DOCTORS' RESOURCE SPECIALISTS

"Victory belongs to the most persevering."
– Napoleon Bonaparte

Client Memo
February 2019

NEWS Updates

2019 Medicare Documentation, Coding, and Payment Update

January always ushers in changes to the Medicare program that affect physician payment and coding, but this year's update is more notable because it includes changes to the documentation requirements, a variety of coding updates, and some added flexibility in Medicare's Quality Payment Program (QPP).

Here's a summary of the changes most relevant to family physicians.

Changes in Medicare Documentation Policy

In 2019, CMS offers physicians some documentation relief, especially as it relates to E/M coding.

CMS is simplifying the documentation of history and exam for established patients. Before 2019, the E/M documentation guidelines provided some limited flexibility in documenting the history of an established patient.

CMS is expanding this flexibility in 2019.

> "For both history and exam, physicians are only required to focus their documentation on what has changed since the last visit or on pertinent items that have not changed."

Physicians do not need to re-record these elements (or parts thereof) if the record contains evidence that they reviewed and updated the previous information.

Additionally, for both new and established patients, physicians no longer must re-enter information in the medical record regarding the chief complaint and history (including the history of present illness) that either ancillary staff or the patient have already entered.

A physician could choose to re-enter or bring forward information when documenting a visit. However, this is now optional.

Lastly, CMS has removed the requirement that the medical record must document the medical necessity of furnishing a visit in the home rather than in the office.

CMS had proposed some additional, significant E/M documentation changes, such as relaxing the requirements and using a single blended payment rate for codes 99212–99215. However, after hearing many concerns from physician groups, CMS decided to revise and delay those proposals until 2021.

Coding Changes

This year's CPT and HCPCS coding changes cover a wide array of services, from chronic care management to virtual encounters.

Inter-professional telephone/internet consultation codes received an overhaul for 2019 along with the addition of two new code sets:

1. 99446–99449 now allow time spent consulting via telephone or internet about a patient's status to also include the time required to review and analyze the EHR.
    - 99446–99449 still require a verbal interaction with the requesting physician and includes the resulting written report.
2. 99451–99452 allows reporting of the same functions without the verbal consultation requirement.

Digitally stored data services/remote physiologic monitoring can now be billed with these CPT codes if the use of a FDA approved device has been prescribed.

- 99453 is used to report the set-up and education for the device.
- 99454 covers a 30-day supply of the device.

- To report the physician review, analysis, care plan, and documentation of these activities, use existing code 99091, minimum 30 minutes.
- 99457 for remote physiologic monitoring treatment management services, 20 minutes or more per month.

Chronic care management (CCM) Services -- code 99490 became a payable service under Medicare in 2015. New in 2019 is CPT code 99491 which covers CCM services performed by a physician or other qualified health care professional, consisting of at least 30 minutes in a calendar month.

> "The higher rate for chronic care management code 99491 reflects the fact that the service is personally performed by the physician."

The 2019 Medicare allowance for code 99491 is approximately $83.97, which is higher than the allowance of $42.17 for code 99490.

Skin biopsy services -- *Biopsy code 11100 and add-on code 11101 have been deleted.*

There are three types of biopsies:
- Tangential biopsy (11102 +11103): $100.91 and $54.42, respectively,
- Punch biopsy (11104 +11105): $126.86 and $62.35, respectively,
- Incisional biopsy (11106 +11107): $153.53 and $73.52, respectively.

Virtual encounters -- CMS now has a billable code for historically non-billable services such as telephone and portal encounters:
- G2012 -- Brief communication technology-based service, e.g., virtual check-in by a physician or other qualified health care professional who can report E/M services provided to an established patient, with five to 10 minutes of medical discussion.
- G2010 -- Remote evaluation of recorded video or images submitted by an established patient, including interpretation and follow-up with the patient within 24 business hours.

Note that these G-codes are created and governed by CMS and are not mandated for use by commercial payers.

Quality Payment Program Changes

Changes created by the Bipartisan Budget Act of 2018:
- Slower transition for physicians for the cost performance category;
- more gradual increase in the performance threshold which is the minimum number of points a physician must earn to avoid a negative payment adjustment;
- MIPS payment adjustments will now only be applied to covered professional services under the Medicare physician fee schedule.

> "Jan. 1, 2019, marks the first year physicians participating in MIPS will see their Medicare payments adjusted, positively or negatively, based on the 2017 QPP performance year."

These are not all the updates within CPT, HCPCS, the Medicare Physician Fee Schedule, or the QPP. These updates reflect a high-level list of the most important changes you may want to know about as 2019 begins.

-- Kent Moore; Amy Mullins, MD, CPE, FAAFP; Erin Solis; Barbara Hays, CPC, CPMA, CPC-I, CEMC, *Family Practice Management*, AAFP, Jan/Feb 2019.

Submit Your MIPS Data Now

The MIPS Data Submission Portal is now accepting 2018 attestations. The deadline for reporting your 2018 data is April 2, 2019, depending on the submission method used.

EIDM Changed to HARP System

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

If you already have an EIDM account with a role for QPP, you'll automatically be transitioned to HARP. You'll use your existing EIDM user ID and password to sign in to the QPP website. Please note that passwords need to be updated every 6 months.

CMS has posted the following videos on the QPP Resource Library to provide step-by-step instructions on how QPP participants can navigate the new HARP system and request access to an organization through the QPP website so you can view, submit and manage data for that organization.
https://qpp.cms.gov/about/resource-library

Video Details
1. Create a QPP Account – reviews how to register for and create a new HARP account.
2. Connect to an Organization: Practice – reviews how to request access ("connect") to a practice so you

can view, submit and manage data on behalf of the practice.

3. Connect to an Organization: APM Entity – reviews how to request access ("connect") to an Alternative Payment Model (APM) Entity so you can view, submit and manage data on behalf of the APM.
4. Connect to an Organization: Virtual Group – reviews how to request access ("connect") to a virtual group.
5. Security Officials: Approving Role Requests – shows how a security official can approve and deny requests from staff users.

CMS is also hosting two 2018 MIPS data submission webinars in February and March. Register today to secure your spot:

Title: MIPS Data Submission for Year 2 (2018) Office Hours – Session 1
Date: Tuesday, February 26, 2019
Time: 2:00 – 3:00 p.m. ET
Register:
https://engage.vevent.com/rt/cms/index.jsp?seid=1370

Title: MIPS Data Submission for Year 2 (2018) Office Hours – Session 2
Date: Tuesday, March 19, 2019
Time: 2:00 – 3:00 p.m. ET
Register:
https://engage.vevent.com/rt/cms/index.jsp?seid=1374

Don't Be Disillusioned By MIPS Incentives

If your organization invested significant money and time into achieving a high MIPS score in 2017, the final incentive payment you received may have felt… well, disappointing, writes Christina Zink in her article "Disillusioned About MIPS Incentives? Here's Why You Shouldn't Be" for *Healthmonix Advisor's* January 11, 2019, issue.

But there's good news: incentives will continue to rise in coming years, and those achieving the highest scores will soon find their efforts rewarded on a much larger scale.

Why Incentives Were Low in 2017

MIPS is budget neutral, which means that high participation rates and high performance have the effect of decreasing the overall budget pool for positive payment adjustments. Because performance thresholds were artificially lowered to 3 points, which could be acquired through any type of submission, participating in and passing MIPS was easy.

What Will Change Moving Forward

This year, though, MIPS won't be so easy. In the final rule for 2018, CMS predicts that only 74% of clinicians will earn a score higher than 70%. The minimum threshold rises to 15 points, and in 2019 it will rise again to 30 points. In 2020 it's predicted to rise even further, to 45 points.

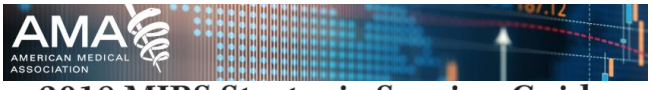
Because of this, and also **because of the increasing weight of the Cost category and the increased difficulty of the Promoting Interoperability category, submission alone won't be enough to pass,** and overall success will be harder to achieve with each passing year.

Consequently, that 1.88% incentive rate will certainly rise.

Performance Year	Payment Year	Max Penalty	Predicted Actual Max Incentive
2017	2019	4%	1.88% actual
2018	2020	5%	2.05%
2019	2021	7%	4.69%
2020	2022	9%	10%+ **

** Accuracy to increase after 2020 proposed rule

So if your organization has invested in MIPS and is currently feeling discouraged by the returns, just keep in mind that as penalties and incentives continue to increase, your preparation will ultimately put you farther and farther ahead of those who chose (and continue to choose) to do the minimum.



2018 MIPS Strategic Scoring Guide

According to the AMA's scoring guide, CMS uses the following formula within each category to determine points earned:

Your MIPS score is based on performance in four categories:

1) Quality (50%);
2) Advancing Care Information (25%);
3) Improvement Activities (15%); and
4) Cost (10%).

Promoting Interoperability Measures Have Changed for 2019

Please go to the Quality Payment Program website (https://qpp.cms.gov) for more details regarding the new reporting measures summarized below.

Objective:	e-Prescribing PI_EP_1
Measure:	**Query for Drug Formulary** - At least one permissible prescription written by the MIPS eligible clinician is queried for a drug formulary and transmitted electronically using CEHRT.
Exclusion:	Any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period.

Objective:	e-Prescribing PI_EP_2
Measure:	**Query of PDMP** – For at least one Schedule II opioid electronically prescribed using CEHRT during the performance period, the MIPS eligible clinician uses data from CEHRT to conduct a query of a PDMP for prescription drug history, except where prohibited and in accordance with applicable law.

Objective:	e-Prescribing PI_EP_3
Measure:	**Verify Opioid Treatment Agreement** - For at least one unique patient for whom a Schedule II opioid was electronically prescribed by the MIPS eligible clinician using CEHRT during the performance period, if the total duration of the patient's Schedule II opioid prescriptions is at least 30 cumulative days within a 6-month look-back period, the MIPS eligible clinician seeks to identify the existence of a signed opioid treatment agreement and incorporates it into the patient's electronic health record using CEHRT.

Objective:	Provider to Patient Exchange
Measure:	**Provide Patients Electronic Access to Their Health Information** - For at least one unique patient seen by the MIPS eligible clinician: (1) The patient (or the patient-authorized representative) is provided timely access to view online, download, and transmit his or her health information; and (2) The MIPS eligible clinician ensures the patient's health information is available for the patient (or patient-authorized representative) to access.

Objective:	Protect Patient Health Information
Measure:	**Security Risk Analysis** - Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI data created or maintained by certified electronic health record technology (CEHRT) in accordance with requirements in 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), implement security updates as necessary, and correct identified security deficiencies as part of the MIPS eligible clinician's risk management process.

Objective:	Health Information Exchange PI_HIE_1
Measure:	**Support Electronic Referral Loops by Sending Health Information** - For at least one transition of care or referral, the MIPS eligible clinician: (1) creates a summary of care record using certified electronic health record technology (CEHRT); and (2) electronically exchanges the summary of care record.
Exclusion:	Any MIPS eligible clinician who transfers a patient to another setting or refers a patient fewer than 100 times during the performance period.

Objective:	Health Information Exchange PI_HIE_4
Measure:	**Support Electronic Referral Loops by Receiving and Incorporating Health Information** - For at least one electronic summary of care record received for patient encounters during the performance period for which a MIPS eligible clinician was the receiving party of a transition of care or referral, or for patient encounters during the performance period in which the MIPS eligible clinician has never before encountered the patient, the MIPS eligible clinician conducts clinical information reconciliation for medication, medication allergy, and current problem list.
Exclusion:	1. Any MIPS eligible clinician who is unable to implement the measure for a MIPS performance period in 2019 would be excluded from having to report this measure, or 2. Any MIPS eligible clinician who receives fewer than 100 transitions of care or referrals or has fewer than 100 encounters with patients never before encountered during the performance period.

Objective:	Public Health and Clinical Data Exchange
Measure:	**Syndromic Surveillance Reporting** - The MIPS eligible clinician is in active engagement with a public health agency to submit syndromic surveillance data from a non-urgent care setting.
Exclusion:	Any MIPS eligible clinician meeting one or more of the following criteria may be excluded from the Syndromic Surveillance Reporting measure if the MIPS eligible clinician: 1. Is not in a category of health care providers from which ambulatory syndromic surveillance data is collected by their jurisdiction's syndromic surveillance system. 2. Operates in a jurisdiction for which no public health agency is capable of receiving electronic syndromic surveillance data or has declared readiness to receive syndromic surveillance data.

Objective:	Public Health and Clinical Data Exchange
Measure:	**Clinical Data Registry Reporting** - The MIPS eligible clinician is in active engagement to submit data to a clinical data registry.
Exclusion:	Any MIPS eligible clinician meeting one or more of the following may be excluded if the eligible clinician: 1. Does not diagnose or directly treat any disease or condition associated with a clinical data registry in their jurisdiction during the performance period. 2. Operates in a jurisdiction for which no clinical data registry is capable of accepting electronic registry transactions or has declared readiness to receive electronic registry transactions as of 6 months prior to the start of the performance period.

Objective:	Public Health and Clinical Data Exchange
Measure:	**Electronic Case Reporting** - The MIPS eligible clinician is in active engagement with a public health agency to electronically submit case reporting of reportable conditions.
Exclusion:	Any MIPS eligible clinician meeting one or more of the following criteria may be excluded if the clinician: 1. Does not treat or diagnose any reportable diseases for which data is collected by their jurisdiction's reportable disease system during the performance period. 2. Operates in a jurisdiction for which no public health agency is capable of receiving electronic case reporting data or has declared readiness to receive electronic case reporting data as of 6 months prior to the start of the performance period.

Objective:	Public Health and Clinical Data Exchange
Measure	**Public Health Registry Reporting** -- The MIPS eligible clinician is in active engagement with a public health agency to submit data to public health registries.
Exclusion:	Any MIPS eligible clinician meeting one or more of the following criteria may be excluded if the clinician: 1. Does not diagnose or directly treat any disease or condition associated with a public health registry in the MIPS eligible clinician's jurisdiction. 2. Operates in a jurisdiction for which no public health agency is capable of accepting information or has declared readiness to receive electronic information.

Objective:	Public Health and Clinical Data Exchange
Measure:	**Immunization Registry Reporting --** The MIPS eligible clinician is in active engagement with a public health agency to submit immunization data and receive immunization forecasts and histories from IIS.
Exclusion:	Any MIPS eligible clinician meeting one or more of the following criteria may be excluded if the clinician: 1. Does not administer any immunizations to any of the populations for which data is collected by its jurisdiction's immunization registry or immunization information system during the performance period. 2. Operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting data or has declared readiness to receive information.

Please be sure to check the QPP website for updates to all of the 2019 MIPS performance categories. Some of the Quality Measure claims reporting codes may have been updated or deleted.

Tips For Faster Credentialing

Credentialing a new provider is a tedious and slow process. Follow these tips excerpted from Lucien Roberts' article "7 Tips for Faster Credentialing" (*Physicians Practice*, January 2, 2019).

Start early

Set a goal of having everything ready to go as early as possible. That means getting everything you can from an incoming provider (an updated CV, copies of licenses and certificates, professional references with contact information) NOW rather than waiting until just before they start.

"Incent" new providers

Slow credentialing impacts the practice's finances, not the incoming provider who likely has a guaranteed salary. Consider linking a provider's start date to the complete and accurate submission of all documents and information needed for credentialing.

Five is better than three

Most payers and health systems will require three professional references and will not start the credentialing process until everything, including the references, are received. As a result, a lagging reference can stop the whole process. This is one of the most frequent delays encountered so ask for five rather than three references.

Outsource credentialing

Credentialing professionals navigate the credentialing process every day and can save lots of time, particularly by getting things right the first time.

The delay is in the details

More than three in four applications are delayed due to errors or omissions. The most common errors include:

- incomplete work history (explain any work gaps of > 30 days);
- incomplete malpractice history, including proof of coverage;
- missing professional references;
- unconfirmed hospital privileges;
- outdated information.

For help with your credentialing needs, please contact Sue or Julie at DRS 1.877.845.2969

Medicare News

CMS Updates Open Payment Data

On January 18, 2019, CMS updated the Open Payments dataset to reflect changes to the data that took place since the last publication in June 2018.

The updated dataset is now available for viewing at https://openpaymentsdata.cms.gov.

CMS updates the Open Payments data at least once annually to include updates from disputes and other data corrections made since the initial publication of the data.

The refreshed Open Payments Data Set includes:

- Record Updates: Changes to non-disputed records that were made on or before November 15, 2018, are published.
- Disputed Records: Dispute resolutions completed on or before December 31, 2018 are displayed with the updated information. Records with active disputes that remained unresolved as of December 31, 2018 are displayed as disputed.
- Record Deletions: Records deleted before December 31, 2018 were removed from the Open Payments database. Records deleted after December 31, 2018, remained in the database, but will be removed during the next data publication in June 2019.

The following is not included in the data refresh:

- Any records submitted to the Open Payments system for the first time after the close of the Program Year 2017 submission window (March 31, 2018).
- Any records that were disputed and for which dispute resolution resulted in a change to the covered recipient.

Note: Updates not included in the refresh are due to the requirement that covered recipients must be provided an opportunity to review data attributed them for accuracy.

For more information about the Open Payments Program timeline, visit www.cms.gov/openpayments.

App Displays What Original Medicare Covers

-- CMS News, January 28, 2019

CMS launched a new app that gives consumers a modernized Medicare experience with direct access on a mobile device to some of the most-used content on Medicare.gov.

The new "**What's Covered**" app lets people with original Medicare, caregivers and others quickly see whether Medicare covers a specific medical item or service. Consumers can now use their mobile device to more easily get accurate, consistent Medicare coverage information in the doctor's office, the hospital, or anywhere else they use their mobile device.

In addition to the "What's Covered" app, through Blue Button 2.0 the agency is enabling beneficiaries to connect their claims data to applications and tools developed by innovative private-sector companies to help them understand, use, and share their health data.

CMS created the app to meet the needs of the growing population of people with Medicare.

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:
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