Part B News

COLLECT EVERY DOLLAR YOUR PRACTICE DESERVES
partbnews.com

January 15, 2018 | Vol. 32, Issue 3

IN THIS ISSUE

All Medicare fees are par, office, national unless otherwise noted.

Physician payments

Modifier 25 payment cuts delayed until March; opposition continues

Practices in a number of states gained a reprieve from planned cuts to modifier 25-appended claims after Anthem, one of the nation's largest health insurers, announced it would postpone until March 1 a policy change that would have cut claims by 25%.

An original proposal, slated for Jan. 1 implementation, would have reduced payments for claims with modifier **25** (Significant, separately identifiable E/M service) by 50%. However, after opposition from the physician community, Anthem announced it would delay all 25-related reductions until March 1, according to medical experts in the regions affected.

*(see **Modifier 25**, p. 6)*

Physician payments

Thousands of providers get GPCI cuts caused by MACRA expiration; payback uncertain

The 1.0 floor on work geographic practice cost indexes (GPCIs) has expired, which means GPCIs in 52 localities — including the states of Wyoming, Oklahoma and Ohio and municipalities such as Atlanta and St. Louis — will see a significant drop in reimbursement this year. And no one is sure when, or whether, the floor will be put back.

One of the features of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the law that repealed

*(see **GPCI cuts**, p. 8)*

Quality Payment Program

QPP reporting portal open; report and get preliminary scores — but hurry

The data-submission tool for reporting your 2017 Quality Payment Program (QPP) measures, which opened Jan. 2 and will be available through March 31, appears to make it easy to report and even predict your score — but go early to stay on top of possible glitches.

While some participants in the merit-based incentive payment system (MIPS) and advanced alternative payment model (APM) arms of the QPP will report their 2017 data via web interface, electronic health records (EHR), registries or qualified clinical data registries (QCDRs), "eligible clinicians" — that is, clinicians who are reporting by attestation or claims without outside assistance — can generate a non-certified report in the new QPP file format or QRDA III file format and manually upload the file into the submission system, CMS announced Jan. 2. Registries and QCDRs will have their choice of using the system to report clients' data or using a new application programing interface (API) CMS has developed for them.

Providers will log in via a button at the top of the front page of *qpp.cms.gov*, using their Enterprise Identity Management (EIDM) information; CMS has made instruction available online on a factsheet (*see resources*). Nonetheless, CMS also suggests providers who intend to use it go in as soon as possible to get to know the system. In previous CMS reporting systems, like the old meaningful use one, "you might get errors even if you put in valid data," says Jennifer Searfoss, Esq., founder of Ashburn, Va.-based SCG Health. Similarly, "with this system, as we play with it, we uncover glitches."

For instance, says Searfoss, "let's say for risk assessment, you say you did it and you put your date in, and that date is 2015. But you can only attest for Jan. 1 to Dec 31, 2017, so the system would reject your result — but you may not necessarily know why it did that. The errors don't say that you made a typo, so you could spend hours staring at it" before you figured out what was wrong.

Tip: Use the QPP help lines at *qpp@cms.hhs.gov* or 1-866-288-8292 and confer with other QPP reporters to share your discoveries of what works and what doesn't. *Part B News* offers its Medical Practice Revenue Cycle Forum as a hangout (*see resources*).

Smooth and with scores

You may be pleasantly surprised, though, by the ease of use of the new site and that it shows you what score your reporting is expected to get if you report for MIPS. "I'm impressed. I think they did a nice job of making it clear and user-friendly," says Beth Houck, vice president, customer experience at SA Ignite, who with her team got a preview of the system.

Subscriber information

Have questions on a story? Call toll-free **1-855-CALL-DH1**

President:
Elizabeth Petersen,
1-800-727-5257, x3432
EPetersen@blr.com

Vice president:
Tonya Nevin, x6036
tnevin@decisionhealth.com

Content manager, medical practices:
Karen Long, x6016
klong@decisionhealth.com

Editor:
Roy Edroso, x6031
redroso@decisionhealth.com

Editor:
Richard Scott, 267-758-2404
rscott@decisionhealth.com

Join our DecisionHealth — Medical Practice & Hospital community!
www.facebook.com/DecisionHealthMP
www.twitter.com/DH_MedPractice
www.linkedin.com/groups/4048762

SUBSCRIPTIONS
Direct questions about newsletter delivery and account status, toll free, to 1-855-CALL-DH1 or email: *customer@decisionhealth.com*

DECISIONHEALTH PLEDGE OF INDEPENDENCE:
Part B News works for only you, the provider. We are not affiliated with any special interest groups, nor owned by any entity with a conflicting stake in the health care industry. For nearly three decades, we've been independently watching out for the financial health of health care providers and we'll be there for you and your peers for decades to come.

CONNECT WITH US
Visit us online at: *www.partbnews.com*.

CEUs
Part B News is approved, through Dec. 31, 2018, for AAPC CEUs. Credential holders can earn 0.5 CEUs by passing each five-question quiz, for up to 12 CEUs per year. For instructions on how to access the quizzes, log on to *www.partbnews.com/home/ceus_read_more*.

ADVERTISING
To inquire about advertising in *Part B News*, call 1-855-CALL-DH1.

Part B News® is a registered trademark of DecisionHealth. DecisionHealth is a registered trademark of. *Part B News* is published 48 times/year by DecisionHealth, 100 Winners Circle, Suite 300, Brentwood, TN 37027. ISSN 0893-8121. *pbncustomer@decisionhealth.com* Price: $597/year.

Houck is also impressed at the granularity of the scoring feature. For example, she says, "they'll show you your quality score, and you can expand to see which six measures they've picked — out of, say, 30 you may have submitted — that give you the highest score. And they will show you bonus point opportunities and factor in benchmarks" on the quality scores.

Tip: Keep receipts

Searfoss reminds you that reporting via this method or any method is not necessarily taken as proof by CMS that you completed the measures, especially the ones that require a simple yes/no attestation; the agency is expected to perform audits as they did for the physician quality reporting system (PQRS) and meaningful use program that might catch you without proof that you did what you said you did (*PBN 1/16/17*).

"In meaningful use, on audit, the auditors often found there was no documentation [for self-reporters]," says Searfoss. "So I worry for them — they don't think about what happens in an audit." Develop a documentation plan based on measure specifications and past reporting standards — for example, says Searfoss, the meaningful use documentation requirements track pretty closely with the current ACI category. — *Roy Edroso (redroso@decisionhealth.com)*

Resources:

- Submitting 2017 Transition Year Data to the Quality Payment Program: *www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/QPP-2017-Data-Submission-Factsheet.pdf*
- *Part B News'* Medical Practice Revenue Cycle Forum: *http://practiceforum.decisionhealth.com/*

Regulatory update

At hearing, Azar open to mandatory bundled programs, drug price deals

Though generally evasive at his hearing before the Senate Finance Committee on Jan. 9, Health and Human Services Secretary nominee Alex Azar did reveal certain policy preferences — some expected, such as a preference for state over federal control of Medicaid, and some less so, such as an openness to mandatory bundled payment programs.

Since previous Secretary Tom Price was known to oppose mandatory bundled payment programs — including the Comprehensive Care for Joint Replacement Model (CJR) and other programs that were suspended or cut back on his watch — many have assumed that Azar also opposes them (*PBN 8/21/17*). But when Sen. Mark Warner, D-Va., praised the CMS Innovation Center, which originated those programs, Azar agreed and said he considered it "one of the very important legs to drive transformation in the health care system under Medicare." When Warner suggested he and the nominee would still disagree on the Innovation Center's mandatory programs, Azar said: "We don't disagree. We have to test hypotheses. And … if to test a hypothesis, it needs to be mandatory instead of voluntary, then so be it."

Generally speaking, there were few surprises in the two-and-a-half-hour meeting with Azar, a former HHS undersecretary and top pharmaceutical executive with Eli Lilly nominated Nov. 13 by President Donald Trump, responding to many questions as he had at his prior meeting with the Senate Committee on Health, Education, Labor and Pensions (HELP) on Nov. 29, with generalities or a pledge to "work with" Congress on a solution rather than a definitive answer (*PBN 12/11/17, 11/30/17*).

But the nominee did reveal some specifics:

- **Open to Part B drug price negotiation, points to Part D model.** Azar was, as before, firm that "drug prices are too high" and he favors "robust generic competition" to bring them down. When asked by Sen. Debbie Stabenow, D-Mich., whether he believed that the government should negotiate drug prices, Azar said, "I think where the government doesn't have negotiation, it's worth looking at" and spoke favorably of "significant negotiation through pharmacy benefit managers" under Part D. For Part B, he said he favored negotiation "where we can do so [in a way that] preserves innovation, access to patients. I want to look at anything that's going to help us with drug pricing."
- **Favors outcome-based drug pricing deals.** Questioned by Sen. Mike Enzi, R-Wyo., about outcomes-based pricing deals, such as the one CMS entered into last summer with Novartis over the leukemia drug Kymriah, Azar said it "can be an important part of how we think about drug prices and value for customers."
- **Favors block grants to Medicaid.** Though he was careful not to use the term, when Sen. Dean

Heller, R-Nev., asked him about the Graham-Cassidy-Heller-Johnson bill — which replaces the failed Graham-Cassidy bill but, like its predecessor, includes block grants that would change the federal government's financial contribution to the states — Azar said it was "very positive" that the bill proposed "empowering states to run their budgets" because under the current system, "if the state comes up with more money, things just increase from the federal government," so states "don't always exercise the creativity or fiscal fraud and waste stewardship as if they own 100% of the money."

- **Open to raising the Medicare beneficiary age.** When asked about this by Sen. Bill Nelson, D-Fla., Azar said he'd "not voiced support for that" but admitted "that would have to be considered in the context of everything else" to "make sure Medicare is going to be sustainable for our beneficiaries over the long run."
- **Favors the Sunshine Act.** "Yes, I'm a big supporter of the Sunshine Act. … I think that transparency is extremely helpful."

The next step for Azar would be a full Senate vote, which the Senate Finance Committee is expected to vote to recommend, though at press time it had not done so. — *Roy Edroso (redroso@decisionhealth.com) with additional reporting by Richard Scott (rscott@decisionhealth.com)*

Compliance

New SAMHSA rule reduces required consent for substance abuse records

Appropriate sharing of records for patients with substance abuse disorders should be easier under a second final rule issued Jan. 3 by HHS and its Substance Abuse and Mental Health Services Administration (SAMHSA). But in some cases, the new rule adds some considerations that might mitigate the advantage.

Rules for handling patient records that include information on the patient's substance use diagnoses or services — often called "Part 2" records after CFR Title 42: Part 2, the relevant regulation — go beyond HIPAA standards. Previously, for example, providers handling such records had to get specific patient consent every time such records changed hands, including otherwise HIPAA-compliant transfers that took place after the provider made authorized release of them — that is, if the provider handed the records off to a hospital, another named consent would be required for the hospital to send them to a lab.

The Jan. 3 final rule, which goes into effect on Feb. 2, clarifies a proposed and a final rule from last January about letting providers and patients arrange consent that allowed appropriate downstream parties to handle the records, patients to specify what portions of their substance records they will authorize for release and what categories of downstream handlers they will allow to have them.

This rulemaking doesn't apply to many providers and transactions but, where it does, it may end some tedious reiterations of patient consent currently required, says Stephanie Gomes-Ganhao, a health law attorney at Shipman and Goodwin LLP in Hartford, Conn.

"Under the existing regulations, if a Part 2 program discloses Part 2 records pursuant to a valid patient consent for any purpose as specified on the patient consent — for example, payment to another entity [such as] a third-party payer — the third-party payer could not then re-disclose the records to its contractors without specific, written patient consent authorizing such a disclosure," says Gomes-Ganhao. But under the new rules, "the third-party payer is permitted to re-disclose the Part 2 records to its contractors if the purpose of that disclosure aligns with the purpose specified in the patient consent — in this case, payment," says Gomes-Ganhao. "In other words, the third-party payer's contractors need not be specifically listed on the patient consent form in order for the third-party payer to re-disclose the Part 2 records to them as necessary to carry out payment activities."

As for the patient's rights under the new rule, the provider must ensure that the purpose specified in the patient consent aligns with the purpose of the re-disclosure.

"If the provider received the Part 2 records pursuant to a patient consent that specified 'treatment' as the purpose of the authorized disclosure, the provider could not then re-disclose these records to the contractor for purposes relating to, for example, staff training without obtaining a valid patient consent that authorizes disclosure of the records for such purpose," says Gomes-Ganhao.

That provider would then need a new consent — though it could be specified to a category of third party, rather than to a named entity.

The final rule also has some minor adjustments, such as authorization of an abbreviated, 80-character notice

(continued on p. 6)

Benchmark of the week

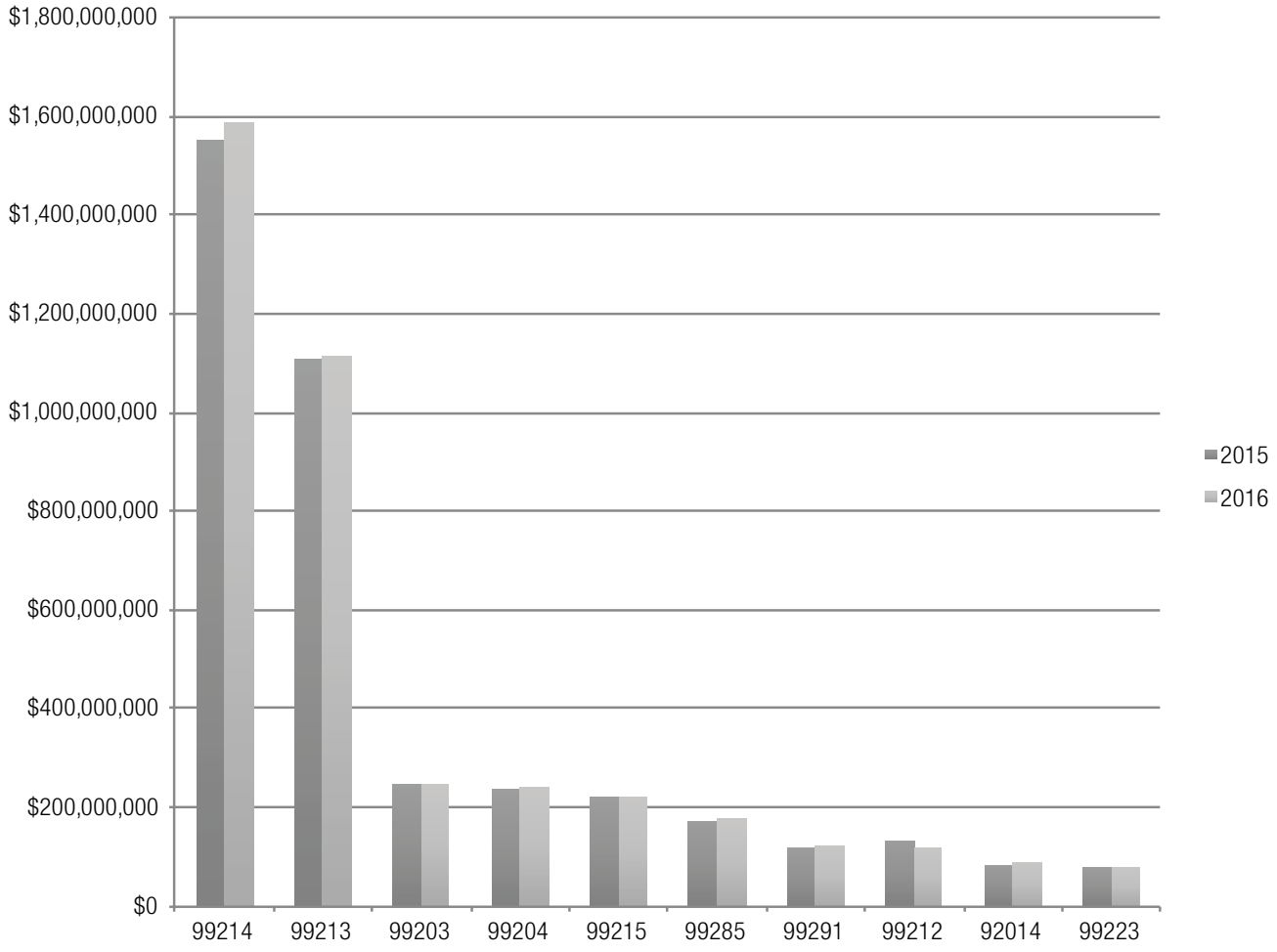
Specialists spread the love on modifier 25-appended E/M claims

Physician practices received significant payments — more than $4 billion — on 10 frequently reported E/M services performed the same day as a minor procedure or other service, according to a review of 2016 Medicare claims data, the most recent available.

The chart below shows the 10 E/M codes that, when appended with modifier **25** (Significant, separately identifiable E/M service), returned the most revenue in 2016. It also compares the same codes to 2015 numbers. Year to year, practices saw a 1.25% rise in total payments, buoyed by strong growth among established office code **99214** (2.2%), emergency department code **99285** (3.1%), critical care code **99291** (5.1%) and ophthalmologic service code **92014** (5.6%).

However, be warned: Payments tied to modifier 25-appended claims are on the chopping block under some insurance plans, and more carriers may follow suit (*see story, p. 1*). A change to modifier 25 payment policy would affect many specialties. For instance, internal medicine filed the most 99214-25 claims in 2016, but other specialists appeared as the most frequent billers of the codes below, including dermatology (**99213**), podiatry (**99203**), cardiology (**99204**), emergency medicine (99285) and ophthalmology (92014) (*see chart, p. 7*). — *Richard Scott (rscott@decisionhealth.com)*

Total payments for modifier 25-appended E/M services, 2015-2016



Source: Part B News *analysis of Medicare claims data*

(continued from p. 4)

of the Part 2 relevance of a document — "Federal law/42 CFR part 2 prohibits unauthorized disclosure of these records" — that can fit into free-text fields in the typical electronic health record (EHR).

Blowback on Part 2

Stakeholders are not entirely happy, though. *Politico* reports that The Partnership to Amend 42 CFR Part 2, a consortium of 39 organizations including the Blue Cross Blue Shield Association and the American Medical Group Association (AMGA), has complained that "continuing to separate patients' substance use disorder records from their medical records puts persons with substance use disorders at risk for unsafe, uncoordinated and uninformed treatment." But that seems to have as much to do with dissatisfaction with Part 2 as with dissatisfaction with this rulemaking.

"Providers should be on the lookout for additional rulemaking from SAMHSA," says Gomes-Ganhao, as the new rule hints heavily at the possibility of additional rulemaking for 42 CFR Part 2 and explicitly states that SAMHSA "plans to explore additional alignment with HIPAA." — *Roy Edroso (redroso@decisionhealth.com)*

Resource:

- Confidentiality of Substance Use Disorder Patient Records: *www.federalregister.gov/documents/2018/01/03/2017-28400/confidentiality-of-substance-use-disorder-patient-records*

Modifier 25

(continued from p. 1)

Anthem also announced it would reduce the 50% pay cut to 25% in all regions in which it plans to adopt the new policy, which includes the states of California, Colorado, Connecticut, Indiana, Kentucky, Maine, Missouri, New Hampshire, Nevada, New York, Ohio and Wisconsin.

The health insurer signaled that it considers many modifier 25-appended claims a duplication of services, according to an October network update that *Part B News* reviewed.

Despite the delay and the decrease in withheld payment, medical organizations continue to take umbrage with the policy that would reduce payments for two distinct services a physician provides to the same patient on a single date of service.

"It's a terrible idea," says Steven Thornquist, M.D., president of the Connecticut State Medical Society and a pediatric ophthalmologist in Waterbury, Conn. "I don't think you'll find any physicians to disagree with that."

Typically, a provider will report modifier 25 when an unexpected issue that demands attention occurs during a scheduled E/M visit. For example, let's say an autistic child presents for a 13-year-old wellness check. During the visit, the provider learns that the patient has an ear infection requiring a separate work-up. Under normal circumstances, a provider would gain reimbursement commensurate with the work performed for the two distinct services.

The proposed policy change would slice off a chunk of that payment, even though "the care the doctor is

providing is the same" as the care that would be provided on separate dates of service, says Matt Katz, executive vice president of the Connecticut State Medical Society.

The cuts, should they take effect, would affect providers across a range of specialties, including primary care and family physicians, says Howard Rogers, M.D., chair of the American Academy of Dermatology's patient access and payer relations committee and a private physician in Norwich, Conn. However, the cut may have a greater financial impact on specialists — such as dermatologists, otolaryngologists and ophthalmologists — who report "a higher percentage of cases" with 25, says Rogers.

Are modifier 25 cuts a trend?

In August, Independence Health Group implemented its own 50% reduction to modifier-25 appended claims (*PBN 8/7/17*). However, the reduced-pay policy of the relatively small Independence Health Group, which covers about 9 million people, may not instill the same foreboding among the provider community as the direction of Anthem, which covers about one in eight Americans.

The currently proposed 25% pay cut applies to all commercial plans in the 12 states mentioned above, plus contract renewals signed after March 1 in Georgia and Virginia.

Some providers worry that Anthem's long reach could result in something of a domino effect. "If Anthem gets away with it, more will do it," predicts Thornquist.

"I think it is going to be the trend now," says Terry Fletcher, CPC, president of Terry Fletcher Consulting in Laguna Beach, Calif. Fletcher believes the looming modifier 25 policy is the insurance market's reaction to situations "where physicians have been trying to get that extra office visit when it isn't warranted," such as a planned procedure without a separate work-up.

However, the policy may induce collateral damage. "It will hurt the practices using the 25 modifier correctly on new [and established] patient visits," says Fletcher. "This will be a huge revenue loss for many."

To date, many groups, including the AMA, the California Medical Association, the American Association of Dermatologists, the American Academy of Otolaryngology – Head and Neck Surgery and others, have aired complaints with Anthem and, in some cases, state insurance boards.

In November, the Connecticut State Medical Society sent a letter to the state's attorney general expressing concern with the proposed policy. That same month the AMA issued new policy at the Interim Meeting of its House of Delegates that would "aggressively and immediately advocate … that both the procedure and E/M codes are paid at the non-reduced, allowable payment rate," according to available records.

Opponents of the policy argue that reduced pay for modifier 25 claims will lead to poorer patient care by handcuffing physicians with a difficult proposition — treat patients during the same encounter and suffer lower pay rates or schedule patients to return for a follow-up visit and receive full payment.

"This is cost-cutting and makes the provider schedule two appointments instead of one to be paid properly," says Maxine Lewis, president of Medical Coding and Reimbursement in Cincinnati.

If pay cuts take effect, a "natural evolution" could occur, in which "providers start breaking up non-emergency appointments," says Rogers. However, that could compromise quality of care and result in a "loss of trust" in how patients view their physicians, he says.

What you can do

Practices in states that are on pace to be affected by the change may have little recourse, says Katz. Many practices in Connecticut have at least half of their patients under Anthem's coverage. In that case, "it would be very difficult to walk away," he says.

However, practices with fewer patients who have Anthem coverage may want to revisit their contracts and see whether it's worthwhile continuing to accept those patients. — *Richard Scott (rscott@decisionhealth.com)*

Specialists that billed the most modifier 25 claims, per code, in 2016

Code	Specialty #1	Specialty #2
99214	Internal medicine	Family practice
99213	Dermatology	Internal medicine
99203	Podiatry	Otolaryngology
99204	Cardiology	Otolaryngology
99215	Internal medicine	Family practice
99285	Emergency medicine	Physician assistant
99291	Emergency medicine	Pulmonary disease
99212	Dermatology	Podiatry
92014	Ophthalmology	Optometry
99223	Cardiology	Nephrology

Source: Part B News *analysis of Medicare claims data*

GPCI cuts

(continued from p. 1)

the annual sustainable growth rate (SGR) adjustment and created the Quality Payment Program, is a section establishing a 1.0 work GPCI floor. GPCIs are used as factors to determine provider reimbursement for each of the Medicare localities under the physician fee schedule. An index above 1.0 would lift provider payments, and an index below 1.0 would drop it.

The 1.0 floor expired Dec. 31, and the new indexes have gone below 1.0 in 52 states and/or metropolitan areas. The biggest losers are South Dakota, Oklahoma and parts of Missouri outside of Kansas City and St. Louis, all of which have seen 3.9% drops in their work GPCIs, according to a *Part B News* analysis of results from CMS' physician fee schedule search tool (*see chart, online at www.partbnews.com*).

That will lead to changes in fee calculations that will cost the losing localities. For example, Oklahoma providers who got $102.33 (non-facility, participating) for billing the level 4 E/M **99214** in 2017 will get $101.52 this year; **27447** (total knee arthroplasty) paid $1,327.69 in Oklahoma in 2017, but this year it's $1,316.06 (even though the total relative value units for that code went up in the 2018 fee schedule).

Watch Congress for fixes

Other CMS programs expired at year's end as well, including the therapy cap exception that lets therapy practices exceed Medicare's annual spending cap when medically necessary.

Congress was expected to fix both of these expired items at the end of last year with bipartisan "extenders" legislation (*PBN blog 12/11/18*). But in the rush to pass the tax bill and other business, they never got around to that and other budget measures.

Some experts tell *Part B News* they're confident lawmakers will make these fixes, perhaps by the deadline for the budget continuing resolution that would keep the government from shutting down Jan. 19.

"The current expectation is the extenders package would be included as part of the omnibus appropriations bill now scheduled for Jan. 19," says John Kelliher, managing director in Berkeley Research Group's Healthcare Policy and Reform group. "GPCI extension would be included in the Medicare extenders part of that larger bill." He says his clients are not concerned and believe Congress is "very likely to eventually act" on such a bill.

But Jennifer McLaughlin, senior associate director, government affairs for the Medical Group Management Association (MGMA), worries about the trade-offs because to pay for the extra government spending the readjusted floor and other such measures would represent, Congress is likely to demand cuts elsewhere.

"Two potential offsets on the table would, we feel, do more harm than good — expanding 2% sequestration on government spending including Medicare and extending the potentially misvalued codes initiative" established by the Achieving a Better Life Experience Act of 2014 (ABLE). That initiative pressures CMS to cut payment on codes it determines are overpriced — for example, the psychiatric codes the agency determined were misvalued in the 2018 physician fee schedule (*PBN 11/13/17*).

"These items are likely be bundled together with CHIP reauthorization and other expired programs," says McLaughlin. "These used to ride on the doc fix, but [since SGR repeal] it's harder for Congress to find a vehicle for that. Congress has sent mixed messages on what their priorities will be in the months before midterms — but the recent change in the CBO estimate on the cost of CHIP may be a factor." That report, issued Jan. 5 to Senate Finance Committee Chairman Orrin Hatch, R-Utah, finds that the repeal of the Affordable Care Act (ACA) individual mandate in the recent tax bill will, by making insurance premiums more expensive and parents more likely to be uninsured, actually make the CHIP program more cost-effective.

If Congress doesn't meet its Jan. 19 deadline, "they may go for a short-term fix and revisit later this winter," says McLaughlin.

There's a good chance that, assuming a fix gets done, the GPCI floor will be re-established retroactively, meaning providers in localities that lost money because of the MACRA expiration will get it back. Retroactive payment adjustments would "probably work the same way as they did in the days of the doc fix — and we would see the same sorts of challenges" for providers, particularly those running on thin margins who can ill afford to wait for back pay, says McLaughlin. — *Roy Edroso (redroso@decisionhealth.com) and Laura Evans (levans@decisionhealth.com).*

Resources:

- CBO letter on CHIP: *www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/s1827_1.pdf*

How did you get this email?

It is illegal to forward **Part B News Online** to anyone else.

It is a free benefit only for the individual listed by name as the subscriber. It's illegal to distribute **Part B News Online** to others in your office or other sites affiliated with your organization.

If this email has been forwarded to you and you're not the named subscriber, that is a violation of federal copyright law. However, **only the party who forwards a copyrighted email is at risk,** not you.

Reward: To confidentially report suspected copyright violations, call our copyright attorney Brad Forrister at 1-800-727-5257 x8041 or email him at *bforrister@blr.com*. Copyright violations will be prosecuted. And **Part B News** shares 10% of the net proceeds of settlements or jury awards with individuals who provide essential evidence of illegal electronic forwarding of **Part B News Online** or photocopying of our newsletter.