DOCTORS' RESOURCE SPECIALISTS

Client Memo
May 2019

"You'll never find a rainbow if you're looking down." – Charlie Chaplin

NEWS Update

MIPS 2018 Data Submission Period Closed; Preliminary Performance Feedback Data for MIPS Now Available

The data submission period for 2018 MIPS closed on April 2, 2019. CMS is currently in the process of reviewing all the data submitted.

If you submitted data through the Quality Payment Program (QPP) website, you are now able to review your preliminary performance feedback data. However, please keep in mind, this is not your final score or feedback.

Your final score and feedback will be available in July 2019 through the QPP Program website. You will be able to access preliminary and final feedback with the same HCQIS Access Roles and Profile (HARP) credentials that allowed you to submit and view your data during the submission period.

Register Now for CMS Web Interface and CAHPS ® for MIPS Survey Reporting for 2019

Groups and virtual groups must register by July 1, 2019 to use the CMS Web Interface and/or administer the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) for MIPS Survey for 2019.

Groups and virtual groups must have 25 or more clinicians (including at least one MIPS-eligible clinician) to register for the CMS Web Interface. Groups and virtual groups with two or more clinicians (including at least one MIPS-eligible clinician) can register for the CAHPS® for MIPS Survey.

To register, please log in to the QPP website.
https://qpp.cms.gov

The registration period opened on April 4, 2019 at 10:00 a.m. EST and closes on July 1, 2019 at 5:00 p.m. EST.

Refer to the 2019 Registration Guide for the CMS Web Interface and CAHPS® for MIPS Survey for step-by-step instructions. As a reminder, you will need a HARP account and the Security Official role for your group or virtual group.

Groups and virtual groups planning to collect and submit 2019 MIPS quality data in other ways do not need to register (e.g., submitting MIPS Clinical Quality Measures through a Qualified Registry or other submission type).

Have You Checked Your 2019 MIPS Eligibility Yet?

The QPP Participation Status Tool is updated and you should view your eligibility status for the 2019 performance period under MIPS as soon as possible. All you need is your NPI number to find out if you need to participate in MIPS during the 2019 performance year.

How CMS Determines Your 2019 MIPS Eligibility Status:

CMS reviews both Provider Enrollment Chain and Enrollment System (PECOS) data and Medicare Part B claims for services provided during two 12-month segments called the MIPS determination period.

- First segment: October 1, 2017–September 30, 2018. Includes a 30-day claims run-out period.
- Second segment: October 1, 2018–September 30, 2019. Does not include a claims run-out period.

The current QPP Participation Status Tool update shows your preliminary 2019 eligibility status based on data from October 1, 2017–September 30, 2018

MIPS Overview for 2019

Amazing Charts Caretracker EHR

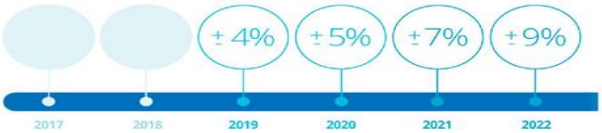
Overview for 2019

- Must use 2015 Certified Technology
- No Bonus except on Quality
- Low Threshold criteria now includes 200 Professional Covered Services
- Can "Opt-In" if not required to report. Must meet 1 or 2 but not all of Threshold Criteria

NEW

- Allowing use of a combination of collection methods
- Smaller set of Objectives and Measures for Promoting Interoperability
- Small Practice Bonus extended only for Quality
- Minimum Threshold 30 points (up from 15 points in 2018)

Timing for MIPS



Performance Period

Same as in Year 2 (2018)

Quality	12 months (Full Calendar Year)
Cost	12 months (Full Calendar Year)
Improvement Activities	90 Days (Can choose any 90 days)
Promoting Interoperability	90 Days (Can choose any 90 days)

Quality

- 45% of total score down from 50% in 2018 (Change)
- Reporting Period Full Calendar Year (365 days)
- 6 Quality Measures meeting Data Completeness
- Can choose Multiple Submission methods instead of just one. (NEW)
- Proposal to remove Low Value Measures (Change)
- Proposal to add New Measures (NEW)
- Only area to receive a Small Practice Bonus (added to score)
- Data Completeness rate the same at in Year 2 (2018) 60%
- Discontinue High Priority Measure bonus for Web Interface Reporting (NEW)
- Only Small Practices can submit Claims based as either and Individual or Group. (NEW)

Measures Removed for 2019

eCQMs	Description
CMS167v7	Diabetic Retinopathy/Macular Edema
CMS 164v7	IVD: Use of Aspirin or other Anti-platelet
CMS 123v7	Diabetes: Foot Exam
CMS 169v7	Bipolar/Major Depression: Alcohol or Chemical Substance Use
CMS 158v7	Pregnant Women that had HBsAg Testing
CMS 65v8	Hypertension: Improvement in Blood Pressure

Claims/Registry	Description
Measure 099	Breast Cancer Resection Pathology
Measure 100	Colorectal Cancer Resection Pathol
Measure 140	Age-Related Macular Degeneration
Measure 156	Oncology: Radiation Dose Limits
Measure 204	IVD: Use of Aspirin
Measure 251	IHC Evaluation
Measure 423	Pre-op Anti-platelet Therapy

Promoting Interoperability Scoring

Total Possible Points for Each 2019 Promoting Interoperability Measure

Objectives	Measures	Maximum Points
e-Prescribing	**e-Prescribing**	10 points
	Bonus: Query of Prescription Drug Monitoring Program (PDMP)	5 bonus points
	Bonus: Verify Opioid Treatment Agreement	5 bonus points
Health Information Exchange	**Support Electronic Referral Loops by Sending Health Information**	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	20 points
Provider to Patient Exchange	**Provide Patients Electronic Access to Their Health Information**	40 points
Public Health and Clinical Data Exchange	**Report to two different public health agencies or clinical data registries for any of the following:** Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Syndromic Surveillance Reporting	10 points

Bolded text in the table denotes required measures.

Removed Measures

Measures that are no longer required for 2019: The following measures will no longer be a part of the PI measures.

- Patient Education
- View, Download, and Transmit
- Secure Messaging
- Patient Generated Health Data

There is **no bonus** for attesting to CEHRT Eligible Improvement Activities

Improvement Activities

- 15% of Total Score in Year 3 (2019)
- 90 day Performance Period
- No bonus for this Category including the PI or dual credit on Quality Measure bonus (NEW)
- New Improvement Activities (NEW)
- Modification of Improvement Activities (Change)
- Removal of Improvement Activities (NEW)
- Self Attest for 2019

It's important to check with your EHR vendor on which eCQM measures are not supported on their system. For example, Amazing Charts Caretracker EHR does not support the following measures for 2019: Bone Density Evaluation, HIV PCP Therapy, and Statin Therapy for prevention of Cardiovascular Disease.

How registries can help your practice succeed in MIPS for 2019 – *QPP SURS Newsletter*, March 2019

Using a Qualified Registry or Qualified Clinical Data Registry (QC/QCDR) is one of multiple options available for collecting and submitting MIPS data.

There are two types of registries, and both can submit MIPS measures on your behalf:

1. Qualified Registries; and
2. Qualified Clinical Data Registries (QCDRs).

The difference between the two is that Qualified Registries are limited to the standard MIPS measures, whereas CMS-approved QCDRs typically offer additional measures that are relevant to specific specialties.

Registries are beneficial for the following reasons:

- Most registries can submit MIPS data to CMS on your behalf across all three performance categories (Quality, Promoting Interoperability, and Improvement Activities).
- If you do not have an EHR, some registries will let you submit your data to them through a spreadsheet, and then they will submit your data electronically on your behalf.
- Some registries can automatically pull data from compatible EHRs, saving you time and effort.
- Some registries will let you submit data retroactively, which may be helpful if you started late in collecting data on quality measures.
- Using a registry can provide you with the data you need to monitor and improve your patient population health, and to get credit for MIPS population health improvement activities.

To choose a registry, consider these questions:

1. Which registries, if any, does your professional association recommend? Look for CMS-approved qualified registries.
2. How much experience does your registry have? CMS regulations change every year, so if your registry has been around for a few years, it probably has some agility in responding to changes.
3. What measures does your registry support? If you have an electronic health record (EHR):
    - How well does your registry communicate with your EHR (and vice-versa)?
    - Does your EHR support the same measures as your registry?
4. Can the data be automatically sent to the registry by your EHR?
5. What is the cost? Is it per provider per category?
6. Does your registry have a data submission deadline that's before the CMS submission deadline?

For the latest resources on QCDRs and Qualified Registries, visit https://qpp.cms.gov/about/resource-library

There's a new Anti-Kickback Statute that most practices don't know about

Are you in compliance with the Eliminating Kickbacks and Recovery Act of 2018 (EKRA)? If you don't know what that is, you are not the only one, which could be a problem.

Peter J Domas, JD, explains what this is in his April 25, 2019, article for *Physicians Practice.* EKRA is part of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT for Patients and Communities Act) that President Donald Trump signed into law October 24, 2018.

As its name infers, the EKRA and SUPPORT for Patients and Communities Act was initially intended to be centered on behavioral health services, specifically the problem of "patient brokering" at certain treatment centers, usually in the area of addiction treatment.

EKRA was drafted to combat this problem and protect a potentially vulnerable patient population. EKRA mirrors language in the Anti-Kickback Statute that specifically prohibits knowingly and willfully soliciting, offering, paying, or receiving any remuneration in return for referring a patient or patronage to a recovery home, clinical treatment facility, or laboratory. (See U.S. Code Title 18(a)(1) & (2)) — CRIMES AND CRIMINAL PROCEDURES)

Most physicians who are not actively involved in behavioral health may not have much interaction with recovery homes or treatment facilities. **Physician practices, however, inevitably have countless interactions with laboratories**, which the statute defines as to have the same meaning as used in the Clinical Laboratory Improvement Amendments (CLIA).

As such, the statute's prohibition applies to any remuneration associated with any referral for such services, whether or not the laboratory test is related to addiction treatment or recovery.

Don't Let Locum Billing Make You Loco – Ronda Tews, CPC, *Healthcare Business Monthly*, April 2019

A locum tenens is a physician who fills in for another physician for a period of 60 days or less. A "locum" is a person who temporarily stands in for someone else of the same profession.

Merriam-Webster also uses the term in a sentence: "I'm just a locum tenens, so any major decisions should be deferred until your regular doctor returns from vacation."

When a physician fills in for another physician, avoid becoming denial crazy by following proper billing requirements.

Here's what you should know about locum tenens — or what the Medicare Claims Processing Manual, Transmittal 3774, refers to as Reciprocal Billing Arrangements.

Requirements of Reciprocal Billing

Reciprocal billing is when a Medicare patient seeks to receive services from their regular physician, but their regular physician is unavailable and has arranged for a substitute physician in their absence.

1. The substitute physician or physical therapist does not provide the services to Medicare patients over a continuous period of longer than 60 days subject to the following exception:
    - ❖ A physician or physical therapist called to active duty in the Armed Forces may bill for services furnished under a reciprocal billing arrangement for longer than the 60-day limit.
2. The regular physician may submit the claim, and (if assignment is accepted) receive the Part B payment for covered visit services that the substitute physician provided.
3. Covered visit services include not only those services ordinarily characterized as covered physician visits, but also any other covered items and services furnished by the substitute physician or by others as incident-to the physician's services.
4. A continuous period of covered visit services begins on the first day the substitute physician provides covered visit services to the regular physician's Medicare Part B patients and ends with the last day the substitute physician provides services to such patients before the regular physician returns to work.
5. This period continues without interruption on days when no covered visit services are: (a) provided to patients on behalf of the regular physician; or (b) furnished by some other substitute physician on behalf of the regular physician.

A new period of covered visit services can begin after the regular physician has returned to work.

Modifiers Must Support Claims

To identify when reciprocal billing occurs, the appropriate modifier must be applied:

- Modifier Q5 -- *Service furnished by a substitute physician under a reciprocal billing arrangement* under the same TIN. It is used when a physician covers for another physician within the same group -- both providers must be enrolled in Medicare.
- Modifier Q6 -- *Services furnished by a locum tenens physician* is used for reciprocal billing when a substitute physician provides the visit/services to Medicare patients over a continuous period no longer than 60 days. The regular physician identifies the services as substitute physician, locum tenens, services.

-- locumstory.com

How It Works

Physicians may retain substitute physicians to take over their professional practices when they are absent for reasons such as illness, pregnancy, vacation, or continuing medical education for no longer than 60 days.

These substitute physicians, known as 'locum tenens' physicians, generally have no practice of their own and move from area to area as needed.

The regular physician generally pays the substitute physician a fixed per diem amount. The substitute physician's status is that of independent contractor, rather than employee, and his/her services are not restricted just to the physician's office.

Services of non-physician practitioners (e.g., CRNAs, NPs and PAs) may not be billed as locum tenens or under reciprocal billing reassignment exceptions.

CPT Code for Remote Monitoring

Eric Wicklund's April 4, 2019, article "CMS Tweaks CPT Code for Remote Monitoring" in *mHealth Intelligence* (April 4, 2019) states that CMS has tweaked its new CPT code for remote patient monitoring, giving providers more leeway in using mHealth for chronic care management and co-ordination.

In a technical correction issued on March 14, 2019, CMS announced that CPT code **99457,** which covers "remote physiologic monitoring treatment management services," can now be conducted by auxiliary personnel "incident to" the billing practitioner's professional services.

Such services are "furnished incident to physician professional services in the physician's office (whether located in a separate office suite or within a patient's institution) or within a patient's home," and are directly supervised by the physician.

The change, which went into effect immediately, opens the door to Medicare reimbursement for mHealth services delivered to the patient at home by a care team, and is particularly helpful to providers engaged in chronic care management (CCM).

By billing CPT code 99457 'incident to,' nurses or licensed care managers can use remote monitoring services to triage patients, allowing them to focus on patients who need intervention or active care the most, and allowing patients who are successfully self-managing to continue to do so.

New Home Health Certification Requirements

Bailey Bryant's reports that lawmakers are pushing for new legislation that would make it easier for patients to gain access to home health care in his article "Newly Introduced House Legislation Would Relax Home Health Certification Requirements" for *Home Health Care News,* April 11, 2019.

If passed, the legislation would allow physician assistants, nurse practitioners and other advanced practice nurses to certify home health care services, potentially cutting the need for a physician out of the equation.

Under current Medicare rules, only physicians can certify patients to receive home health services, a common point of contention within the home health care industry.

Nurse practitioners, certified-nurse midwives, clinical nurse specialists, and physician assistants offer invaluable, personal, professional care to so many people around the country," Representative Jan Schakowsky (D-ILL) said in a press release announcing the news. "This legislation will make their cost-saving, high-quality services more directly accessible to Medicare patients in need, while greatly reducing the costs of these services.

Home health providers argue that the Medicare physician-certification policy is outdated, as many patients receive primary care from non-physician clinicians, such as nurse practitioners or physician assistants. This is especially true in rural and underserved communities.

In general, when a Medicare beneficiary under the care of a nurse practitioner needs home health, a physician, who may not serve as the patient's primary care practitioner, has to be called to certify the need for home health services.

In a statement shared with *Home Health Care News*, Washington, D.C. based Partnership for Quality Home Healthcare (PQHH) Chairman Keith Myers applauded the bipartisan legislation as a practical and pragmatic approach to improving access to home health services for seniors who need them most, including those who receive primary care through non-physician clinicians.

The National Association for Home Care & Hospice (NAHC), the American Association of Nurse Practitioners, the American Academy of PAs, the American College of Nurse-Midwives and the American Nurses Association are also among the bill's supporters.

AHCCCS Audits on Physicians' and Mid-Level Practitioners' Claims

In accordance with AHCCCS's guidelines, all rendering providers must bill under their own NPI number. **As a result, incident-to billing is not permissible for mid-level practitioners.** (A rendering provider is defined as the individual who provided care to the client and needs to be reported as such in box 24J of the CMS 1500 claim form.)

Per the AHCCCS participating Provider Agreement General Terms and Conditions: "No provider may bill with another provider's ID number, except in Locum Tenens situations. A Locum Tenens provider must submit claims using the AHCCCS provider ID number of the physician for whom the Locum Tenens provider is substituting or temporarily assisting." Locum Tenens arrangements will be recognized and restricted to the length of the Locum Tenens registration with the American Medical Association.

In connection with on-going activities to monitor claim payment and billing, Steward Health Choice identified claims submitted to Health Choice inappropriately that are non-compliant with this billing policy.

Steward Health Choice will continue auditing claims and/or encounters for this purpose. Claim denials and/or recoup payments may be issued on any incorrect claim submission.

To prevent this from occurring, please review your organization's billing practice for compliance with these requirements.

Under AHCCCS, "Incident To" billing is NOT ALLOWED. Each practitioner must bill for only those services he/she provided. No practitioner may bill for services provided by another practitioner except in locum tenens situations.

On the other hand, Medicare does permit "incident to" billing for certain patients in non-institutional settings. For example, physician office services provided by NPs and PAs to established patients can be billed directly by the NP or PA or can be billed as "incident to" by the supervising physician.

Medicare guidelines, however, must be followed some of which are listed below:

- The physician must have performed an initial service (at a prior date) and developed a plan of care. Services can then be delivered "incident-to" this plan.
- The physician must continue active participation on the patient's care (re-enter the case at regular intervals).
- The patient must be an established patient without a new problem.
- The service must be delivered in an office setting. ***There is no incident-to in a hospital setting, including the ER.***
- A physician must be in the office supervising the NPP. This does not need to be the physician who developed the plan of care.
- Medicare does not require the physician to sign every note, but it is recommended that the physician do so, as the claim is submitted under the physician's NPI number.
- Some non-Medicare payers may require Modifier SA when billing for incident-to services under the physician's NPI number.

If you need assistance with credentialing your Mid-level Practitioners, please contact Sue or Julie at 1.877.845.2969.

MEDICARE NEWS

QMB Billing Requirements

Are you in compliance with Qualified Medicare Beneficiary (QMB) billing requirements? People with Medicare who are in the QMB program are also enrolled in Medicaid and get help with their Medicare premiums and cost-sharing.

Medicare providers may not bill people in the QMB program for Medicare deductibles, coinsurance, or copays, but state Medicaid programs may pay for those costs.

Providers who inappropriately bill individuals enrolled in QMB are subject to sanctions. Establish processes to routinely identify the QMB status of Medicare beneficiaries prior to billing for items and services:

States require providers to enroll in their Medicaid systems for claim review, adjudication, processing, and issuance of Medicaid RAs for payment of Medicare cost-sharing. Check with the states where your beneficiaries reside to determine the enrollment requirements.

Correct billing problems that occur. If you erroneously bill individuals enrolled in the QMB program, recall the charges (including referrals to collection agencies) and refund the invalid charges they paid.

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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