Vol. 5,
Issue 6

The Business of Medicine

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REVENUE CYCLE MANAGEMENT

Why telemedicine could be the next frontier

Technology is ubiquitous in modern society, and just when we thought that computers could not replace the "human touch" of a healthcare provider, technology is making specialized care accessible to patients anywhere there is an internet connection. CMS has now approved "virtual visits" via bilateral video and audio communications between a provider and patients.

This will improve access to care for patients in geographically underserved areas or in areas where some specialists are not available. According to the American Hospital Association's *Trend Watch* (January, 2015), an estimated 3.2 million patient visits are expected to be delivered via telemedicine by 2018. Below is a table containing the current telemedicine HCPCS Level II and CPT codes that have been set by the American Medical Association:

Sample of AMA-Approved Telemedicine Codes - 2017

Service	HCPCS Level II	CPT
Office or other outpatient visit		99201-99215
Annual wellness visit (#1 & #2)	G0438-G0439	
Telehealth consultation (ED or initial inpatient)	G0425-G0427	
Follow up hospital services		99231-99233
Follow up nursing care facility		99307-99310
Transitional care management		99495-99496
Kidney disease education		
Diabetes self-management training services	G0108-G0109	
Individual psychotherapy		90832-90834 & 90836-90838
Family psychotherapy -with or without the patient present		90846-90847

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Annual depression screening	G0444	
Annual alcohol misuse screening	G0442	

Work Group for Electronic Data Interchange. "Innovative Encounters Issue Brief: Introduction to Telehealth Codes," December. 21, 2016.

Modifiers for telemedicine services

Per CMS, in 2017 a practitioner may submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service along with a modifier **95,** to indicate that "synchronous telemedicine service rendered via real-time interactive audio and video telemedicine."

For example, **99201-99205** may be billed for an initial Level 1 visit via telemedicine. The location where health services and health-related services are provided or received through telemedicine would be billed through Medicare as Place of Service code (POS) **2.** Check with your commercial payers on their provider website to confirm that they are actively covering telemedicine services using these modifiers.

Here are five steps from AdvancedMD to successfully implement a telemedicine program in your practice:

1. Determine your objective. Decide your goal. Do you seek to expand patient access to your practice into evenings and weekends? Or perhaps you would like to more closely monitor your chronic or elderly patients? Whatever your objectives, telemedicine can improve patient outcomes, provide additional revenues, and even attract new providers to your practice with this new care delivery medium.

2. Appoint a telemedicine "Champion" within the practice to promote its benefits to your staff, to select and implement the technology, to plan the telemedicine workflow, and to train and coach patients and staff during implementation.

3. Market the benefits of telemedicine to patients. Use email and text message appointment reminders to create awareness of the telemedicine option to fill empty slots in your schedule and reduce no-shows. The Champion can guide patients on how to access and to use the telemedicine feature.

4. Practice a telemedicine visit in the roles of both provider and patient. It can take practice to learn how to present well on camera. Be mindful of the background, ambient noise and your body language to make sure you come across professionally and credibly before you go live with real patients.

5. Meet state licensing requirements. If the patient is located in another state, the originating state in which the patient is located is considered the "place of service". Therefore, the physician must comply with that state's licensing rules and regulations. Each state's medical board has its own rules governing delivery of telemedicine services across state lines (and they are actively changing). Some are easing restrictions on providers in contiguous states, so be certain to check state regulatory requirements frequently.

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QUALITY REPORTING

Practices gear up for 90 days of MIPS reporting

Halfway through the first reporting year for the Merit-based Incentive Payment System (MIPS), some practices are only doing the bare minimum reporting to avoid a 2019 Medicare pay cut. But other groups, particularly larger groups, are committed to reporting as much as possible to earn the biggest bonus they can.

"My goal is to get 70-plus points per provider," says Joseph Mathews, practice administrator at Advanced Orthopaedics & Sports Medicine in Houston, Tex. "This is the first year so I don't think many people will be going for it all the way. Very few people are going to try that hard, so we hope to be among the very few."

In addition to the maximum positive adjustment of +4% in 2019, the providers with the highest points (100 points total are possible) would receive a share of additional bonus money from a $500 million pool. These providers are termed "exceptional performers" by CMS and few practices have their sights on meeting this standard in 2017, Mathews believes.

His practice plans to report for 90 days, beginning in August. The 90-day reporting option now appears to be gaining popularity among practices that are pushing for larger incentive bonuses. One reason is a major new clarification from CMS (see sidebar, pg. 5).

At OrthoIllinois in Rockford, Ill., the plan is to report for 90 days starting in the early fall, says Terry Anderson, director of informatics. She shares the same goal as Mathews' group: Hitting at least 70 points for each of their MIPS-eligible providers. So far, the toughest task at the 34-provider group has been sorting through the available MIPS measures to determine which give the most "bang for the buck," Anderson says. "That was daunting. But once we had the measures we wanted, so far I think it's been easier than expected."

What to report for 90 days

For 2017, only three of the four MIPS components will be counted toward your score. The fourth component, Cost Performance, will be calculated automatically by CMS (as it will be in all MIPS years), but will not count toward your final score. Thus in 2017 a full slate of MIPS reporting would consist of the following, for 90 consecutive days:

- Reporting at least six Quality Performance measures, of which one must be an Outcomes measure;
- Reporting one High-weight or multiple Medium-weight activities under the Improvement Activities component; and,
- Reporting all Base measures for the Advancing Care Information component (ACI; previously known as EHR meaningful use).

There are four ACI Base measures for the 2017 transition year:

1. Security Risk Analysis (attest yes/no)
2. E-prescribing (report numerator/denominator)
3. Health Information Exchange (report numerator/denominator)
4. Providing Patient Access (e.g. via patient portals)

CMS expands list of providers exempt from MIPS

A total of 806,879 providers are now exempt from having to participate in the Merit-based Incentive Payment System (MIPS), according to the latest CMS calculations of their Medicare Part B charges.

These charges are used to determine whether providers are exempt from MIPS via the "low-volume threshold," which was part of the Medicare Access and CHIP Reauthorization Act (MACRA), the law that created MIPS. The low-volume threshold applies to providers who have less than $30,000 in Medicare charges over a contiguous 12-month period, or those who see fewer than 100 unique Medicare patients over a contiguous 12-month period.

CMS determines the eligible physicians and sends out exemption letters accordingly – you don't need to take any action to apply for this exemption. Because MIPS applies in its first year to physicians and non-physician practitioners such as nurse practitioners and physician assistants, the exemption is calculated for those non-physician providers as well.

Are any of your providers actually exempt? If you haven't received a notification letter – CMS has been sending them periodically as it updates its calculations – there's a faster way to know. The agency has released an online MIPS eligibility tool that you can access by visiting https://qpp.cms.gov/learn/eligibility. All you need to do is enter the National Provider Identifier (NPI) of the provider you want to look up.

Note: Being exempt means that a provider will not be penalized for not participating in MIPS. They will also not earn any incentive money if they choose to participate anyway.

Other exemptions also apply

Two other exemptions are also behind the 806,879 figure: providers new to Medicare this year are automatically exempt, as are providers participating in a CMS-recognized Alternative Payment Model (APM).

CMS had projected that as many as 780,000 providers could be exempt from MIPS due to the low-volume threshold and the other exemptions, but now the number has exceeded their most aggressive projections.

CMS: 90 days could still yield full MIPS bonus

Even though 2017 is half over, there's still plenty of time to report MIPS measures for a 90-day period, and that's enough to get the full +4% bonus, CMS recently clarified. The agency has updated its language on the Quality Payment Program website, which now states that "if you only report 90 days, you could still earn the maximum payment adjustment – there is nothing built into the program that automatically gives a reporter a lower score for 90-day reporting."

It was generally assumed that providers who report more days would be somehow advantaged over those who report for fewer days, given that CMS originally required MIPS reporting to occur over the entire calendar year. In the MIPS final rule, CMS made 2017 a "transition" year and offered multiple routes to report, including the bare minimum option that would guarantee a 0% payment update in 2019 (i.e., no penalty).

Now, any consecutive 90-day reporting period can be used to compete with top reporters in 2017 for the MIPS bonus money. **Remember:** Because the program is budget-neutral, the pool of bonus cash will come in part from the payment penalties applied to those providers who do not report. This means your providers can wait until Oct. 1, 2017 to begin full-scale MIPS reporting and still be eligible for the maximum positive update of +4% to Part B payments in 2019.

Cash incentive remains for full-year reporting

Note: There is still an advantage to reporting for more than 90 days, CMS says on the QPP website: "The MIPS payment adjustment is based on the data submitted. The best way to get the maximum MIPS payment adjustment is to participate full year. By participating the full year, you have the most measures to pick from to submit, more reliable data submissions, and the ability to get bonus points."

A MIPS composite score of 70 points would put a provider in position to get the +4% payment bonus. But there is also a $500 million pool of bonus money for "exceptional performers" and this money would be given to providers who earn bonus points. A maximum MIPS composite score of 100 points is possible. Look for a detailed dissection of the MIPS composite score in the upcoming July 2017 issue of *The Business of Medicine*.

Practices: A 4% bonus is a big deal

Just how much is a +4% Medicare payment boost worth? It depends on the practice, but for both groups interviewed, the dollar value is significant. Mathews estimates his Houston-based group, which has 26 providers (including six physical therapists), stands to earn about $180,000 based on a 4% Part B payment boost. This doesn't count any exceptional performer money.

At OrthoIllinois, CEO Don Schreiner estimates that a 4% boost would be worth approximately $300,000, again without exceptional performer money. "That $300,000 would reduce our overhead by about 0.8% ... it would ultimately represent a 1.5% increase to our bottom line," he says. There's no question that a large group like OrthoIllinois enjoys a major advantage, being able to hire someone like Anderson, the informatics director. "We're fortunate to have somebody like Terry and I just don't know how a smaller practice could do this without a dedicated person."

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CONGRESSIONAL ACTION

Congress could delay radiography cuts

CMS began cutting the payments you receive for taking X-ray scans using analog equipment on Jan. 1 of this year. The move is intended to gradually prod providers into investing in more advanced X-ray equipment known as digital radiography (DR). AAOE has been engaged in a long and persistent discussion with members of Congress to address the impact these cuts have on orthopaedic providers and practices.

Now, key Republican members of the House of Representatives have signaled their willingness to support legislation to delay steeper cuts to X-ray payments in 2018, if "offsets" can be found. AAOE is pushing these members of Congress for a two or three-year delay whose financial impacts to the Medicare program would be theoretically offset by

greater penalties after the delay ends, says Bradley Coffey, government affairs manager for the AAOE in Indianapolis.

"House members have made it clear to us that a repeal of the cuts are off the table, because the expected revenue from those cuts is being set aside to offset a cut to the multiple procedure payment reduction rule for radiologists," Coffey explains. The benefit of a two or three-year delay to orthopaedic providers would be additional time to purchase the DR technology and implement it into their workflow, he says.

Review: X-ray cuts planned over 7 years

The payment cuts that are now in effect apply to the technical component (TC) of X-ray scans done on analog equipment. This means that physical interpretation, paid via the professional component (PC) of the CPT code for the X-ray scan, is not affected by the rule, now or ever.

Coffey estimates, based on AAOE member surveys, that approximately 4% to 7% of the membership is still using analog film and has thus been affected by the cut, which is 20% of the TC in 2017.

However, if Congress doesn't act before Jan. 1, 2018, CMS will expand the cut to X-rays taken using computed radiography (CR), which would affect nearly 80% of the AAOE membership, Coffey says. The CR cuts would reduce the TC of X-rays done via CR by 7% in 2018, and the penalty goes up to 10% in 2023.

In 2018, the average orthopaedic practice using CR technology would lose approximately $19,000 with a 7% cut to the TC of their X-rays, according to AAOE projections.

CMS has pointed out that DR technology has considerable benefits over analog or even CR: it produces digital images of the scan results in seconds, and the images are sharper

New DoctorsManagement clients

Client	Services provided
Primary care provider, LA	Practice assessment
Medical group, NJ	Practice assessment
Orthopedic group, MO	Annual baseline audit
Orthopedic group, VA	Annual post-bill audit
Orthopedic practice, GA	OIG gap analysis and plan
Orthopedic hospital department, OH	Provider audit
Pain management clinic, FL	Annual post-bill audit
Physical therapy group	Human resources consult
Mental health group, CT	OSHA/HIPAA consulting
Dental practice, TX	OSHA/HIPAA consulting
Solo practitioner, PA	OSHA/HIPAA consulting
Surgery center, OH	OSHA/HIPAA consulting
Dermatology practice, TN	OSHA/HIPAA consulting
Allergy lab testing group, MS	CLIA technical consulting
Physician group practice, PA	CLIA technical consulting
5 new credentialing clients, 1 new DMU student, 1 new DMU renewal	
9 NAMAS boot camp registrations, 102 total conference registrations, 11 webinar purchases, 8 manual purchases, 21 new memberships, 79 renewals	

and more detailed, while exposing the patient to less radiation. However, upgrading to DR can be costly. "Our surveys show the average cost to upgrade is about $80,000 to $100,000 for a practice," Coffey says.

AAOE survey data has gotten some results as low as $30,000 and as high as $300,000, Coffey says. Practice size and geographical differences probably account for some of these outliers, but even a $30,000 upgrade isn't cheap for a small practice while the time spent retraining staff on the new equipment is another sunk cost.

Expect action later this year

Coffey hopes Congress will take action later this year. A bill that delays the 2018 CR cuts by two years would be guaranteed to come with a penalty higher than 7% after the two years are up, but the extra time means far more orthopaedic practices will have had time to adopt DR technology.

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COMPLIANCE

HHS: Healthcare cybersecurity in 'critical' condition

The nation's healthcare provider organizations are at greater risk of cybersecurity breaches than any other type of organization, according to a highly-anticipated HHS report on the state of cybersecurity across the industry.

Entitled "Report on Improving Cybersecurity in the Health Care Industry," the 96-page document paints an alarming picture of practices and hospitals with lax cybersecurity protocols being actively targeted by criminal hackers and even foreign nation states.

"Real cases of identity theft, ransomware, and targeted nation-state hacking prove that our health care data is vulnerable," the report, authored by a special cybersecurity task force within HHS, states. Patient data is a prize for such attackers, who use it for "nefarious purposes such as fraud, identity theft, supply chain disruptions, the theft of research and development, and stock manipulation," the report states.

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June 28-29	**NAMAS E&M Auditing Boot Camp,** Austin TX
July 10-11	**NAMAS CPMA Boot Camp,** Jacksonville FL
July 26-27	**NAMAS E&M Auditing Boot Camp,** Nashville TN
Aug. 1-2	**NAMAS E&M Auditing Boot Camp,** Boston MA
Aug. 8-9	**NAMAS E&M Auditing Boot Camp,** Raleigh NC
Aug. 17-18	**NAMAS E&M Auditing Boot Camp,** Tampa FL
Aug. 17-18	**NAMAS CPMA Boot Camp,** Asheville NC
Sept. 14-16	**National Organization of Rheumatology Managers (NORM) Annual Conference,** Kansas City, MO – Sean Weiss
Oct. 8-11	**MGMA 2017 Annual Conference,** Frank Cohen
Nov. 1-2	**NAMAS E&M Auditing Boot Camp,** Salt Lake City, UT
Nov. 7-8	**NAMAS E&M Auditing Boot Camp,** Cincinnati OH
Nov. 16-17	**NAMAS CPMA Boot Camp,** Tallahassee FL

Report offers 6 'imperatives'

The HHS task force outlines six key imperatives as a result of its findings, and while many involve consolidating various state and federal initiatives to improve cybersecurity, some were highly specific and spoke to measures needed at the level of individual practices and organizations. The imperatives are:

1. Define and streamline leadership, governance, and expectations for health care industry cybersecurity. This step includes a suggestion to amend Stark law to allow physicians to receive financial assistance from healthcare organizations to pay for cybersecurity software.

2. Increase the security and resilience of medical devices and health IT. This step includes a recommendation to "secure legacy systems," including old operating systems or EHR/practice management software that is no longer supported by vendors and is now vulnerable to security exploits.

3. Develop the health care workforce capacity necessary to prioritize and ensure cybersecurity awareness and technical capabilities. The report recommends "identifying people and tools for addressing the small and medium-sized health care organizations which cannot typically afford full-time technical resources." It suggests smaller groups share cybersecurity staff and vendors rather than omit them entirely.

4. Increase health care industry readiness through improved cybersecurity awareness and education. This includes a recommendation that healthcare associations include additional education sessions on cybersecurity at conferences and trade shows.

5. Identify mechanisms to protect R&D efforts and intellectual property from attacks or exposure.

6. Improve information sharing of industry threats, risks, and mitigations.

Look for more detailed guidance on what your practice can do to improve its cybersecurity in a future issue of *The Business of Medicine*.

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