to lose half of

their patients. Opt-out works best if you have a lot of well-to-do patients.

Before opting out, Medicare requires physicians to poll their patients and sign agreements with those who decide to stay with the opted-out physician. Many of these patients cut back on visits or drop out of the practice altogether.

Con: Opting Out Is Hard to Do

Physicians who want to opt out have to think long and hard about it because if you fail, it's hard to go back into Medicare. The whole process of opting out, from deciding whether to do it, applying, and finally regaining a positive bottom line, will take 3-4 years, says Mr. La Penna.

There are only four dates a year when doctors can opt out: January 1, April 1, July 1, and October 1. Medicare carriers must receive the opt-out affidavit at least 1 month before the date you choose.

OPTED-OUT PHYSICIANS HAVE A SAFETY NET. IF THEY HAVE SECOND THOUGHTS WITHIN 90 DAYS OF OPTING OUT, THEY CAN OPT BACK IN WITH LITTLE FUSS.

Physicians who should avoid opting out, according to Mr. La Penna, include:

- Doctors in small practices who want to keep open the possibility of joining a large organization. When you opt out, you're sealing yourself into a small, independent practice;
- Some physicians with hospital privileges. Many hospitals require that physicians who provide on-call services must cover all patients, including those on Medicare;
- Physicians who are members of independent practice associations (IPAs) and physician-hospital organizations (PHOs).
- Physicians who want to moonlight in emergency departments or urgent care facilities as these facilities want doctors who can bill Medicare.

Dr. Huntoon, however, takes issue with some of these problems. He says many physicians in groups have opted out, even when they're the only ones in the group to do so. He adds that sometimes a whole group opts out, such as Mayo Clinic.

Huntoon concedes that emergency departments and urgent care facilities often don't accept opted-out physicians, but says there is no reason to do so. Medicare covers opted-out physicians whenever their patients have an emergent condition.

Congress Facing Pressure to Pass Telehealth Bill for Senior Care – Eric Wicklund, *mHealth Intelligence,* November 19, 2018

Connected care advocates are pressuring Congress to pass the RUSH Act, which aims to increase telehealth and telemedicine services in senior care facilities.

-- Telehealth Solution.com

Connected care advocates are lobbying Congress to pass the Reducing Unnecessary Senior Hospitalizations (RUSH) Act of 2018, which aims to reduce re-hospitalizations at qualified skilled nursing facilities by giving them more incentives to use telemedicine and telehealth to improve patient care.

Among those pushing for passage of the bill is Health IT Now. The broad-based coalition fired off a letter to lawmakers last week following CMS's release of a report on the use of telehealth in Medicare.

"In this report, CMS makes the case for passage of the bipartisan, Health IT Now-endorsed RUSH Act better than we ever could ourselves," Joel White, the group's executive director, said in the letter. "Now, the agency should put its findings into action by joining us in calling for swift passage of this sorely needed legislation during the current 'lame-duck' session."

"A growing chorus of lawmakers have already offered up the bill, which enjoys support from respected patient organizations such as the Alzheimer's Association and the Michael J. Fox Foundation, for possible year-end consideration, and we intend to see it happen," White added. "Presented with clear findings directly from CMS, lawmakers should have no reason to dither on advancing this worthy solution."

PDMP Use More Burden, Less Blessing Without EHR Integration

Under pressure to stall the rising death toll associated with the opioid epidemic, CMS and state regulators have pushed the use of prescription drug monitoring programs (PDMPs) as a way to ensure healthcare providers understand a patient's full medication history when writing prescriptions, writes Kate Monica in her October 16, 2018, article for *EHR Intelligence.com.*

A CMS opioid roadmap released earlier this year lists PDMP use as a key component of its three-pronged strategy to curb opioid abuse among Medicare beneficiaries. Utilizing PDMP data can help providers ensure opioid use disorder (OUD) prevention and treatment efforts target patient populations who need them most. Additionally, PDMP use can signal to providers which patients may be doctor shopping, or obtaining opioid prescriptions from multiple prescribers.

However, querying PDMPs can be burdensome and inefficient for providers at organizations without access to the databases built directly into their EHR systems.

Requiring providers across care settings to query state PDMPs that lack usability can slow the prescribing process to the detriment of patient satisfaction.

"There is a point to which it becomes more burden than benefit, and that just precludes doctors wanting to prescribe and having to take that extra time," California Medical Association (CMA) President Theodore M. Mazer, MD, told *EHRIntelligence.com*. "What it's doing in the real-world is driving physicians from prescribing really low level pain medications," he added.

The PDMP first debuted as a searchable, user-facing database within California's Controlled Substance Utilization Review and Evaluation System (CURES) in 2009. By 2012, less than ten percent of providers were using the database.

An August 2018 *JAMA Surgery* study found PDMP use negatively affects clinical efficiency without offering much benefit as a tool for reducing opioid prescribing for patients undergoing elective surgery procedures.

Mr. Mazer and others at CMA have urged CMS to require EHR vendors to integrate easily-accessible PDMP links directly into provider EHR systems to further reduce administrative burden. "We won't have to back out of one system, open another system, open CURES, and check CURES. When you go to write a script on an EHR, it should automatically query the state database and maybe multiple state databases with one click, he stated.

In addition to boosting EHR integration of PDMP links, improving interoperability across the healthcare industry would further optimize the efficiency of the databases.

Mandatory EPCS Starts January 1, 2019, in Arizona

Each prescription for a Schedule II opioid MUST be transmitted electronically in Arizona's six largest counties (Maricopa, Mohave, Pima, Pinal, Yavapai and Yuma) by January 1, 2019, and for all other counties by July 1, 2019.

EPCS Steps for Prescribers

1. Contact your EHR or e-prescribing vendor and ask if they are certified to do EPCS.
2. Complete identity proofing requirement.
3. Obtain dual authentication device or process
4. **Set up access controls.**
5. **Go live with EPCS and adjust workflow to manage all prescriptions in one application.**

Please Note: The above process can take up to 2 or more weeks to complete so don't delay.

Please note: Caretracker clients can EPCS without using the EHR component

Hardship Waiver

As mentioned in the October 2018 newsletter, a one-year waiver is available to prescribers who face hardships that prevent the implementation of EPCS by the deadline. The waiver form is available on the homepage of the Board of Pharmacy website:

https://docs.google.com/document/d/1xPvHif5Hnt_hpu2nFIXCC9hx9ye_TMl-wR66QFys1Z0/edit

The deadline for waiver applications is December 15, 2018. If you have questions on EPCS or the Click for Control campaign, please contact Health Current at (602) 688-7200 or eRx@healthcurrent.org. A fact sheet is also available on the HealthCurrent website:

https://healthcurrent.org/information-center/controlled-substances

The waiver will allow prescribers to continue writing scripts for a year while giving them more time to implement EPCS in their offices.

2019 CPT Codes Address Digital Medicine

There will be 335 CPT code changes next year with 212 codes being added, 73 being deleted, and 50 being revised.

Some of the changes include:

- Skin Biopsies with Expanded Options for Procedure Type -- CPT® code 11100 (Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion) — in addition to its add-on code +11101 for additional lesions — will be deleted for 2019. You'll have six new codes in their place:

    i. 11102 - Tangential biopsy of skin (eg, shave, scoop, saucerize, curette); single lesion
    ii. +11103 - each separate/additional lesion (List separately in addition to code for primary procedure)
    iii. 11104 - Punch biopsy of skin (including simple closure, when performed); single lesion
    iv. +11105 - each separate/additional lesion (List separately in addition to code for primary procedure)
    v. 11106 - Incisional biopsy of skin (eg, wedge) (including simple closure, when performed); single lesion
    vi. +11107 - each separate/additional lesion (List separately in addition to code for primary procedure).

- For 2019, psychological and neuropsychological testing evaluation services are to be performed and reported by a professional Four new codes for psychological test evaluation are:

    i. 96130 - Psychological testing evaluation services, the first hour;
    ii. 96131 – Psychological testing evaluation services, each additional hour;
    iii. 96132 - Neuropsychological testing evaluation services, the first hour; and
    iv. 96133 - Neuropsychological testing evaluation services, each additional hour.

The following CPT codes used to report psychological and neuropsychological testing services will be eliminated: 96101, 96102, 96103, 96118, 96119 and 96120.

- Additional codes will be available to report test administration and scoring:

    i. 96136 - Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes;
    ii. 96137 - Each additional 30 minutes (List separately in addition to code for primary procedure);
    iii. 96138 - Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes;
    iv. 96139 - Each additional 30 minutes (List separately in addition to code for primary procedure).

The 2019 CPT code set also addresses the increasing reliance physicians and their staff have on technology to enhance and improve patient care, with the addition of:

- Three remote monitoring codes that will help physicians account for monitoring patients at home and gathering data for care coordination:

    i. 99453 – Remote monitoring of physiologic parameters (weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment;
    ii. 99454 – Remote monitoring of physiologic parameters, initial; device(s) supply with daily recordings or programmed alert transmission, each 30 days; and
    iii. 99457 - Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff, physician, or other qualified healthcare professional time in a calendar month requiring interactive communication with the patient or caregiver during the month."

- Two new codes for physician services furnished using communication technology:

    i. G2012 - Brief communication technology-based service, e .g. virtual check-in; and
    ii. G2010 - Remote evaluation of recorded video and/or images submitted by an established patient.

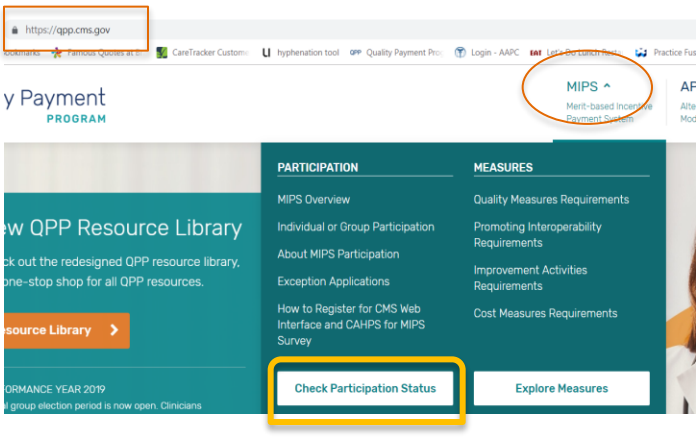
- The addition of supplemental codes to the list of telehealth services:
    i. G0513 for prolonged preventive services; first 30 minutes and
    ii. G0514 for each additional 30 minutes
    iii. Above code(s) listed separately in addition to the code for the preventive service.

- Two new codes addressing nonverbal communication technology to coordinate care between consulting and treating physicians:
    i. 99451 - Interprofessional telephone, internet, electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time; and
    ii. 99452 Interprofessional telephone, internet, electronic health record referral service(s) provided by a treating or requesting physician or other qualified health care professional, 30 minutes.

2018 Quality Payment Program Reminders

Check Your Final 2018 MIPS Eligibility Status

You can now check the Quality Payment Program (QPP) Participation Status Tool to view your final 2018 eligibility status for the Merit-based Incentive Payment System (MIPS). Please go to https://qpp.cms.gov and click on the dropdown next to the MIPS heading. Then click on the white box marked 'Check Participation Status.'



Enter your INDIVIDUAL NPI number where indicated and your MIPS eligibility as an individual and as a group will appear.

Your initial 2018 MIPS eligibility status was based on CMS review of Medicare Part B claims and PECOS data from **September 1, 2016, to August 31, 2017.**

Now, we've updated your eligibility status based on our second review of Medicare Part B claims and PECOS data, from **September 1, 2017, to August 31, 2018**.

Your status may have changed, so we encourage you to use the QPP Participation Status Tool to confirm your final 2018 MIPS eligibility.

If, after the first review earlier this year, you were determined to be:

- ❖ Eligible for MIPS: Your eligibility status might change, and you may no longer be eligible. You should use the tool to make sure you're still eligible.
- ❖ Not eligible for MIPS at a particular practice: Your eligibility status, based on your association with that particular practice, will not change.

Perform or Review a Security Risk Analysis

One of the most neglected and ignored requirement of reporting on the ACI category (aka meaningful use) is the Security Risk Analysis.

Note, however, that entities that create, receive, maintain, or transmit electronic protected health information (ePHI) **must complete a Security Risk Analysis under HIPAA regardless of whether they participate in ACI.** Allocate time to address any deficiencies to ensure that you can successfully attest.

2018 MIPS Data Submission Deadlines

The submission window opens January 2, 2019 10 am EST. Submission due dates will vary by reporting mechanism:

Submission Method	Deadline
Claims Reporting	March 1, 2019
CMS Web Interface	March 22, 2019
All Other methods **	April 2, 2019

** Please note: registries have their own deadlines for receiving data from providers and groups. Please make sure to check their submission schedules.

2018 Program Requirements

Performance Period:

- Quality: 12-month calendar year performance period (instead of 90 days minimum)
- Cost: 12-month calendar year performance period.
- Advancing Care Information: 90 days minimum performance period
- Improvement Activities: 90 days minimum performance period

Performance Threshold – set at 15 points (instead of 3)

- How to achieve 15 points:
  - Report all required Improvement Activities or
  - Meet the Advancing Care Information base score and submit 1 Quality measure that meets data completeness or
  - Meet the Advancing Care Information base score, by reporting the 5 base measures, and submit one medium-weighted Improvement Activity or
  - Submit 6 Quality measures that meet data completeness criteria.
- Additional performance threshold stays at 70 points for exceptional performance.

MIPS Exception Applications – Applications due December 31, 2018.

CMS provides the opportunity for MIPS-eligible clinicians to apply for exceptions if they don't meet the minimum threshold exclusion:

1. In order to be exempt from all performance categories of MIPS, MIPS eligible clinicians must qualify for the EXTREME AND UNCONTROLLABLE CIRCUMSTANCES exception.
2. The Promoting Interoperability Hardship Exception only applies to the Promoting Operability category of MIPS.
   - Clinicians will have their Promoting Interoperability performance score re-weighted from 25% to 0%, with the 25% reallocated to the Quality performance category.
   - ***Providers must still attest to the other three performance categories: Quality, Cost, and Improvement Activities.***

MIPS-eligible clinicians that are considered Special Status (i.e. hospital-based clinicians, NP's, PA's, non-patient facing, etc) will be automatically reweighted and will not need to submit a Quality Payment Program Exception Application.

Applications can be completed on the Quality Payment Program website: https://qpp.cms.gov

DRS would like to wish you all a happy and healthy holiday season!

DRS Holiday Schedule:

Monday, December 24th – DRS phone lines will be open until noon
Tuesday, December 25th – DRS will be closed

Monday, December 31st – DRS phone lines will be open until noon
Monday, January 1st – DRS will be closed

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 Sue or Julie at 1.877.845.2969.

For more information about any of these articles, we invite you to contact:
Susan Magalnick or Julie Serbin @ DRS 1.877.845.2969

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