Get a First Look at New Quality Measures in CMS’ Volume-To-Value Evolution

Brace yourself for CMS to rate you on these six quality domains.

You know that audacious idea about moving Medicare payments from a volume-to-value-based reimbursement structure? That wasn’t just a fleeting notion — the Centers for Medicare & Medicaid Services (CMS) has taken its first big step in making it a reality.

Prepare for the New MIPS & APMs

CMS intends to move at least 50 percent of Medicare payments from fee-for-service (FFS) to alternative payment systems based on quality and/or value by 2018, notes Todd Rodriguez, partner and co-chair of Fox Rothschild LLP’s Health Law Practice. And on Dec. 18, 2015, CMS published a draft Quality Measure Development Plan (MDP), which creates a framework for the development of quality measures under the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).

As early as the end of 2016, the Obama administration “has set an aggressive goal of linking 30 percent of Medicare payments to quality or value,” said partner attorney Laurie Cohen in a Jan. 7 analysis for Nixon Peabody LLP. “The quality measure development process is a critical foundation to achieving such goals.”

Will MDP Become More Painful than SGR?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) specifically mandated that CMS post a draft plan for developing quality measures by Jan. 1, 2016, Cohen noted.

Many physicians celebrated MACRA’s passage, mostly because the law brought an end to the “much despised” Sustainable Growth Rate (SGR) method of adjusting Medicare payment rates, wrote Don McCanne, MD in a Dec. 29, 2015 blog posting for the Physicians for a National Health Program (PNHP). And essentially the trade-off was the requirement to establish the MIPS and APMs.

The newly released MDP outlines how CMS will build a quality measure portfolio for MIPS and APMs based on prior quality-measure development strategies, policies, and principles. The MDP focuses on the gaps CMS identified in the quality measure sets that it currently uses for the:
The plan offers recommendations for filling these gaps. Future quality-measure development will prioritize person- and caregiver-centered care experience, patient-reported outcomes and patient health outcomes, communication and care coordination, and appropriate use of resources across the following six quality domains:

1. Clinical Care;
2. Safety;
3. Care Coordination;
4. Patient and Caregiver Experience;
5. Population Health and Prevention; and

No More Payment Updates

MACRA effectively sunsets payment adjustments for the three existing clinician reporting and incentive programs — the PQRS, VM, and Meaningful Use. Ending these payment adjustments will “accelerate the alignment of quality measurement and program policies,” CMS says.

“Perhaps the main reason that physicians, who happened to be aware of MIPS and APMs, were not concerned is that they replaced” the PQRS, VM, and Meaningful Use programs, McCanne posited. “Many thought that this would bring efficiency to existing programs by coordinating them under MIPS.”

Still, the quality measures that these three programs utilize will initially form the foundation for the MDP, Cohen pointed out.

Expect 13 Types of Measures

How it works: “The draft MDP sets forth the process for the annual solicitation, validation, and approval of quality measures that will be utilized in the MIPS,” Cohen explained. “CMS will annually solicit professional organizations and other stakeholders for new or updated quality measures through an annual Call for Measure.”

Then, CMS will establish an annual list of quality measures for MIPS through the rulemaking process, Cohen stated. In selecting a quality measure for inclusion in the annual rulemaking, a consensus-based organization — such as the Measure Applications Partnership of the National Quality Forum (NQF) — must endorse the measure. Otherwise, the measure must be evidence-based, likely determined by the rating criteria that NQF uses.

According to a recent summary by the American Academy of Orthopaedic Surgeons (AAOS), CMS expects the portfolio of quality measures to continuously evolve to include measures that:

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Physician Quality Reporting System (PQRS)  
Value-Based Payment Modifier (VM)  
Medicare Electronic Health Record (EHR) Incentive Program for Eligible Professionals (EPs), also known as Meaningful Use.

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Physician Quality Reporting System (PQRS)  
Value-Based Payment Modifier (VM)  
Medicare Electronic Health Record (EHR) Incentive Program for Eligible Professionals (EPs), also known as Meaningful Use.
1. Follow the patient across the continuum of care for those populations with one or more chronic conditions;
2. Emphasize patient outcomes balanced with process measures;
3. Address patient experience, care coordination, and appropriate care use;
4. Promote multiple levels of accountability;
5. Apply to multiple types of providers;
6. Are appropriate for low-volume, particularly rural, providers;
7. Are adopted from other payment systems and applicable to physicians and other professionals;
8. Align with other models and reporting systems (including Medicaid, other federal partners, and the private sector) and are specified for multi-payer applicability;
9. Account for variation and diversity in payment models;
10. Use EHR-generated data, based on existing provider workflows and created as a byproduct of clinical care provision;
11. Incorporate broader use of qualified clinical data registries (QCDRs);
12. Yield results stratified by race, ethnicity, gender, and other demographic variables available to enable providers to identify and reduce disparities among vulnerable populations; and
13. Are suitable for public reporting on CMS’ Physician Compare website.

Offer Up Your 2 Cents

Bottom line: “Although the plan is only in draft, it sheds important light on what Medicare payment systems are likely to look like commencing in 2019 and beyond,” Rodriguez

(Continued on next page)
If you have been wondering how to bill the two codes for advance care planning (ACP) that the Centers for Medicare & Medicaid Services (CMS) accepts, look for help from a new MLN Matters article that clarifies how and when to use these codes.

**Background:** Effective Jan. 1, you can collect about $86 for 99497 (Advance care planning including the explanation and discussion of advance directives such as standard forms [with completion of such forms, when performed], by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member[s], and/or surrogate) and about $75 for +99498 (each additional 30 minutes).

To determine whether you should apply a patient’s deductible to her ACP service, and also whether to bill the patient a coinsurance amount, you should first read through the notes to determine whether the ACP was performed during an annual wellness visit (AWV), CMS says in MLN Matters article MM9271.

If your provider performs the ACP service as an optional element of an AWV, you should report both the AWV and the ACP and waive the deductible and coinsurance for both services. “ACP services furnished on the same day and by the same provider as an AWV are considered a preventive service,” the article notes. “Therefore, the deductible and coinsurance are not applied to the codes used to report ACP services when performed as part of an AWV.”

**Exception:** On the other hand, if you furnish an ACP service outside of an AWV visit, you should collect the coinsurance and apply the visit to the deductible, the article notes.

**Example:** A patient presents for his annual wellness visit and asks the doctor to also discuss creating an advance directive to denote his wishes if he ever lacks the capacity to make those decisions on his own. You’ll report G0438 (Annual wellness visit; includes a personalized prevention plan of service [PPPS], initial visit) for the AWV, as well as 99497 for the ACP service, together on the same claim form. You should append modifier 33 (Preventive services) to 99497 to ensure that the deductible and coinsurance are waived.

**Resource:** To read more about coding and billing for ACP services, visit www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9271.pdf.
Boost This Year’s Cash Flow with These Expert Pointers

Are you hoping to avoid last year’s mistakes and make 2016 a happier year from a reimbursement perspective? A little guidance from a billing expert can help you stop making billing errors and start collecting more revenue. Read on for tips from Vinod Gidwani, founder of Currence Physician Solutions in Skokie, Ill., who shared his experiences handling medical practice billing with Eli.

Ensure You’re Getting Contracted Amounts

One big area where Gidwani sees practices losing money consistently is in reconciling payments against the corresponding contracted fee schedules. Once you contract with a payer, you should expect to receive the contracted amounts for all of your services — but you can’t simply trust the insurer to send you those fees. You should double-check your receivables and ensure that you are collecting exactly what you agreed to when you signed the contract.

“In 2016, practices should review all their managed care contracts and take a sample of some payments from all insurance companies and match the payments against their respective contracted fee schedules,” says Gidwani, whose company measures the financial performance of medical practices to ensure that their billings are optimal. “Any discrepancies must be brought to the attention of the insurance company and if the situation warrants, the practice should request a re-adjudication of claims paid incorrectly.”

Example: Suppose the insurer is shorting you $1.00 every time you report 99213. If you bill this code five times a day, you’re losing $1,300 a year due to that simple oversight.

It is also important to ensure physicians are credentialed correctly for all locations of the practice, Gidwani adds. “With all the new insurance companies competing in the marketplace under the Affordable Care Act, accurate credentialing will avoid claims being denied. The practice should also check all the insurance websites it has contracted with, to make sure all the physician names appear on the website under the ‘Doctor Search’ button.”

Pre-Check Eligibility

In addition to being a watchdog over your payers, you should also enact a few standard practices within your medical office to ensure you are prepped and ready to collect the maximum amounts that you’re due, Gidwani says.

One area where you can capture payments from the get-go is to check patient eligibility before they present to your practice, he advises. “It’s equally important to look at those eligibility reports — they have a wealth of information on benefits, deductibles, copays, etc.,” he advises. “Having this knowledge prior to the visit empowers the front desk to set the right expectations on collecting balances from the patient. It is also important for the practice to have a clear financial policy that is communicated effectively with the patient.”

In addition, insurers may require pre-authorizations for services that they previously did not, which could end up costing you down the road if you don’t comply. “The expansion of Medicaid to managed care as well as the proliferation of Medicare Advantage plans now require prior authorizations for many services rendered,” Gidwani says. “The practice should know when prior authorizations are required and ensure they get these authorizations prior to the service being rendered.”

Don’t Let Denials Rise Too High

Another way to ensure that money keeps flowing into your practice is to catch denials before they pile up, Gidwani says. “Make sure that the percentage of claims denied on first submission is five percent or less,” he notes. “The cost to follow up denied claims is very high, which increases billing costs and negatively impacts the bottom line.”

In addition, when a patient calls regarding a bill, use the conversation as an opportunity to collect from the patient, he adds. Spend as much time as necessary to explain the bill to the patient, and answer the patient’s questions methodically and patiently. You don’t want to miss the opportunity to collect outstanding balances due from the patient.

“In summary, there are no ‘short cuts’ in the medical billing process, nor does one need ‘magic’ in their hands to collect dollars efficiently,” says Gidwani, who offers more information on medcurrence.com. “Being diligent, thorough, knowledgeable, compliant and pro-active throughout the process will always bring positive results.”
If you have been puzzling as to how to code for telehealth services provided by teaching physicians and whether the rules apply to them, there’s help at hand. Get the Centers for Medicare & Medicaid Services’ (CMS’s) stand on the issue from Kenneth J. Marsalek of CMS’s Division of Practitioner Services, who shared some applicable tips during a Dec. 9, 2015 Medicare Physicians Open Door Forum.

**Background:** CMS covers telehealth services for patients who are in a rural Health Professional Shortage Area (HPSA) or a county outside of a Metropolitan Statistical Area (MSA). The clinician performing the telehealth service must use “an interactive audio and video telecommunications system that permits realtime communication between you, at the distant site, and the beneficiary, at the originating site,” CMS says in its Telehealth Services Fact Sheet.

**Coding rules:** Depending on the service, you can typically bill a standard E/M code such as 99201-99215 for these services, or an appropriate G code, such as G0425 (Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth). You should also append modifier GT (Via interactive audio and video telecommunications systems) to the code that you submit to your MAC.

**CMS Offers 2 Examples**

Because teaching physicians operate under different rules than non-teaching clinicians, many coders are puzzled about the possibility of reporting their services under the telehealth rule. Marsalek illuminated the issue, reminding practices that “Generally, in order to bill Part B, a teaching physician must either personally furnish the service or be physically present for the key critical portions of the service furnished by the resident,” he said.

Because being “physically present” requires the doctor to be in the same room as the patient, it’s hard to fathom how telehealth applies to teaching physicians. Marsalek suggested the following two telehealth scenarios that are possible under the teaching physician rules.

**Scenario 1:** A resident travels to a rural area to personally examine patients, but the teaching physician is at a distant site and supervising the resident via telehealth. “Our response is that in this case, the teaching physician is furnishing the service as the distant site physician,” Marsalek advised. “The resident may be serving as the telepresenter. If the teaching physician is furnishing all key critical elements of the service, then he would be allowed to bill Part B.”

**Scenario 2:** A resident performs a patient examination in a rural hospital, and consults a distant site specialist via telehealth. “In this case it appears that the consulting physician is not the teaching physician, so therefore this is not a teaching physician issue,” Marsalek said. “The consulting physician is furnishing a billable telehealth

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Don’t Change POS for SNF Patient in Office

**Question:**
We have a scenario where our physicians are seeing skilled nursing facility (SNF) patients in the office, yet the patient does reside in a nursing home. We are receiving recoups from Medicare HMOs for our visits. Is it appropriate to change the place of service (POS) code to the skilled nursing facility even though services were not provided at that location?

**Answer:**
You shouldn’t change the POS to “nursing home” for the office visits. However, it is likely that your payments are being made directly to the SNF under the consolidated billing rules.

**How it works:** Under consolidated billing, a SNF receives a basic per diem rate per level of care for each resident, which covers all costs (routine, ancillary, and capital) related to the services furnished to beneficiaries. The bundled services are billed by the SNF to the Part A MAC in a consolidated bill.

“The outside supplier must look to the SNF (rather than to Medicare Part B) for payment,” according to CMS’ 2015 Consolidated Billing guidelines. In the situation quoted above, your doctor is the “outside supplier.”

To properly bill and collect for services provided to SNF patients, you should contact the facility on the day of the patient’s appointment to confirm whether the patient is in a Part A or Part B stay. If he is not covered by Part A, you may bill your Part B carrier for all the services you provide.

In order to be paid for the expenses that your physician incurs while treating SNF patients, you should create a contract with the SNF. “The SNF can effect an ‘arrangement’ through any means that specifies the arranged-for services for which the SNF assumes responsibility, and the manner in which the SNF will pay the supplier for those services,” CMS says in its Consolidated Billing Best Practices fact sheet.

It is in your practice’s best interest to meet face-to-face with local SNF administrators to review technical charges and establish a direct contract or agreement for payment of the technical services as part of the consolidated reimbursement.

The contract should also list your billing information and include a disclaimer stating that you expect payment for services rendered regardless of the nursing facility’s reimbursement status with the Medicare carrier. Provide an executed copy of the contract to the facility, and keep one for your records.

Know the Rules if the TP and Resident are Together

A caller phoned into the forum to ask what would happen if the resident and teaching physician are together at the remote site, but the patient is at a different site and the visit is taking place via telehealth. “Can the resident document it and the teaching physician put an attestation on it and still bill for it?” the caller asked.

This should be billable, Marsalek advised. “I believe the teaching physician has to co-sign the resident’s note and say they were present for the key critical portion of the service,” he advised. Then you can report it as a teaching physician service.

Industry Notes

**Get Ready for Overhauled EHR Incentive Program**

CMS projects that by the end of this year, 30 percent of Medicare payments will be linked to quality of care rather than the quantity of procedures performed — and that transition will impact every aspect of your payments, including your electronic health records (EHRs). To that end, the agency is overhauling the EHR incentive program that you’ve gotten to know since CMS debuted it in 2009.

“We have been working side by side with physician organizations and have listened to the needs and concerns of many about how we can make improvements that will allow technology to best support clinicians and their patients,” said CMS Administrator Andy Slavitt and Karen DeSalvo, MD, National Coordinator for Health IT in a Jan. 19 announcement.

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CMS is currently working under four principles that will guide the EHR transition, as follows, Slavitt and DeSalvo noted:

- Rewarding providers for outcomes that they can achieve with patients via technology;
- Giving practices the flexibility to customize their health IT systems to their needs;
- Offering more avenues to access electronic health information, such as apps and plug-ins;
- Creating national interoperability standards to ensure data flows appropriately.

CMS intends to work closely with the provider community as the agency further fine-tunes the upcoming EHR transition. To read more about the program, visit http://blog.cms.gov/2016/01/19/ehr-incentive-programs-where-we-go-next/.

CCI Takes Aim at New Prolonged Service Codes

Just as quickly as several new CPT® codes went into effect, the new edition of the Correct Coding Initiative (CCI) ensured that you can’t report them all together. CCI version 22.0, which went into effect on Jan. 1, impacts the following prolonged services codes:

- 99415 — Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service)
- 99416 — Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; each additional 30 minutes (List separately in addition to code for prolonged service).

You should consider these codes included in Q0091 (Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory) and G0101 (Cervical or vaginal cancer screening; pelvic and clinical breast examination). All of these edits include a modifier indicator of “1.”

Note: You should also consider these prolonged services codes (99415, 99416) included in 99497.

Finally, your preventive codes (9938x-9939x) and E/M codes (99201-99225) now include ventilation codes (94002-94004, 94660-94662). All of these edits include a modifier indicator of “0,” meaning you cannot separate these edits under any circumstances.

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