tci Newsletters

Medicare Compliance & Reimbursement

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In this issue

Policy

MedPAC Proposal Aims to Nix 'Incident To'

Hint: This could impact your bottom line.

If your practice utilizes "incident-to" billing for care administered by nurse practitioners (NPs) and physician assistants (PAs), you may be looking at a Medicare pay cut down the road.

Reminder: Currently, when a non-physician practitioner (NPP) performs an incident-to service, the NPP can bill Medicare under the supervising physician's National Provider Identifier (NPI), resulting in 100 percent reimbursement for the care. But if NPPs file services under their own NPIs, they are paid at only 85 percent reimbursement for the same service.

As the policy stands, it translates to a big pay bump for many practices. Done correctly, incident-to billing can add 15 percent to a practice's bottom line when an NPP performs an incident-to service, explains **Jean Acevedo, LHRM, CPC, CHC, CENTC,** president and CEO of **Acevedo Consulting Incorporated** in Delray Beach, Florida.

Review MedPAC's Reasoning and Recommendations

Last month, the **Medicare Payment Advisory Commission** (MedPAC) recommended that Congress get rid of incident to, and instead have NPs and PAs bill Medicare directly for their services at the 85 percent rate, notes MedPAC's quarterly report. The reasoning behind this policy suggestion is threefold and surrounds billing transparency, boosting primary care, and saving the **Centers for Medicare and Medicaid Services** (CMS) money.

"Given the growing roles of NPs and PAs and their shift away from primary care, Medicare's 'incident-to' rules and lack of specialty data create several problems, including obscuring important information on the clinicians who treat beneficiaries and inhibiting Medicare's ability to identify and support clinicians furnishing primary care," MedPAC says.

Breakdown: According to the Commission, there are three things that factor into its recommendation to cut incident to. Firstly, between 2010 and 2017, the use of NPs — particularly APRNs — and PAs billing Medicare "more than doubled." Plus, fewer students pursue primary care medicine as a career choice than in the past, and MedPAC is concerned about the "pipeline of future primary care physicians," the report indicates. Lastly, MedPAC insists that the numbers are fuzzy, and that background details on incident-to billing are "limited" and require more study.

"Surprisingly, MedPAC didn't focus on the money, but on the lack of transparency of treatment data as a result of 'incident-to' billing and the migration of NPs/PAs to specialty care," counsels attorney **Rhonda Frey**, with law firm **Frost, Brown, Todd LLC** in Florence, Kentucky.

Frey adds, "It seems MedPAC believes that the expansion by NPs/PAs from primary care to specialty practices was not contemplated when incident to was introduced; and elimination of incident to may, thus, be a backdoor way to stop that migration."

Even though money wasn't the overarching factor in MedPAC's recommendation, the change could significantly cut Medicare's spending, and that could prompt CMS to "take MedPAC's recommendation to eliminate incident-to billing for midlevel providers seriously," explains partner attorney **Adam Robison**, in the Houston office of **King & Spalding LLP**.

Robison adds, "First, MedPAC estimated that this recommendation would save the Medicare program $50 to $250 million in the first year. Second, in MedPAC's opinion, there is not likely to be a reduction in the quality of care or clinical outcomes for Medicare beneficiaries."

Could This Change Be Around the Corner?

This isn't the first time MedPAC's discussed problems with incident to. In fact, the June quarterly report doubles down on issues covered in the Commission's December meeting. However, the feds don't always follow through on MedPAC suggestions, and sometimes they slow walk implementation of unpopular recommendations. Yet, if Congress does decide to cut incident to, expect a quick turnaround, experts warn.

"It's hard to predict timing when it comes to the government, but I'd look for them to move on this pretty quickly, if that's the direction they choose to go, since making this change doesn't need to change anything from a clinical perspective," says Frey.

Robison agrees. "As to whether CMS will include the change in the 2020 [Medicare Physician Fee Schedule] MPFS may depend on a variety of factors," he says. "For example, this may require a statutory change by Congress as incident-to services are permitted medical services under the Social Security Act. If this is the case, then CMS would not be permitted to include this change in the 2020 MPFS unless Congress intervenes in the interim."

The public would also need to weigh in on a billing change like this, too, and that is likely to impact both the timing and context of the policy. "We would anticipate that various physician organizations and associations will strenuously oppose any such rulemaking," cautions Robison.

Practices May Take a Financial Hit If Incident To Is Cut

If your staff includes a fair number of PAs and NPs, you may feel the fiscal crunch if incident to goes away.

If CMS takes up MedPAC's suggestion and "eliminates incident-to billing, midlevel providers will be required to bill for services performed under their own NPIs, which are paid at 85 percent of the fee-for-service schedule," points out Robison. "Therefore, if the recommendation ends up being adopted, physician practices would see reductions in revenue."

Future hires: This Medicare payment cut may cause some physician practices to steer away from hiring APRNs and PAs and decrease "their use of midlevel practitioners," suggests Robison.

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Frey agrees, "I would guess that some physicians whose primary motivation is reimbursement will begin to see NPs/PAs as less useful to them if they can't obtain reimbursement at 100 percent. But for those more focused on patient care or those in rural areas or locations where it's difficult to attract physicians, there probably will be no change in perspective."

Medicare Compliance & Reimbursement will continue to monitor the feds reaction to MedPAC's recommendation and any policy changes that follow.

Resource: See MedPAC's quarterly report at www.medpac.gov/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf?sfvrsn=0.

ICD-10-CM

See New Eye Fracture, Poison Codes Available Oct. 1

CMS offers new code options for pulmonary embolisms in 2020.

Last month, the **Centers for Medicare and Medicaid Services** (CMS) updated the ICD-10-CM code list for 2020. The expansions, revisions, and updates include almost 400 changes and go into effect on Oct. 1.

Background: The good news about this year's ICD-10-CM tabular addenda, which highlights changes to the 2020 code set, is that the changes are manageable. "The 2020 Tabular Addenda is only 36 pages, some of which are mostly blank," notes **Jan Blanchard, CPC, CPMA**, pediatric solutions consultant at Vermont-based **PCC**.

All told, there are seven deleted codes, 328 new subcategories and codes, and 35 revised subcategories and codes. Fortunately, "there are lots of cleanup changes among these. Some are corrections from parentheses, for supplementary words, to square brackets, and for manifestations. Still others are propagation of edits and additions into corresponding advice statements. So, don't be concerned by the overall number of changes," says Blanchard.

Check out New Pulmonary Embolism Codes

Effective Oct. 1, you'll find new codes that allow additional specificity in pulmonary embolism coding. The codes open up the options when seeing patients who have blood clots in their lungs. The updates apply to the I26.9 category (*Pulmonary embolism without acute cor pulmonale*), as follows:

- I26.93 (*Single subsegmental pulmonary embolism without acute cor pulmonale*)
- I26.94 (*Multiple subsegmental pulmonary emboli without acute cor pulmonale*)

Here's what that means: "Cor pulmonale" refers to an abnormal enlargement of the right side of the heart due to a disease of the pulmonary blood vessels or the lungs. The presence or absence of this added complication virtually decides the direction your coding goes in determining the final code. If the physician notes cor pulmonale during the encounter, you will select from I26.0- (*Pulmonary embolism with acute cor pulmonale*) and these new codes.

For example, a case of simple septic pulmonary embolism will now map to I26.93. If the physician can confirm the underlying infection, you would report this code as well. These new codes allow you to specify whether the patient has multiple emboli or just one in the absence of cor pulmonale.

Coder tip: If the provider can't identify the type of pulmonary embolism, you have an easy way out. Pulmonary embolism not otherwise specified (NOS) will be classified to I26.99, informs **Carol Pohlig, BSN, RN,**

(Continued on next page)

CPC, ACS, Senior Coding & Education Specialist at the **Hospital of the University of Pennsylvania.**

Review DVT Code Expansions

Coding for deep vein thrombosis (DVT) will get a lot more detailed under ICD-10 starting in October. Here's what you can expect.

Diagnosis: Embolism is the obstruction of a vessel by a clot or foreign substance (such as plaque or fatty deposits). Thrombosis is obstruction by a blood clot. The codes featured here are specific to deep vessels, and that means the codes are appropriate for DVT, whether the patient's particular condition is considered acute or chronic.

Under the I82.4 (*Acute embolism and thrombosis of deep veins of lower extremity*) and I82.5 (*Chronic embolism and thrombosis of deep veins of lower extremity*) categories, ICD-10 will expand to debut four new sections:

- I82.45x (*Acute embolism and thrombosis of peroneal vein*): This five-code set ranges from I82.451 (*... right peroneal vein*) to I82.459 (*... unspecified peroneal vein*). These codes are site and laterality specific.
- I82.46x (*Acute embolism and thrombosis of calf muscular vein*): This range also includes five codes ranging from I82.461 (*... right calf muscular vein*) to I82.469 (*... unspecified calf muscular vein*), each of which is site specific to the side of the body affected.
- I82.55 (*Chronic embolism and thrombosis of peroneal vein*), which includes five codes from I82.551 (*... right peroneal vein*) to I82.559 (*... unspecified peroneal vein*), all describing laterality.
- I82.56 (*Chronic embolism and thrombosis of calf muscular vein*), which also expands out to five codes that specify laterality as above.

The codes are a welcome addition, not only because they supply some much-needed specificity. "Until now, coders could only report such conditions with other and unspecified codes, which could specify laterality, but not specify location as distal — calf — or proximal — thigh." says **Sheri Poe Bernard, CPC, CRC, CDEO, CCS-P**, author of the AMA book, *Risk Adjustment Documentation and Coding*.

Tip: Remember, the clinician's documentation will need to be clear about the vessel(s) and limb(s) involved for you to choose the most appropriate ICD-10 code.

See New Poisoning Code Options

If you thought the section of ICD-10 related to poisoning codes could use some help, CMS delivers with several new codes for the T50.91 section (*Poisoning by, adverse effect of and underdosing of multiple unspecified drugs, medicaments and biological substances*). The new section now allows you to specify the manner in which a patient was poisoned by multiple drugs, whereas in the past, there wasn't a section that specifically noted that patients were poisoned due to a variety of drugs.

For instance, you'll find such codes as T50.912A (*Poisoning by multiple unspecified drugs, medicaments and biological substances, intentional self-harm, initial encounter*) and T50.911 (*Poisoning by multiple unspecified drugs, medicaments and biological substances, accidental (unintentional)*).

Similar sections follow to denote adverse effects of multiple drugs (T50.915) and underdosing of multiple unspecified drugs (T50.916).

CMS Debuts New Heatstroke, Eye Fracture Codes

When you see patients for heatstroke, you currently only have the option to note the heatstroke visit, and you can't indicate whether the visit pertains to an initial, subsequent, or sequelae-related encounter. The ICD-10 code book will now expand out sections T67.01 (*Heatstroke and sunstroke*), T67.02 (*Exertional heatstroke*), and T67.09 (*Other heatstroke and sunstroke*) to allow you to explain the visit stage.

And because only one code currently exists for orbital bone fractures, you'll find several new codes for these conditions, such as 20 codes under the new subcategory S02.12 (*Fracture of orbital roof*), as well as over 40 new options to describe the specific site of an orbital wall fracture (S02.83 to S02.84), and seven codes to describe "fracture of orbit, unspecified" (S02.85).

R**esource:** To check out the complete list of new ICD-10 codes, visit the CMS website at www.cms.gov/Medicare/Coding/ICD10/2020-ICD-10-CM.html.

Clip and Save

Review and Dispute MIPS 2018 Data With This Primer

Tip: Check your performance feedback ASAP.

Right now, your practice is probably focused on 2019 Merit-based Incentive Payment System (MIPS) measures and submissions. But you may want to backtrack and take a look at 2018's results to ensure your future Medicare payment is in the positive.

What: The **Centers for Medicare and Medicaid Services** (CMS) recently released providers' 2018 performance feedback and final scores for perusal.

Details: The 2018 MIPS submissions can be viewed on the Quality Payment Program (QPP) website through the HCQIS Access Roles and Profile (HARP) system with your MIPS credentials. Your feedback includes your payment adjustments — positive, negative, and/or neutral — that impact your 2020 Medicare payment.

Reminder: If you didn't switch over to HARP when the Enterprise Identity Data Management System (EIDM) was dismantled back in January, you'll need to do that first before you can check out your MIPS 2018 data or request a targeted review (see *Medicare Compliance & Reimbursement*, Vol. 45, No. 1).

MIPS APMs: Plus, the 2018 MIPS Alternative Payment Model (APM) entity data is available for review, too. According to CMS, the 2018 information covers participants under the following MIPS APM models:

- Medicare Shared Savings Program Accountable Care Organization (ACO)
- Next Generation ACO
- Comprehensive Primary Care Plus
- Oncology Care Model
- Comprehensive ESRD Care

"Under the MIPS APM scoring standard, the performance feedback will be based on the APM entity score, and is applicable to all MIPS eligible clinicians within the APM entity. This feedback and score does not have any impact on assessments performed by the specific model," explains CMS.

Know the Targeted Review Basics

If you're a MIPS eligible clinician, group, virtual group, or part of an APM and believe there are final score or feedback errors, you can request a targeted review of your 2018 results. During this process and according to what you've requested to be reviewed, CMS will look into one of five categories:

- Submissions' errors
- Eligibility or special status
- Measures' issues
- Extreme and uncontrollable circumstances
- General issues

According to the QPP targeted review frequently-asked-questions (FAQs) set, CMS will not take up review requests for things like MIPS methodology, performance standards, and identification of measures on sites like Physician Compare.

Consider these five important factors before you submit a targeted review:

1. **Contact person:** Choose wisely who will submit your targeted review form for your practice. The submitter will be the primary point of contact for follow-up requests.
2. **Issue:** Determine an issue category and back up your request with a comprehensive explanation.
3. **Documentation:** Compile your MIPS 2018 supporting documentation now. Performance data, EHR extracts, third party information, proof of participation, and more might be requested, the QPP guidance suggests.
4. **Privacy:** Encrypt and password protect your supporting documentation, keeping privacy in mind.
5. **Updates:** Check your contact email for targeted review results. If you want the current status on your case, call QPP at 1-866-288-8292 and have your targeted review request number handy, the FAQ indicates.

If CMS finds errors and changes are made to your final score and 2020 payment, remember that "targeted review decisions are final and not eligible for further review," the agency reminds.

The deadline to request a MIPS 2018 targeted review is Sept. 30, 2019.

Resource: Sign in with your HARP or MIPS credentials at https://qpp.cms.gov/login to review your MIPS 2018 data.

Reader Questions

Know How 'Regular Hours' Are Defined

Question:
Our practice has decided to stay open this Labor Day, and we've let our patients know about these extra hours ahead of time. Do we report CPT® code 99050 along with an E/M code for the holiday hours?

SuperCoder Subscriber

Answer:
No. One of the biggest sources of confusion on this issue occurs when practices try to decide to apply 99050 (*Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service*) or 99051 (*Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service*) for services outside of regular office hours or during holidays.

In this case, providers will see patients during regularly advertised hours, so 99050 cannot apply. Instead, you will need to use 99051 in addition to an E/M service code from 99201-99215 (*Office or other outpatient visit for the evaluation and management of a new/established patient ...*) because your providers will see patients during holiday hours that your practice has posted.

"You can only use 99050 for patients scheduled outside of your posted business hours," says **Mary I. Falbo, MBA, CPC**, CEO of Millennium Healthcare Consulting Inc. in Lansdale, Pennsylvania.

Consider this example: Your office has posted hours of 8:00 AM to 6:00 PM Monday through Friday, and 8:00 AM to 12:00 PM on Saturdays. A provider then sees a patient at 2:00 PM on Saturday afternoon. In this scenario, 99050 would be the correct code choice to use with an E/M office code, as the physician provided the service after the practice had closed.

Industry Notes

Vendors and Partners Must Use MBIs, Too

Statistics shows that providers are doing a great job with the Medicare card transition. However, vendors and business associates may have missed the memo, and could still be submitting claims with the old numbers.

Details: According to the **Centers for Medicare and Medicaid Services (**CMS), on or after Jan. 1, 2020, your claims must be submitted with the Medicare Beneficiary Identifiers (MBIs) "no matter what date you performed the service." And that includes submissions from your vendors and/or clearinghouses, an *MLN Connects* suggests.

If the claims you send to your vendors/clearinghouses come back and "you see both the Health Insurance Claim Number (HICN) and the MBI on your remittance advice, your vendor/clearinghouse is not using the MBI to submit your claims," CMS says. The agency cautions Medicare practices to fix this issue before it's too late.

Reminder: You and your vendors may submit claims with HICNs through the transition period ending on Dec. 31, 2019. But, any claims sent after that date with the HICN instead of the MBI will be rejected, including vendor submissions, CMS warns.

Read the *MLN Connects* guidance at www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive-Items/2019-07-18-eNews.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending.

MAC Offers New TPE Advice in Q-and-A Set

If you've got questions about the Targeted Probe and Educate (TPE) medical review program facilitated by the Medicare Administrative Contractors (MACs), look no further. MAC **Palmetto GBA** uploaded a new question-and-answer set to its "Medical Review" online guidance.

The Q-and-A, which references questions specifically from Palmetto GBA's TPE "Hot Topics" teleconference on June 3, covers various medical review issues on topics like:

- » OASIS submissions
- » Appeals and denials
- » Timeframes
- » Therapy reviews
- » Probe round specifications
- » Error rates and chances
- » Additional development requests (ADRs)
- » MAC contact information
- » Medicare Advantage
- » Home health

Review the TPE guidance at www.palmettogba.com/palmetto/providers.nsf/DocsR/Providers~JJ%20Part%20B~Medical%20Review~Targeted%20Probe%20and%20Educate~BDWLCN4415?open.

ZIP Code Edit Leads to Hospice NOE Errors

A claims system glitch has been returning numerous Notices of Election (NOE) to hospices in error, but a fix is on the horizon, indicates Medicare Administrative Contractor (MAC) guidance.

Problem: "NOEs submitted beginning 7/1/2019 are being RTP for the provider ZIP Code," HHH MAC **National Government Services** says in an email to providers. "The reason code the NOEs are receiving is 32114. It has been determined the issue is in the Fiscal Intermediary Standard System (FISS)."

Normally NOEs aren't edited for ZIP code, notes HHH MAC **CGS** on its website.

Solution: A fix is scheduled for Aug. 19, CGS says, meaning on Aug. 20 "NOEs submitted via EDI submission should process without editing for the ZIP code." In the meantime, "providers may submit NOEs through DDE to avoid this issue," HHH MAC **Palmetto GBA** says on its website.

Alternately, "Palmetto GBA will also process and allow late NOE exceptions for this specific issue," the MAC says. "Agencies shall enter remarks on the exception request stating 'NOE was incorrectly returned due to the ZIP Code issue with reason code 32114.'" If the agency submitted a new NOE via DDE due to the RTP and that NOE was late, "please include the claim number (DCN) for the EDI submitted NOE that was returned," the MAC adds.

CGS also says it will allow late NOE exceptions for this reason with the same message. But "providers may correct their NOEs that are in RTP with reason code 32114 by entering the full 9-digit ZIP code," also, the MAC offers.

Acupuncture May Be Covered By Medicare in the Near Future

If your patients suffer from lower back pain, you may be able to utilize acupuncture and get paid for it.

Last week, the **Centers for Medicare and Medicaid Services** (CMS) proposed acupuncture be covered under Medicare for beneficiaries with chronic back pain, indicates an agency release. The acupuncture proposal, which would specifically cover Medicare patients in National Institutes of Health (NIH) clinical trials and involved in CMS-approved research, aims to offer alternative options to opioid use for pain, suggests the release.

"Today's proposal represents the Trump Administration's commitment to providing Americans with access to a wide array of options to support their health," says **Alex Azar**, **Department of Health and Human Services** (HHS) secretary. "Defeating our country's epidemic of opioid addiction requires identifying all possible ways to treat the very real problem of chronic pain, and this proposal would provide patients with new options while expanding our scientific understanding of alternative approaches to pain."

Read CMS's release on the acupuncture proposal at www.cms.gov/newsroom/press-releases/cms-proposes-cover-acupuncture-chronic-low-back-pain-medicare-beneficiaries-enrolled-approved.

(Continued on next page)

OCR Releases New Guidance on HIPAA and Health Plans

To better clarify patient data sharing between two separate health plans, the **Department of Health and Human Service Office for Civil Rights** (OCR) released a frequently-asked-questions (FAQs) set to address quandaries.

The new offering supports better care coordination between health plans and surrounds the uses and disclosures of patients' protected health information (PHI), according to the release. There are only two questions and answers, but the OCR gives in-depth explanations with references to the related parts in the HIPAA Privacy Rule.

Both answers offer scenarios to help covered entities (CEs) understand what is and what is not allowed.

Check out the FAQs at www.hhs.gov/hipaa/for-professionals/faq/3014/uses-and-disclosures-for-care-coordination-and-continuity-of-care/index.html.

ASPR-TRACIE Addresses Hurricane Season

The feds offer new advice and insight in the wake of the California earthquakes and the impending hurricane season.

The **Department of Health and Human Services Office of the Assistant Secretary for Preparedness & Response the Technical Resources, Assistance Center, and Information Exchange** (ASPR-TRACIE), which offers a plethora of technical help and medical information before, during, and after disasters, updated its online resources.

In addition to its extensive disaster resource library and technical aids, ASPR-TRACIE has updated its files with the "Major Earthquakes & Cascading Events: Potential Health and Medical Implications" brief. Some of the hot topics include breaking down immediate, short-term, and long-term concerns, public health management, emergencies, disease, and more. Health IT is of particular focus for the agency as it relates to patient tracking, reunification, and safety.

In preparation for the 2019 hurricane season, ASPR-TRACIE and the **Centers for Disease Control and Prevention** (CDC) are offering a webinar on planning, communication, and health risk associated with hurricanes.

You can review both the earthquake and hurricane advice as well as other useful technical tools to deal with emergency and disaster situations at https://asprtracie.hhs.gov.