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ACCOUNTING

How taxes impact mortgage interest

After remaining at historic lows for many years, interest rates are on the rise. While the upward move still keeps most mortgages below 4%, many people are refinancing before rates go any higher. With this increased activity and the recent upswing in new home sales, we thought it would be a good time to go over the tax ramifications of a home mortgage. Below we will discuss the current tax law as it relates to mortgage interest. Please note that the Trump administration has vowed to change our tax laws, and thus significant changes could be possible that may modify our guidance.

To be able to deduct mortgage interest, a taxpayer's itemized deductions (the largest of which are mortgage interest, charitable contributions, and state taxes) must exceed the standard deduction amount. If all of a taxpayer's itemized deductions do not exceed the standard deduction (currently $6,350 for single or $12,700 for married filing jointly), then the taxpayer would simply deduct the standard amount.

Assuming your itemized deductions exceed the standard amounts above, then we need to look at what qualifies as mortgage interest. To bore you with some tax code, Section 163(h)(3) allows a mortgage interest deduction for:

i. Acquisition indebtedness with respect to any qualified residence of the taxpayer, or

ii. Home equity indebtedness with respect to any qualified residence of the taxpayer

So long as the debt was used to acquire your qualified residence or is home equity in your qualified residence, you should be able to deduct it. Simple, right? As with anything in tax, there are some limits. First, what is a qualified residence? Usually, this will be your principal home and possibly a second residence. Both must have sleeping, cooking, and toilet

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facilities. This sometimes means it can be a boat or house trailer as long as you spent 14 days there or did not rent it out.

For married individuals, the aggregate amount of acquisition debt cannot exceed $1 million (half that for single taxpayers). This is debt incurred when acquiring, constructing or substantially improving the property. For example, if you and your spouse buy a $950,000 home and mortgage $750,000 of the purchase price, that interest is deductible. If, however, you and your spouse purchase a beach home in addition to that home, and it has a value of $950,000 and another mortgage of $750,000, then you have exceeded the $1,000,000 limit. In that case, only a pro rata portion of the total mortgage debt would be deductible. You have $1.5 million of debt but are limited to only a deduction on $1.0mm, so 2/3rds of your mortgage interest is deductible.

The above is an example of debt incurred when purchasing a home, but home equity loans are very common and can occur many years after a purchase. In the case of home equity loans, interest is only deductible on up to $100,000 of debt (again, half that for single taxpayers). In most cases, the two limits are combined allowing for a deduction on interest of up to $1.1 million. The easy take-away is this, if your mortgage is greater than $1 million, expect to have some of that deduction limited.

Many homeowners refinance their mortgages before their original loan is paid off. This can make financial sense for a number of reasons, but there is one big caveat when it comes to the interest deduction. The loan cannot exceed the original cost of the home plus improvements. For example, let's assume you bought your home in 1990 for $300,000 and mortgaged $250,000. Then again in 2010 (10 years before the 30 year mortgage is paid off), you decide to refinance, but surprise, your home is now worth $600,000 and the bank will let you refinance up to $400,000. Because the $400,000 exceeds the original purchase price, some or all of the mortgage interest deduction may be limited.

As with all areas of the tax code, there are a number of exceptions and limitations. The bottom line is to discuss with your tax advisor any major financial decisions surrounding mortgages BEFORE you take action. There may be ways, with proper planning, to avoid a tax surprise.

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CONGRESSIONAL ACTION

ACA repeal revived with passage of House bill

House Republicans have resurrected their efforts to repeal the Affordable Care Act (ACA), making compromises to earn the votes of their more conservative members to pass the American Healthcare Act (AHCA) May 4.

Republican members of the House of Representatives, under pressure from President Donald J. Trump to make progress on one of his central campaign promises, eventually agreed to change the AHCA by making the bill less like the ACA, stripping away more of its provisions. While its passage is a success for those who favor repeal, the Senate is guaranteed to produce a drastically different bill, and both chambers must agree on a final bill. "Whatever comes out of the Senate, it's not going to be

like the final House bill that passed," says Bradley Coffey, government affairs manager for the American Association of Orthopaedic Executives (AAOE) in Indianapolis.

The AHCA contains two key changes from its original version that were needed to win over more conservative members in the House: Allowing states to opt out of the pre-existing conditions requirement, and allowing states to reduce the minimum required benefits package for any insurance plan.

Here's a full list of provisions in the bill that now sits before the Senate:

- **States' choice on pre-existing conditions.** States can choose to allow insurers to charge much higher premiums for patients with pre-existing conditions. The first version of the AHCA banned higher premiums and did not give states a choice, exactly like the ACA. Even if states opt to keep the pre-existing conditions measure, the AHCA has a crucial caveat that allows higher premiums for pre-existing conditions if a patient has a lapse in insurance coverage over the most recent 18-month period.
- **States' choice on mandatory benefits.** States can choose to reduce the minimum set of required benefits for any insurance plan, to the point where some plans could offer very few benefits, but be significantly cheaper. The first version of the AHCA established a set of mandatory benefits similar to the ACA, but with fewer benefits (for example, striking items such as maternity care).
- **Lifetime benefit cap could return.** Because of the above bullet on states being able to define mandatory benefits, states could choose not to require a lifetime cap on insurance benefits. Thus some plans could include a lifetime cap on benefits, though the sickest patients who would be hurt most by such a cap would probably be looking to purchase more comprehensive plans anyway.
- **High-risk pools.** The AHCA sets aside approximately $115 billion over nine years for "high-risk pools" in each state. These pools would contain the sickest patients and this money would be earmarked to help states defray the costs of insuring them. However, critics contend that because the AHCA doesn't mandate that states use all of this money toward high-risk pools (the money could be used in a variety of ways, such as paying for preventive services instead), the $115 billion won't be enough. Some studies suggest that it would cost more than $115 billion *annually* to adequately fund high-risk pools.
- **Individual mandate goes away.** The AHCA eliminates the ACA's individual mandate, which requires individuals to purchase health insurance or pay a tax penalty.

- **Age-based tax credits.** Unlike the ACA's income-based tax credits, which help offset the cost of insurance premiums, the AHCA relies on age-based tax credits which are phased out for higher-income individuals (above $75,000 for single individuals and above $150,000 for married couples). The result is a more regressive approach to subsidizing the costs of health care that wouldn't be as generous to the poor, but would reduce the overall costs of the program.

Repeal still has a long way to go

Republicans celebrated the House's passage of the AHCA, but the legislative path forward is still full of formidable obstacles. First it must pass the Senate, then be reviewed again by the House, and only with both chambers of Congress in agreement would the resulting bill reach President Trump's desk for his signature.

In the Senate, Republicans have a much narrower majority, and can only pass the AHCA with a simple majority by relying on reconciliation rules. These rules restrict the types of measures that can be passed in legislation to only those that affect revenues and spending. Other measures, such as removing ACA provisions that ban higher premiums charged by insurers for pre-existing conditions, do not directly affect federal revenues and spending, so they could not be passed via reconciliation.

Also, several Republican Senators are seen as political moderates with less conservative constituencies, and they have already expressed hostility toward some of the changes in the AHCA. Sen. Bill Cassidy (R-La.), stated that he could not support a bill that would weaken the ACA's protections for people with pre-existing conditions. Sen. Susan Collins (R-Maine), criticized the AHCA for significantly reducing coverage, including significant cuts to Medicaid.

Thus the Senate is expected to craft its own bill, with Republicans forming a 13-man working group under the leadership of majority leader Mitch McConnell (R-Ky.), who told reporters May 8 that the AHCA's legislative path "will not be quick, simple, or easy."

However, Democrats can't count on a united front in the Senate against the eventual Senate bill, Coffey says. "Several Democrats face Republican challengers in 2018 and have a motivation to vote for a Senate repeal bill," he explains. "I think you're going to see an enormous amount of pressure on these Democrats from conservative states to make some kind of a deal."

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MEDICARE RULES

CMS and HHS issue first rules under new leadership

As the two federal agencies that wield the greatest power over the healthcare industry, CMS and HHS have been making a quiet transition to new management for nearly three months. During that time, which included a 60-day freeze on all new rulemaking and an initial failure by Republicans to repeal the Affordable Care Act (ACA), CMS Administrator Seema Verma and HHS Secretary Tom Price have settled into their new roles while offering only measured comments on the repeal effort.

One of the first major indicators for how much Verma would involve herself in the effort came in the middle of April, when she met with representatives from top insurance companies who were hoping for answers on whether the Trump administration would continue federal subsidies for ACA premiums. However, Verma appeared to be non-commital, and CMS offered only a vague statement after the meeting, saying that "All parties came to the table committed to maintaining an active dialogue to improve care for patients and focus on long-term solutions that will fix the problems created by the ACA."

Ultimately, President Trump and Republican leaders in Congress decided to keep the ACA subsidy cash flowing until at least September, via the $1 trillion budget bill that marked the first major piece of bipartisan legislation passed under President Trump.

Policy shift toward state-level regulation

More telling is a recent move by CMS to issue a checklist tool to states who wish to opt out of ACA requirements. The Section 1332 State Innovation Waiver Checklist is designed to make it easier for states to complete waiver applications that would allow them to create high-risk pools and help insurers purchase reinsurance to offset coverage costs.

"Today's guidance addresses the ACA's impact in driving up insurance costs and reducing choices," Verma said in a May 16 statement, the date CMS released the checklist. "State initiated waivers that implement high-risk pool/ state-operated reinsurance programs will help lower premiums, stabilize the health insurance exchange, and meet the unique needs of each state."

It's fitting that Verma is pushing state-specific innovations; in her previous career, she rose to national prominence by working to implement conservative reforms of state Medicaid programs.

Secretary Price also framed the checklist tool as a necessary hedge against the effects of the ACA as it is currently implemented. "The failure of the individual marketplaces under Obamacare is driving insurers out of counties and states at an alarming rate, leaving millions of Americans without choices for affordable health insurance," Price said in a statement. Earlier this month, Price sent letters to the governors of all 50 states encouraging them to seek ACA waivers.

Rulemaking resumes as Price anticipates ACA repeal

With the end of the 60-day regulatory freeze issued by President Trump, both HHS and CMS are back to issuing transmittals and policies. One of the more consequential changes is a streamlining of the web enrollment process for insurance plans on the ACA's exchanges. The new "Proxy Direct Enrollment Pathway" allows patients to find and apply for insurance plans entirely through third-party insurer websites. This bypasses the federal exchange site, Healthcare.gov, entirely, giving patients an uninterrupted experience on the insurer website.

Though both Verma and Price are opposed to the ACA and looking forward to its repeal, they are also in the position of having to keep it running as smoothly as possible to avoid patient coverage disruptions until a new law is passed. The Proxy Direct Enrollment Pathway is an effort to keep the ACA's exchange markets stable, Verma said in a statement. "It is common sense to make it as simple and easy as possible for consumers to shop for and access health coverage. It is time to get the federal government out of the way and give patients the best tools to make their own healthcare decisions. We look forward to continuing to work with private partners to make sure these streamlined enrollment pathways are available, secure, and ensure a high degree of program integrity."

In March, Price lamented the first failed attempt by Republicans to pass a repeal bill in the House of Representatives, saying then that lawmakers had moved too quickly to set an artificial timeline. Now that a modified bill has managed to pass in the House, Price is bullish on a Senate version passing sometime this summer, telling conservative radio host Hugh Hewitt that a Senate bill could be ready by August.

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CODING

How to properly apply 5 key global period modifiers

CMS wants to eventually eliminate the global surgical package, but for now your physicians, coders, and billers must still comply with all of the bundling rules and modifier headaches that come with it.

To help you manage your 10-day and 90-day global period procedures, this article will discuss when and how to use the modifiers most relevant to the global period. **Remember:** The global surgical period or package refers to the complete set of care associated with a surgical procedure, including the pre-operative, intra-operative, and post-operative care. Typically most of the modifiers affect post-op care, as post-op care accounts for the vast majority of services that are provided beyond the actual surgery.

Zero days could still require a modifier. Keep in mind that procedures with 0-day global periods don't have bundling issues associated with post-op care, though they will most likely need a modifier to be reported with a same-day E/M service. This would apply, for example, to any joint injection code, such as **20606** (Arthrocentesis, aspiration and/or injection, intermediate joint or bursa [e.g., temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa]; with ultrasound guidance).

10-day global periods have no pre-op periods. Procedures with 10 global days are minor procedures such as removal

of an orthopaedic implant. The 10-day global period begins the day of the surgery and continues for 10 days after the surgery – effectively making it a total of 11 days.

90-day global periods include 1 pre-op day. Procedures with 90 global days are major procedures and make up the bulk of orthopaedic surgeons' services. The 90-day global applies to procedures such as joint replacements/revisions, open/closed fracture repairs, fusion procedures, and SLAP repairs. The 90-day global period begins the day *prior* to the day of the surgery and continues for 90 days after the surgery – effectively making it a total of 92 days.

Below are the modifiers that physicians will use when dealing with their most common procedures:

- **Modifier 57** – Decision for surgery (major procedure only)
- **Modifier 58** – Staged or related procedure during global period
- **Modifier 78** – Unplanned return to OR during global period
- **Modifier 79** – Unrelated procedure during global period
- **Modifier 24** – Unrelated E/M service during global period

New DoctorsManagement clients	
Client	**Services provided**
Solo practitioner, FL	Practice start-up
Pain management group, SC	Practice start-up
Mental health center, NH	Practice start-up
Gastroenterology practice, OH	Revenue cycle assessment
Health system, OH	Coding education and development
University system, VT	Coding audit
Multispecialty group, PA	Coding audit
Solo practitioner, AR	NAMAS onsite education
Urgent care group, NC	Audit appeal representation
Dermatology group, SC	Administrative law judge hearing representation
Mental health center, NH	New provider enrollment
Plastic surgery practice, OR	Group purchasing enrollments
Family practice, TX	Group purchasing management transfer
Family practice, LA	Group purchasing enrollments
Lab services group, PA	Group purchasing enrollments
OB/GYN group, AL	Group purchasing enrollments
Pain management group, NC	Group purchasing enrollments
Dermatology practice, SC	Group purchasing enrollments
Dermatology practice, VA	Group purchasing enrollments
Dentistry practice, TN	Group purchasing enrollments
Women's health center, FL	Group purchasing enrollments
Vascular surgery practice, FL	Group purchasing enrollments
Clinic group, TN	Group purchasing enrollments
Plastic surgery practice, TX	Credit card processing services

Modifier 57: Decision for surgery

For all services with a 90-day global period, related services rendered the day before the surgery are generally considered to be bundled into the code for the surgery. This is where modifier 57 (decision for surgery) comes in.

If an E/M service related to the surgery is performed either the prior to, *or the day of* the surgery, it will not be billable without modifier 57. To support modifier 57, the physician's note must demonstrate that the E/M service was needed to ascertain the need for surgery. Modifier 57 applies most in situations where a patient is suddenly ill and requires a major intervention. If a major procedure has long been scheduled (e.g., a total hip joint replacement for a patient who was slowly losing mobility), then modifier 57 wouldn't apply because the need for the surgery was determined long ago.

Remember that modifier 57 is used to show that a face-to-face visit was needed to determine the need for the procedure.

Modifier 58: Staged or related procedure during global period

When the patient returns during the global period for another procedure related to the procedure that triggered the global period, the follow-up procedure is considered bundled into the post-operative care. However, if modifier 58 is appended, such procedures can be billed.

Modifier 58 indicates that this subsequent procedure (or multiple procedures) was planned prospectively at the time of the original procedure (i.e., staged), or that it is more extensive than the original procedure. The follow-up procedure will begin a new post-op period (global period) once performed. The key word for modifier 58 is "staged *or* related." It is either/or.

For example, if a surgeon performs limited debridement of an infected wound, then finds that the infection had spread and a more extensive debridement is needed, he has the patient return during the 90-day global period for the limited debridement. A more extensive procedure is carried out in the subsequent encounter. This subsequent procedure is more extensive than the first procedure, and thus modifier 58 is billable allowing full reimbursement of the second procedure.

For major procedures in which a cast or splint is needed for the patient, the initial cast/splint application is bundled into the surgery code, though the supply codes for the equipment are billable. Subsequent applications are billable with modifier 58.

Modifier 78: Unplanned return to OR during global period

When the patient experiences complications or any problem related to the surgery that triggered the global period, and those complications/problems are severe enough to warrant a return to the operating room (OR), then procedures done in the OR become separately billable with modifier 78.

Modifier 78 applies to procedure codes only, and requires that the return to the OR be a result of problems *related* to the original surgery. If the problems are *unrelated*, then modifier 79 (see below) is the correct modifier.

The same diagnosis code as the original procedure or related diagnosis codes would be expected, and the operative note should also make it clear that the procedures being done in the OR subsequent to the triggering surgery are related to that surgery.

Note that modifier 78 reduces payment for the procedures it is appended to by 20% to 30% depending on payer.

Modifier 79: Unrelated procedure during global period

Similar to modifier 78, modifier 79 is used only with procedure codes for procedures done during the global period of a prior surgery. However, modifier 79 indicates that these subsequent procedures are wholly unrelated to the prior surgery.

A diagnosis different from that used for the original surgery is required, and the new surgery code or codes will begin new global periods if any apply. Because these procedures are not related to the original procedure, modifier 79 allows full payment at the usual fee schedule rate.

Modifier 24: Unrelated E/M service during global period

All face-to-face E/M services done during the global period for a procedure is bundled into that procedure, if the visit is related to the diagnosis supporting the procedure. However, if the patient comes in during the global period for an unrelated problem (different diagnosis code), then modifier 24 applies.

Modifier 24 is used with E/M services only and the physician's note must make it clear that the problems being evaluated and managed are not related to the problems that produced the medical necessity for the surgery. Different ICD-10-CM diagnosis codes must be used and the progress note must also be clear that the visit is unrelated to the surgery.

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