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# The Business of Medicine

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CONGRESSIONAL ACTION

## Trump says ACA repeal may take a year; Price confirmed for HHS

The repeal and replacement of the Affordable Care Act (ACA) could take up to a year — a sudden, significant departure from President Donald J. Trump's earlier assertion, made just last month, that it would only take a matter of weeks.

In an interview with Bill O'Reilly of Fox News, Trump was asked whether an ACA replacement would arrive in 2017 and replied "yes, in the process and maybe it'll take till sometime into next year but we're certainly going to be in the process."

Trump had previously stated that the repeal and replacement of the ACA would be "essentially simultaneous" and that it would occur in the weeks following the confirmation of his pick for HHS Secretary, Rep. Tom Price (R-Ga.).

The extra time could be just what Republicans need to regroup. While an ACA repeal was an easy campaign promise, it has clearly turned out to be a difficult exercise in governing, says Bradley Coffey, government affairs manager for the AAOE in Indianapolis. "I think really this is the president trying to take some heat off of Congressional Republicans for the moment."

Though Trump's latest statement was vague, practice managers welcomed the news. "This change to at least a year makes a lot more sense to me, as a practice administrator," says Barry Hubert, CMPE, COPM, administrator at Blue Ridge ENT in Boone, N.C. and also president-elect of the AOA. Trump's promise to deliver a comprehensive ACA replacement within weeks had been viewed skeptically by many in the healthcare industry, Hubert says.

### Reality hits for GOP lawmakers

The obstacles to Trump's original plan materialized clearly in Congress, with Republican members in both chambers acknowledging the stakes. If the repeal-and-replace is botched in a way that destabilizes insurance

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markets and leaves Americans without coverage, "Republicans will own it lock, stock and barrel, and we'll be judged on that," Rep. Tom McClintock (R-Calif.), said during the GOP's annual retreat in Philadelphia on Jan. 27.

That date, Jan. 27, had been set by Republicans as an informal deadline to pass a repeal bill, but the day came and went without action. The key stumbling block is the lack of any consensus plan, Coffey says. While Republicans have campaigned on repealing the ACA, and several have offered replacement legislation, there is no single replacement program ready to go.

Republicans are also facing increased resistance to a wholesale repeal that would cause many to lose coverage. At town halls across the country, several Republican Congressmen faced scores of constituents angry at the prospect of suddenly losing their health insurance coverage, and were shouted down as they tried to answer questions about the ACA repeal.

Trump's earlier statement about a fast repeal-and-replace was seen as torpedoing earlier plans by Republicans to quickly pass a repeal-only bill that would tack on a two or three-year effective date to claim credit for a repeal while giving Congress, HHS, and industry stakeholders time to converge on a comprehensive, detailed replacement program.

As we reported in the January issue of *The Business of Medicine*, Republicans would also need at least several Democratic votes to pass a true ACA replacement; while the reconciliation rules can be used to defund and effectively repeal the ACA with a simple majority, those rules can't be used to pass the replacement. Trump's latest statement could buy valuable time to try and win Democratic support; the window of one year and change could signal a shift back in the direction of a repeal bill with a replacement program to come later, experts believe.

## Tom Price confirmed for HHS

The ACA repeal effort has received a boost with the successful confirmation of Rep. Tom Price (R-Ga.) as HHS Secretary, albeit under a party-line, 52-47 vote in the Senate. Price, a former orthopaedic surgeon, is seen as being well-versed in healthcare policy, having authored a comprehensive bill to replace the ACA called The Empowering Patients First Act of 2015 (H.R. 2300). Price, a staunch conservative, has received a mixed reception from physicians, though the AMA was quick to endorse his nomination.

Price's legislation (see related story, pg. 5) has been held up as a basis for the eventual Republican ACA replacement, but it did not include a delayed effective date or much in the way of measures to facilitate a stable transition from the current ACA.

With the extra time afforded to Republicans based on Trump's latest statement, Price's plan may no longer be as crucial as it was. His legislation would drastically reduce subsidies by replacing them with age-based tax credits. It would also reverse the ACA's Medicaid expansion in favor of conservative models such as those launched by Seema Verma, a healthcare consultant that Trump has tapped to head CMS. Verma will begin her confirmation hearings with an appearance before the Senate Finance Committee on Feb. 16.

Whatever Republicans decide on, they will need to act quickly to stabilize markets and reassure insurance companies that still have ACA plans in effect, experts say. Already, many insurers are fleeing the individual market to avoid losses should a repeal bill pass that would eliminate current federal subsidies for low-income beneficiaries.

### Next steps in Congress

The House Energy and Commerce Committee has been working with the non-partisan Congressional Budget Office (CBO) to craft elements of an ACA repeal bill that it hopes to introduce on March 1. House Speaker Paul Ryan (R-Wis.) has said that he wants to pass repeal legislation in the first quarter of 2017, which would give lawmakers until the end of March.

At this point, it's not clear whether a repeal bill introduced in the House of Representatives would deliver on President Trump's promise of a replacement to go along with the repeal, though if the GOP meets the March 1 deadline, it would be well on its way to satisfying Trump's ambiguous "sometime next year" goal for fulfilling the ACA repeal-and-replace promise.

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## Breaking news: CMS extends meaningful use deadline for 2016

You now have until March 13 to register and attest to meaningful use for the 2016 program year, a task you must perform in order to avoid a Medicare payment penalty in 2018. CMS had previously set at deadline of Feb. 28, so practices are only getting two extra weeks, but the additional time could make the difference for some groups.

Providers face a 3% Medicare payment penalty in 2018 if they failed to attest by March 13, 2017. Many in the healthcare industry had complained to CMS that they needed more time to prepare their attestations when the agency suddenly announced that the 2016 reporting period was being reduced to 90 consecutive days instead of the full calendar year. CMS only made the announcement in November 2016, giving practices little time to prepare.

About 171,000 eligible providers failed to attest for the 2015 reporting period, and are seeing a payment penalty that took effect Jan. 1, 2017, CMS reported in a recent release.

CODING GUIDANCE

## 5 tips for billing E/M visits with same-day endoscopies

We often see the routine, casual use of modifiers with E/M codes on a claim that already contains a procedure code on the same date. Among the most common of in-office procedures are endoscopies, particularly though not exclusively for otolaryngologists. We at DoctorsManagement also know that payers are getting tougher and tougher on E/M codes being billed the same day as minor, in-office procedures. They are continuing a longstanding effort to bundle as many services as possible, and it's important that physicians, coders, and billers understand how to get paid for the extra work they do in these scenarios without falling afoul of bundling audits.

The most common endoscopies ENT providers are likely to consider billing an E/M with are nasal endoscopies (e.g. CPT **31231**), laryngoscopies (e.g. CPT **31575**), and less commonly, nasopharyngoscopies (CPT **92511**), says Teresa Thompson, CPC, president of TM Consulting in Carlsborg, Was. Given how frequently these codes are reported alongside an E/M code, the ENT provider's documentation becomes crucial, says Thompson, who specializes in ENT coding and compliance.

This is because Medicare and most private payers classify these types of endoscopic procedures as minor surgical procedures and assigns zero global days to these codes. Thus, according to Medicare's National Correct Coding Initiative (NCCI) edits, the typical pre- and post-service work associated with the injection are considered to be part of the payment for the procedure itself.

To report the E/M, providers must append modifier 25 (**significant, separately identifiable evaluation and management service** by the same physician or other qualified health care professional on the same day of the procedure or other service) to the E/M code. The use of modifier 25 is a perennial favorite of payer auditors when they review E/M services, Thompson says.

Here are five tips to ensure your ENT providers are using modifier 25 properly, and getting paid when their E/M services truly are separately reportable.

**1. Document need for scope.** Payers expect physicians to first use the indirect mirror exam, and only resort to the more invasive endoscope when the mirror exam isn't working.

Providers must document why the scope is needed on top of the mirror, Thompson says. All it takes is a simple explanation such as "can't visualize problem with mirror" or "patient has gag reflex, unable to tolerate mirror," she says.

**2. Don't repeat the same verbiage.** Don't repeat the same language for each note when it comes to the rationale for the endoscopy. For example, if the provider tries to save time by writing "can't visualize" on every note, this can look suspicious to auditors who may interpret it to be note cloning, Thompson says.

**3. Established patients make modifier 25 harder.** Often, an ENT provider's note will begin with a statement like "patient is 3 months past thyroid cancer needs to be scoped." This is problematic because it suggests the endoscopy was planned, and the provider knew that the patient was coming in for the procedure. If a procedure is planned, and the problem requiring the procedure has been previously evaluated and managed, there is no case to support a separate E/M code for the visit

**4. New patients more easily support modifier 25.** Most endoscopies are diagnostic in nature, which means it's easier to support modifier 25 and a separate E/M for a new patient, Thompson says. With a new patient, the E/M can be supported on the grounds that the provider had to first evaluate the patient's problem (which is new to the provider) before deciding that an endoscopy was necessary, but this picture must be painted by the documentation, she says.

**5. Significant or separate?** A good rule of thumb is to ask whether the E/M code is addressing something significant or separate. You only need to satisfy one of these key requirements. The E/M is significant if it describes work that goes above and beyond the typical pre-op and post-op work associated with the procedure (for example, it's more complex due to comorbidities). The E/M is separate if it describes work that addresses a problem separate from the problem being addressed by the procedure (for example, a hearing problem managed in the same visit as a throat problem).

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**LEGISLATIVE ANALYSIS**

## Could Tom Price's bill be the ACA's successor?

Tom Price, a former orthopaedic surgeon and now a former Congressman, has been confirmed as HHS Secretary, a role that gives him tremendous power over how a replacement to the Affordable Care Act (ACA) is implemented. Secretary Price will also shape the future of Medicare and Medicaid, and the extent to which HHS and CMS will support ongoing

transitions ranging from electronic health records (EHRs) to the ICD-10 diagnosis code set.

In 2015, then-Congressman Price introduced the Empowering Patients First Act, which is now seen as a likely blueprint for the eventual Republican replacement for the ACA. While there is no consensus around any replacement legislation, President Donald J. Trump has stated that the push for repealing and replacing the ACA will begin in earnest after Price's confirmation, says Bradley Coffey, government affairs manager for the AAOE in Indianapolis. "He's always said he would wait to push on the ACA until after Price gets in, and that could mean Price's plan is where they want to start from."

Though it seems clear that Republicans will want to tweak Price's plan, starting with measures to ease the transition away from the current ACA, and by adding a possible implementation delay, much of the Price plan follows longstanding conservative policy prescriptions.

## The Price plan analyzed

The Empowering Patients First Act is 242 pages long and is one of the most thorough replacement bills authored by Republicans. Here's a breakdown of its key provisions:

- **Weakens the preexisting conditions clause** which prevents insurers from charging higher premiums to cover patients with preexisting conditions. Price's plan maintains this requirement, but it does allow higher premiums for individuals who have not maintained continuous coverage (defined as 18 months of continuous insurance).

- **Completely eliminates the Medicaid expansion** that has played a significant role in reducing the number of uninsured Americans. Price's plan offers no replacement for this expansion.

- **Reduces employer-tax exclusion for insurance**. This is a significant move, because the ACA currently does not tax health benefits, which causes the federal government to miss out on an estimated $260 billion in tax revenue. Price's plan limits the employer-tax exclusion to $8,000 for individual plans and $20,000 for family plans, which is likely to be highly unpopular with Americans who currently obtain coverage through their employer. This measure will make such plans significantly more expensive, though some employers may decide to be more generous and simply absorb the cost.

**New DoctorsManagement clients**

| Client | Services provided |
|---|---|
| Ophthalmology practice, CO | Practice assessment |
| Endocrinology practice, SC | Practice assessment |
| Primary care practice, LA | Practice assessment |
| Orthopaedic practice, KY | Practice start-up due diligence |
| Plastic surgery group, FL | Financial projections |
| Dermatology group, SC | Practice assessment |
| Nephrology group, FL | Financial projections |
| OB/GYN practice, AL | Practice start-up |
| Urgent care group, TX | Managed care |
| Hospital, GA | Compliance audit |
| Health system, GA | Compliance audit |
| Family practice, GA | HR consulting |
| Gastroenterology group, TN | CLIA start-up and consulting |
| Women's healthcare group, NC | CLIA start-up and consulting |
| Health center, MO | OSHA/HIPAA training |
| Dental practice, TX | OSHA/HIPAA training |
| 27 new NAMAS memberships, 30 membership renewals, 4 new power buying clients | |

• **Eliminates the ACA's individual mandate** that all Americans must be insured or pay a tax penalty.

• **Funds a high-risk pool, but offers little cash** for it. The Price plan would assign $3 billion to a high-risk pool for patients with significant preexisting conditions to help them afford coverage. This amount is far less than other Republican proposals, such as Speaker Ryan's Better Way plan, which would put $25 billion toward high-risk pools (adding $2.5 billion per year to reach $25 billion over 10 years).

• **Replaces the ACA's income-based subsidies** to help Americans obtain plans with an age-adjusted tax credit to mitigate the cost of premiums. Those ages 18-35 would get $1,200 in credits while those ages 51 and up would get the highest amount, $3,000 in credits. Thus wealthy Americans would receive the same amount of help that poor Americans do if they are the same age.

• **Eliminates required benefits for all plans**. The ACA includes an "essential health benefits" list that all plans must meet at a minimum, including items such as preventive care, mental health services, pediatric care, and maternity services. The Price plan eliminates any such requirement, which would allow insurers to offer bare-bones plans with much lower premiums.

### A cheaper plan, but certain to see changes

Price's plan is far less costly than the ACA, but offers far fewer benefits. Price's fellow Republicans in Congress are particularly unlikely to stomach a complete elimination of the ACA's Medicaid expansion. In fact, Vice-President Mike Pence, in his previous role as governor of Indiana, took advantage of federal Medicaid expansion dollars to fund a conservative reform of Medicaid that emphasized health savings accounts to expand coverage. Pence chose Seema Verma, a healthcare consultant who is now Trump's nominee for CMS Administrator, to lead that Medicaid reform effort.

Thus some version of the Medicaid expansion is likely to be tacked on to Price's plan and be a part of the legislation that Republicans ultimately attempt to pass.

Price's provision to limit the employer-tax exclusion may be even more controversial with Republicans, who could see it as a tax on businesses. The provision makes the Price plan much less costly, and will please deficit hawks in Congress, but it is unlikely to be popular with most Americans who get their health insurance through their employer.

*The Business of Medicine* will continue to analyze Republican legislative efforts to replace the ACA as more information becomes available over the coming months.

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COMPLIANCE

## 9 top OIG physician audit targets in 2017

Next year, you'll need to pay particular attention to your Medicare meaningful use attestation data, your providers' Medicare credentialing, compliance with the "two-midnight" rule, and more, according to an analysis of the 2017 HHS Office of Inspector General (OIG) Work Plan by *The Business of Medicine*.

Below is a preliminary overview of the top nine OIG audit targets that impact physician practices in 2017.

**1. Medicare EHR bonus payments.** CMS has doled out more than $20 billion in EHR incentive payments to physicians and hospitals. The OIG wants to intensify efforts to ensure that these payments went out to eligible providers and organizations that actually attested properly. The OIG will review CMS data on its incentive payments to "identify payments to providers that should not have received incentive payments (e.g., those not meeting selected meaningful use criteria)." The OIG also states that it will review all long-term plans by CMS to ensure accurate payments over the life of the meaningful use program. If your practice has received meaningful use payments, it may be a good idea to have your attestation data and records stored in one place in case you are subject to a CMS or OIG meaningful use audit.

**2. Review of physician and other provider enrollment.** This audit target is a recurring one for the OIG and means that the agency will verify that your physicians and non-physician providers (including physician assistants and nurse practitioners) are properly enrolled in Medicare. Because Medicare's enrollment process can be complex, it's a good idea to sign into the Provider Enrollment, Chain and Ownership System (PECOS) to verify that your providers are fully credentialed and don't have any outstanding issues, such as a

revalidation request (CMS requires all providers to revalidate their enrollment with Medicare every few years).

**3. Payments for nebulizers and related drugs.** An OIG review of Medicare payments for nebulizer machines and related inhalation drugs found that at least 50% of claims were improperly paid. Given the potential scope of the improper billing, the OIG will be reviewing claims for nebulizers and related drugs in 2017 to determine if documentation exists to fully support medical necessity.

**4. Effects of the "two-midnight" rule.** The OIG wants to see whether hospitals are properly following the two-midnight rule implemented by CMS Oct. 1, 2013, to ensure that inpatient and outpatient payments are being properly made. The rule established inpatient payment as appropriate if physicians expected patients to last at least two midnights, other outpatient payment would be appropriate. While hospitals are the chief target, any physician who performs admissions should also pay heed to this target, since it's their documentation that will be reviewed.

**5. Comparison of provider-based vs. freestanding clinics.** OIG wants to see whether services billed under provider-based place of service (POS) codes such as POS 11 for office/outpatient are actually being rendered in free-standing settings, such as ambulatory surgery centers (ASCs). Because provider-based POS codes boost payment by factoring in greater overhead associated with professional services, they pay more for the same CPT codes. This could lend itself to abuse. Make sure your providers use the proper POS code (POS 24) when billing for services in the ASC setting.

**6. Prolonged services.** When an E/M service far exceeds the typical visit time associated with the level of service, prolonged service CPT codes (**99354-99357**) may be billed with proper documentation. OIG will be reviewing claims for prolonged service codes to ensure that the services are medically necessary and that documentation requirements (including face time with patients) are being met.

**7. Payments for orthotic braces.** Medicare payments for orthotic braces, including back and knee braces, have more than doubled since 2009; some types of knee braces have seen their payments triple in that time. OIG will take aggressive action to determine whether these payment increases are substantiated. OIG will compare Medicare payments for these braces to payments by private insurers to assess the scope of any possible wasteful spending.

**8. Necessity and documentation for orthotic braces.** This audit target explicitly calls for the OIG to review Part B payments for orthotic braces, looking for medical necessity to be supported by documentation. The OIG believes that some DMEPOS suppliers are billing for unnecessary services, including patients receiving multiple braces, and cases where braces were billed for patients who were not seen by the referring physician.

**9. Part B payments for chiropractic services.** Medicare Part B only pays for chiropractic manual manipulation of the spine to correct subluxation if there is a neuro-musculoskeletal condition that is covered. Chiropractic maintenance therapy is not covered because CMS has determined it does not meet medical necessity. OIG believes maintenance therapy is occurring in some cases where chiropractic manipulation is being billed. OIG inspectors will be reviewing claims to ensure compliance with the above policy.

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