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The Business of Medicine

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MEDICARE RULES

Experts: CMS underwhelms with MIPS proposed rule

CMS has finally unveiled its vision for the future of Medicare's incentive programs in the form of the long-awaited Merit-Based Incentive Payment System (MIPS) proposed rule, released April 27. Experts are still breaking down its many provisions, but in this article *The Business of Medicine* will cover the highlights, which include more specialty-friendly quality measures, but not as much flexibility as many physician practices would have preferred.

"A lot was promised but not a lot was changed," says Bradley Coffey, MA, government affairs manager for the American Academy of Orthopaedic Executives in Indianapolis. "For example, the meaningful use program has a new name, but it's virtually unchanged." CMS has created a public fact sheet explaining the MIPS proposals, including new measures for quality reporting and meaningful use, that you can download in PDF format.

The payment adjustments under MIPS are slated to begin in 2019, though you may be affected far sooner, starting on Jan. 1, 2017, which is the beginning of the first MIPS performance period that will determine the 2019 payment adjustments. All providers who are enrolled in Medicare Part B will be subject to MIPS, with a handful of exceptions for those newly enrolled, those with 100 or fewer Part B patients and $10,000 or less in charges. There is also an exception for providers who are "significantly participating" in an Advanced Alternative Payment Model (APM). Unfortunately, many existing pay-for-performance programs, such as the Bundled Payments for Care Improvement (BPCI) and the Comprehensive Joint Replacement (CJR) programs, count as APMs, according to the proposed rule.

Note: A key requirement of the law that authorized MIPS is that MIPS must be budget-neutral with respect to the program's cost to Medicare. The table on page 3 shows the payment adjustment schedule established in the MIPS proposed rule.

(continued on pg. 2)

Year	2019	2020	2021	2022 & beyond
Positive adjustment*	4%	5%	7%	9%
Negative adjustment	Up to 4%	Up to 5%	Up to 7%	Up to 9%
*Positive adjustments can be less than or greater than the amount specified per year, based on budget neutrality needs				

Positive adjustments can be greater than the corresponding negative adjustment, and the law allocates a special $500 million fund for additional performance bonuses to providers for the first five MIPS payment years. This amount is exempt from budget neutrality to incentivize providers to perform as well as they can.

To determine whether a provider gets a positive, negative, or neutral adjustment, CMS will calculate a MIPS score based on four components, which are basically rebranded versions of Medicare's existing and ongoing incentive programs. Below is a breakdown of these four components and their contribution to a provider's overall MIPS score.

Quality Category (previously PQRS)

This component replaces the Physician Quality Reporting System or PQRS. It's the single biggest piece of the MIPS score, accounting for 50% of the score in 2019, the first MIPS payment year. In a major improvement for providers, the Quality Category **requires six quality measures to be reported, down from nine** in PQRS. In its official fact sheet, CMS promises "more than 200 measures to pick from and more than 80% of the quality measures proposed are tailored for specialists."

CMS is also proposing 23 preset measure sets that are designed for 23 different specialties, ranging from primary care specialties such as internal medicine and OB/GYN to highly specialized taxonomies such as thoracic surgery and plastic surgery. These measure sets simply replace the six-measure requirement and are an effort by CMS to respond to complaints that its quality programs cater only to primary care and leave specialists without clinically relevant measures.

Each measure set includes a combination of relatively familiar measures by the National Committee for Quality Assurance (NCQA), most of which are existing PQRS measures, and previously unused measures by the various specialty societies representing the 23 distinct specialties.

Advancing Care Information Category (previously Meaningful Use)

One of the most-touted CMS reforms has been the promise, by CMS Acting Administrator Andy Slavitt, to replace the meaningful use EHR Incentive Program. Meaningful use will indeed be gone, and replaced with the Advancing Care Information Category under MIPS. This category accounts for 25% of the MIPS score in 2019.

The biggest change is that this quality program won't be "all-or-nothing" like meaningful use, in which providers either attested successfully and received the entire incentive payment, or failed to meet all the necessary criteria, and received nothing.

Instead, the Advancing Care Information Category of MIPS gives providers a point score of up to 131 points based on the measures they report, all of which are adapted from existing stage 3 meaningful use criteria. Earning 100 points or more will grant providers the maximum 25 points possible for the Advancing Care Information Category, which adds to the overall MIPS score.

Clinical Practice Improvement Activities Category

This component covers a number of options such as care coordination, patient engagement, and patient safety. It's also an umbrella category for all manner of existing alternative payment programs, such as patient-centered medical homes and accountable care organizations. For 2019, this component is worth 15% of the total MIPS score. Each improvement "activity" is weighted with a different point score. CMS will prioritize certain activities as high or medium, though the specifics remain unclear.

Some of the proposed activities include:

- **Expanded practice access.** Same day appointments for urgent needs and after-hours access to clinician advice.
- **Population management.** Monitoring health conditions of individuals to provide timely healthcare interventions or participation in a QCDR.
- **Care coordination.** Timely communication of test results, timely exchange of clinical information to patients and other MIPS eligible clinicians or groups, and use of remote monitoring or telehealth.
- **Achieving health equity.** High quality healthcare for underserved populations including persons with behavioral

health conditions, racial and ethnic minorities, sexual and gender minorities, people with disabilities, people living in rural areas, and people in geographic HPSAs.

• **Emergency preparedness and response.** Eligible clinician or group participation in the medical reserve corps, registration in the Emergency System for Advance Registration of Volunteer Health Professionals, reserve and active duty military MIPS clinicians and group activities, group and clinician participation in domestic or international humanitarian medical relief work.

Cost Category (previously Value-based Modifier)

This category, also referred to as "resource use," replaces the existing Value-based Modifier (VBM) program and will account for 10% of the total MIPS score in 2019. Unlike the other three categories, the Cost Category is calculated by CMS based on Medicare claims data. Providers don't have to perform any separate submission process, according to the proposed rule.

To calculate cost score, CMS will use a methodology similar to the one created for the VBM. Also, CMS is proposing several episode-based measures, such as for inpatient treatment of hip and femur fractures. Patient claims with these diagnoses would trigger the episode, and the cost of the episode would be compared against benchmarks.

Closing thoughts

Overall, the MIPS proposed rule shows that CMS is listening to providers and offering more flexibility and customization for its incentive programs, but there's still much more room for improvement, the AAOE's Coffey says. "These are moves in the right direction. We appreciate that CMS has made changes with specialties in mind, but overall many of the provisions were created with primary care in mind."

The official public comment period ends on June 27 and you have until then to give CMS your feedback. The agency is required by law to review all comments, even though it may not necessarily respond to each in the final rule. To view submitted comments or to submit a comment to the proposed rule, visit *The Federal Register* page for MIPS.

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CODING

CMS to allow unbundling of shoulder debridement

Some orthopaedic specialists could see a significant financial benefit thanks to an upcoming CMS move to allow surgeons to separately bill an arthroscopic shoulder debridement procedure, *The Business of Medicine* has learned.

Specifically, CPT **29823** (arthroscopy, shoulder, surgical; debridement, extensive) has long been considered inclusive to other major arthroscopic procedures of the shoulder, such as **29824** (arthroscopy, shoulder, surgical; distal claviculectomy including distal articular surface) and **29827** (arthroscopy, shoulder, surgical; with rotator cuff repair).

This won't be the case starting on July 1, when CMS will revise the National Correct Coding Initiative (CCI) edits to make 29823 separately billable alongside the other arthroscopic procedures outlined above.

The edits have been in place because of the logic that for a major arthroscopic procedure such as a rotator cuff repair

or claviculectomy, surgical portals have already been made in the body, allowing additional, less comprehensive procedures such as debridement to be performed without removing the arthroscope and creating separate portals. It is currently possible to override the existing CCI bundling edit by appending modifier 59 (distinct procedural service) or the related subset modifier XS (distinct anatomical site) to the less comprehensive code, 29823. However, using these modifiers would indicate that the debridement was being performed at a different site on the body or in a separate session.

Now, CMS has accepted an argument made by the American Academy of Orthopaedic Surgeons (AAOS) that, from an anatomical standpoint, the shoulder "is technically three anatomic synovial joints and two articulations," and therefore the provider should be compensated for the work of performing the debridement without making a separate arthroscopic incision, according to an AAOS statement.

"This is a great win for orthopaedic patients and we are extremely pleased that CMS fully understood and adopted our perspective," AAOS President Gerald Williams, Jr., MD, wrote in a letter to Reps. Tom Price, MD (R-GA) and John Barrasso, MD (R-WY), both of whom worked with the AAOS to advocate for the changes. The AAOS, along with other orthopedic surgery groups, have been pushing for this change since 2010, sending letters and requesting face-to-face meetings with federal officials.

Whether your practice performs these procedures or you're a coder or auditor, this represents a significant billing and coding change – but you must remain vigilant with regards to documentation. Even though the debridement is now separately reportable, the operative note must still clearly indicate that the debridement was carried out, including all the usual documentation requirements including the type of surgical tool used, any anesthesia used, amount of tissue removed, patient tolerance, etc.

Look for these changes to appear in the next CCI version 22.2 at the CMS NCCI page. The CCI edits are updated quarterly.

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PRACTICE MANAGEMENT

Finding a realistic mindset for selling your practice

The doors to your new practice are open. The many sleepless nights, the blood, the sweat, and the tears are all distant memories as you take a sigh of relief because finally you have turned the corner: You have gone from the practice start-up phase to running a successful, functioning medical practice. Your dream is now officially a reality. As the years go by and you build a great reputation in the community, suddenly you face a new phase of practice ownership; you're ready to sell your practice.

You're a few decades more mature than when you started, which you anticipated, but you're facing a stark new reality that couldn't be anticipated. Instead of having a multi-million-dollar practice that any doctor in the market would be crazy *not* to purchase, the "professionals" tell you that your practice is worth about 10% of what you expected. It practically comes down to the value of the exam chairs, the waiting room furniture, and the medical equipment.

What? How did this happen? Is this a valid assessment of the financial worth of your practice, of decades of hard work? This can't be! Sadly, this is an all too common scenario. Most physicians do so many things "right," but simply forget to plan ahead for a transition of their practice sometime far off in the future. There is good news. Much like the days when you were a student, and you could control whether you received a "C" grade or achieved an "A," you have control over your practice transition.

What can you do to continue the dream? The following tips can you receive the maximum value on the sale of your practice and gain the sense of satisfaction of knowing that the many years of hard work and sacrifice were worth every moment.

1. Don't relax the last few years. If you are nearing retirement, don't "coast" during those last few years by taking more days off or seeing fewer patients per day. The last few years are actually the most crucial, and can greatly impact the price a buyer will pay for a practice. Lower revenues and profits can completely wipe out the brand name and goodwill that you have spent your entire career building.

2. Remember – the buyer is buying a business, not a job. Many physicians assume that, if they took home

$800,000 in wages and profits from the business, its value should be based on that amount. But how much of that $800,000 were wages? Specifically, how much of the $800,000 would be wages to hire a replacement at fair market value? If it cost $650,000, then the actual profit from the practice to base the sale value on would be $150,000. This is one of the biggest mistakes physicians make when estimating the value of their practice. Unfortunately in many cases, this mistaken belief causes a discrepancy of millions of dollars from what a doctor thinks a practice should be worth versus what it actually is.

3. Don't just look at the normal buyers. Don't rule out the option of searching for an individual buyer or smaller groups to buy your practice, especially if you have a smaller office. Most physicians automatically assume that the best buyer is a hospital or large group practice, and in many cases, this might be the best option. However, it's not always the case, and a complex series of variables must be considered, including the local market, your specialty, your payers, and the demographics of your patient population. Many physicians feel they have to sell to a larger entity because no one else is willing to buy, when the reality is that a diverse array of buyers likely exist.

4. Think practice transition, not practice sale. This is especially true if you know you are going to step aside or retire in the next five years or so. Find someone early and transition the practice to them. This helps stability and value.

5. Seek help and seek it early! Specifically, at least three to five *years* before you are looking to sell, seek experienced help so you have the time and expertise to best position your practice for sale. Much like a realtor showcases a home at an open house, expect to "show" your practice to potential buyers. Remember, your challenge is to begin planning a few years in advance on the ways you will position and prepare your practice so that it will be optimally attractive to potential buyers.

DoctorsManagement has the experience and expertise to help you through the entire process, one that will ensure you find the right buyer and get maximum value for your practice. Why not contact us to see if you are positioning yourself correctly? We would be happy to answer any questions and you can contact us any time via my email below.

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COMPLIANCE

CMS to require uniform use of modifier JW for discarded drugs

All physician practices, regardless of their location or Medicare Administrative Contractor (MAC), will soon be expected to follow standard Medicare billing and documentation rules in order to get paid for the portion of an injected drug or biologic that was not administered to a patient. The change, detailed in Transmittal 3058 to the Medicare Claims Processing Manual, bcomes effective July 1.

The requirements are intended to standardized billing and accountability for discarded drugs across Medicare, rather than rely on a hodge-podge of MAC-specific requirements that can vary by location.

How to bill for discarded drugs

Once the policy is implemented, providers will be required to attach **modifier JW** (drug amount discarded/not administered to any patient) to the J-code for any drug that is not actually administered *except* when the drug is acquired as part of a competitive acquisition program (CAP).

Previously, use of the JW modifier was at the discretion of each individual MAC. The policy applies to single-use vials and any other type of single-use package.

When there are discarded drugs or biologics, this means the claim for the drug would need to have two lines just for the drug. One line would include the code for the drug and the amount that was administered to the patient. The second claim line would include the same code, the amount of the drug that was not administered to the patient, and the JW modifier.

Medicare will pay for the unused portion of the drug at the same rate as the amount that was actually administered.

In addition, and this is a critical point for the provider who actually administers the drug and documents the administration, the amount of the drug that is not administered during the visit **must also be documented in the patient's medical record** for that encounter.

The practice would not use the JW modifier on a separate claim line in an instance where the billing unit represented

by the code is the full amount of the drug that is in the single use vial or container.

Clinical examples

Let's consider an example of a drug where a single-use vial contains 10 mg and one unit of the HCPCS code for the drug is equal to 10 mg. In this scenario, the provider would bill only for one unit of the HCPCS code, regardless of whether any was discarded.

Suppose 7 mg of the drug was administered and the other 3 mg was discarded. If the provider were to bill a second claim line for the discarded drug with the JW modifier, in this instance, it would result in an overpayment if the MAC paid both lines of the claim, because each payment would be for 10 mg of the drug, or 20 mg, when only 10 mg was actually used during the encounter.

Even in these situations, we recommend that your provider document how the drug was used, both the amount administered to the patient and the amount discarded. The only difference would be that only one unit of the appropriate J-code would be billed.

Providers should use the time between now and July 1 to familiarize themselves with these concepts and transition to these new stringent requirements on billing for drugs and biologics administered in the office.

Note: For some providers, their MAC already has these relatively strict requirements in place, so they won't face any change. Many others will need to adapt. Even if the MAC doesn't currently require the JW modifier to be appended for discarded drugs and biologics, its payment system should be set up to process these claims ahead of the July 1 implementation date.

Groups should also require clinicians who inject drugs into the patients to begin to document the amount of the drug discarded into the clinical note, then self-audit some of these services ahead of the July 1 implementation date.

MACs will typically pay the claims based on how the JW modifier is being used on the claim itself, but a MAC audit that uncovers the drug wastage not being properly documented in the medical record could result in a substantial repayment demand, especially given the high per-unit prices of many injectable drugs.

Multi-use vials are not subject to the JW modifier usage policy or to payment for any wastage, as it's expected that the drug would be used on subsequent encounters with the same patient or a different patient.

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5 techniques to improve patient collections

Patient collections continue to be one of the most difficult, yet most controllable aspects of the medical practice revenue cycle. Having helped countless practices improve their revenue cycle, we know at DoctorsManagement that asking for money from patients can be the scariest part of your job, depending on how passive or aggressive you are.

While collecting monies from insurance carriers isn't always easy, collecting from patients can be uniquely challenging from a business, personal, and even emotional standpoint. Asking for money can be awkward and is never easy, but it's an absolute necessity. Failure to ask for money that a patient owes could lead to a breach of your participation agreement with payers or even a False Claims Act violation.

In this article, we'll cover some proven techniques to boost patient collections. Before we start, let's make one thing clear: *Many patients believe their coinsurance is optional.* Many patients also believe that your physicians – all physicians – make enough money that an extra $20 or $30 bucks won't hurt them.

At the same time, this problem doesn't seem to exist when it comes to collecting cash for cosmetic services that they've begun to offer more and more in the last few years to create ancillary revenue. For example, there are OB/GYN practices that now offer weight management and laser hair removal or skin resurfacing. These services are completely non-covered, cash-first affairs, yet practices rarely have a problem collecting before any service is rendered. Often, the patients who are lined up to pay cash for these cosmetic services are the same patients who complain when asked for their $20 coinsurance or their $250 deductible for actual covered services.

With all that said, let's review some actual techniques for collections:

1. Be assertive with your patients. For example, use a sales technique called "assuming the sale." This can be scripted for your office staff: "Mr. Patient, you have a coinsurance of $25 for today's visit. How would you like to pay – cash, check, or credit card?"

2. Don't give patients the option to defer payment. Asking questions like "can you pay today?" should be actively discouraged. If a patient can't pay during the visit, you can offer a payment plan or follow up per your policy, but you have to filter for paying patients first.

3. Never insult your patients. Being assertive doesn't mean being rude, and rudeness can be non-vocal. Encourage your front office staff to be polite, pleasant, and friendly – but assertive and firm when asking for payment.

4. Educate your patients on the importance of paying their coinsurance and/or deductible amounts. They need to know that their insurance company expects them to do their part when it comes to coinsurance and deductibles. Explain the

difference between copay (which are a fixed flat amount and paid whenever a specific type of service is used) vs. coinsurance (usually a percentage and applied even after the deductible is met).

5. Provide all new patients with a policy brochure that outlines your practice's policies, including whether you offer payment plans and, critically, your policy for dismissing patients for non-payment. You need to be clear that there will be eventual consequences for non-payment, while also being clear that your physicians would never discriminate or abandon patients who need urgent care.

Remember, you can't allow patients to dictate how your practice is run. Allowing bad behavior will encourage future bad behavior.

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