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The Business of Medicine

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PRACTICE MANAGEMENT

As cuts loom, should you switch to digital radiography?

Last year, Congress passed the Consolidated Appropriations Act, which includes reductions in reimbursements for imaging performed with analog X-ray and computed radiology systems, beginning in 2017 and beyond. Medicare will begin to reduce payments by 20% on analog X-ray systems in 2017 and in 2018 there will be payment reductions for using computed radiography (CR). With this new policy now the law of the land, many offices are wondering whether it makes sense to upgrade to Digital Radiography (DR), and if so, how to handle it from a practice management standpoint.

If you are using DR, then you have already converted and you are ahead of the curve. If your office is still using CR, then you may be wondering what the pros and cons are of each technology. The table on page 3 summarizes our thoughts on the matter.

What's the financial impact of switching from CR to DR?

It will be more expensive to switch to DR from CR; this is a fact that cannot be ignored. How much more expensive really depends on the needs of your office. This can range from an average of $27,500 to $300,000 depending on the size and the aforementioned needs of your office. It also depends on if you are looking at used vs. new devices, or if you are looking at a retro-fit. As this is an average, the costs may be lower or higher. Bringing in an expert would be best to help assess your office's individual needs.

By waiting to upgrade from a CR to a DR, providers may see their Medicare payments cut by 20% for submitting claims for analog X-rays. In addition, Medicare cuts for CR imaging will be cut by 7% starting in 2018, according to the CMS Physician Fee Schedule proposed rule (see related story, pg. 5).

(continued on pg. 3)

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Computed Radiography (CR)		Digital Radiography (DR)	
Pros	Cons	Pros	Cons
• Less expensive than DR • Your staff already knows what they're doing (no change equals less training for staff)	• Your Medicare payments will be reduced • It will be harder to find replacement parts when something goes wrong • Connectivity issues to EHR/EMR	• Enhanced image quality and manipulation of images • Faster image acquisition times and review • Integration to EHR/EMR • Accurate images the first time • Lower radiation patient dosage • Gained real estate	• It's costlier in every aspect • Retraining staff costs time and money

Would switching affect my workflow throughout my office?

The initial installation will disrupt the workflow of the typical office, but once the conversion is made it should actually improve the workflow. Digital film storage should save time, which will ultimately save the practice money. On average, the process of generating and storing a scan is about two minutes faster with DR technology than with CR technology.

Tips to make the change

Henry Schein Medical is one supplier of DR services and our process for a potential client practice is outlined below:

1. A field service representative would visit to assess your office needs
2. An equipment site evaluation would be conducted
3. A Site Inspection Report would be produced and delivered
4. Specific type of equipment and/or upgrades will be determined and configured
5. The equipment would be delivered
6. On-site installation and set-up will take place
7. Calibration and upgrade applications will be performed

Ultimately, offices will have to decide if now is the time to upgrade to DR or whether to take their chances on the reduction of Medicare payments. If your office currently performs in-office imaging, and you'd like more information, please contact Craig King (cking@drsmgmt.com) at DoctorsManagement.

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MEDICARE RULES

6 highlights from 2018 fee schedule proposed rule

Your practice could be in for some major changes in 2018 if Medicare's Physician Fee Schedule proposed rule is any indication. CMS is looking at changing its guidelines for E/M codes for the first time in more than 20 years, as well as recognizing new telehealth services, updating payments for various codes, and more.

Now available online in PDF, it's one of the shorter proposed rules, coming in at just 815 pages. The rule sets a slightly lower conversion factor than was called for due to budget neutrality and something called the "target recapture" amount. The target recapture reflects the amount of

savings that CMS must recoup due to losses from services deemed to be misvalued. As a result, instead of the 0.5% positive update, the conversion reflects only a 0.29% update. The new conversion factor for 2018 will be $35.9903, up from $35.8887 in 2017. Anesthetists will have a similar percentage update, but going in the opposite direction, with a conversion factor of $22.0353, which is lower than this year's conversion factor of $22.0454.

Let's review some of the key proposals in the proposed rule:

1. Gradual changes to E/M coding guidelines. In a nutshell, CMS agrees with enduring criticism from the provider community that its guidelines for documenting E/M services and selecting E/M code levels is outdated and should be changed. The agency is open to multiple approaches, and for 2018 and the near-term, it suggests removing specific requirements for documenting the patient's history and physical exam, leaving providers to choose an E/M code level based on the medical decision making component alone (see full story below).

2. Medicare Diabetes Prevention Program (MDPP). The program, first unveiled in 2016, would allow non-clinicians to act as diabetes "coaches" and actually bill Medicare for educating pre-diabetic patients. The move was intended to take pressure off primary care physicians, of which there is a national shortage, while addressing one of the costliest conditions Medicare pays for. The start date for enrollment is being pushed back to April 1 from Jan. 1, 2018.

3. New behavioral health codes. These include Collaborative Care Management services that exist as HCPCS codes **G0502-G0504** but will convert to CPT (currently listed in the proposed rule as placeholder codes **994X1-994X3**), cognitive assessment (already in existence as **G0505**), and several others.

4. Continuation of X-ray cuts. For X-rays performed using computed radiography technology, the proposed rule would continue implementation of phased cuts to the technical component (TC) of such services. In 2018,

CODING

Could 2018 forever change E/M coding and documentation?

The most fundamental rules for documenting and coding evaluation and management (E/M) services could see a major change in 2018 under provisions in Medicare's Physician Fee Schedule proposed rule for next year.

These changes could include simply eliminating two of the three key components of an E/M visit – the history and exam – or reducing the requirements for them, among many possible suggestions outlined in the proposed rule. In this article, we'll take a deeper look at one of Medicare's most potentially consequential proposals.

CMS has been reluctant to alter its E/M documentation guidelines – widely adopted by all payers – because the potential impact is enormous. Providers across all specialties practicing in all settings rely heavily on E/M services, and the sheer volume of utilization has made E/M services a regular audit target by the HHS Office of Inspector General (OIG). Even so, CMS has kept the same guidelines in place for more than two decades.

CMS acknowledges longstanding criticism

The 1995 and 1997 guidelines, named for the years in which they were established, have been criticized for being too restrictive and not clinically relevant. In the proposed rule, CMS voices strong agreement. "Stakeholders have long maintained that both the 1995 and 1997 guidelines are administratively burdensome and outdated with respect to the practice of medicine, stating that they are too complex, ambiguous, and that they fail to distinguish meaningful differences among code levels," the agency writes. "In general, we agree that there may be unnecessary burden with these guidelines and that they are potentially outdated ... the guidelines have not been updated to account for significant changes in technology, especially electronic health record (EHR) use, which presents challenges for data and program integrity and potential upcoding given the frequently automated selection of code level."

History and exam: No longer needed?

Every E/M visit contains three components: the history, the exam, and the medical decision making (MDM).

(continued on pg. 5)

this would result in a reduction of 7% to the TC of X-rays performed using computed radiography. CMS is trying to phase out all film-based imaging in favor of digital radiography. All X-rays done with digital radiography will have their TCs paid in full.

5. Nasal/sinus endoscopy code changes. CMS is proposing to cut the work relative value units (wRVUs) for 10 nasal/sinus endoscopy codes, based on recommendations made by the AMA's Relative Value Update Committee (RUC). Codes **31254-31256**, **31267**, **31276**, and **31287-31288**, and **31295-31297** will all see wRVU reductions averaging 15% to 20%. The proposed rule also introduces five new endoscopy codes that haven't yet received complete CPT code numbers from the AMA. The new codes will run from 31XX1 to 31XX5 and represent endoscopies that include related services which are already frequently billed together with endoscopies.

6. Big boosts, some cuts to tracheostomy codes. A mixed bag of changes are being proposed for tracheostomy codes. The most common planned tracheostomy is getting a reduction in wRVUs, while more difficult tracheostomies are getting significant wRVU increases.

- **31600** (Tracheostomy, planned, separate procedure): 5.56 wRVUs, down from 7.17.

E/M coding and documentation *(cont. from pg. 4)*

CMS singled out the first two components as being "more significantly" outdated, but also wants comments on whether changes should be made to how the MDM is documented.

"As long as a history and physical exam are documented and generally consistent with complexity of MDM, there may no longer be a need for us to maintain such detailed specifications for what must be performed and documented for the history and physical exam," CMS writes in the proposed rule. The 1995 and 1997 guidelines, as defined by Medicare, have always emphasized that MDM is the most important component and is the overarching criterion for selecting an E/M code level. Eliminating any specific requirement for the history and exam would allow an E/M code to be selected based on the MDM or the amount of face time spent, if more than half of that time was spent on counseling the patient and/or coordinating his or her care.

The proposed rule doesn't lay out a single specific set of guidelines for how E/M coding would work with the first two components removed, but it offers several points:

- If history and exam are removed, CMS would effectively leave the documentation of these elements at the discretion of the rendering provider.
- This doesn't mean no history or exam would be documented, because the medical record would still need to be readable to other providers who see the same patient.
- There would still be legal reasons as well for providers to document specific details in the history and exam, such as negative findings for certain organ systems or body areas that would support a differential diagnosis.

A gradual process

The effort to finally update the E/M guidelines will take time and require ongoing, constructive feedback from healthcare providers and organizations, CMS acknowledged. "We believe that a comprehensive reform of E/M documentation guidelines would require a multi-year, collaborative effort among stakeholders," the agency writes in the proposed rule.

On this issue, as much as any other in the proposed rule, CMS wants to hear from you (see instructions on submitting public comments, pg. 6). A lack of stakeholder input and consensus was one reason the 1995 and 1997 guidelines have remained in place for so long, without significant change, CMS states in the proposed rule.

"We believe that revised guidelines could both reduce clinical burden and improve documentation in a way that would be more effective in clinical workflows and care coordination," the agency concludes.

- **31601** (Tracheostomy, planned, separate procedure; younger than 2 years): 8.00 wRVUs up from 4.44.
- **31603** (Tracheostomy, emergency procedure; transtracheal): 6.00 wRVUs, up from 4.14.
- **31605** (Tracheostomy, emergency procedure; cricothyroid membrane): 6.45 wRVUs up from 3.57.
- **31610** (Tracheostomy, fenestration procedure with skin flaps): 12.00 wRVUs up from 9.38.

Submit your comments to CMS now

Given the major changes in the proposed rule that would affect ENT practices, such as the endoscopy codes and possible E/M coding changes, it's important for stakeholders to share their thoughts with CMS. You have until Sept. 11 to submit comments, and one of the easiest ways is online submission. Click here to visit the comments page for the 2018 fee schedule proposed rule. CMS typically releases the fee schedule final rule at the end of October or the first two weeks of November.

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REVENUE CYCLE MANAGEMENT

Blue Cross plan cuts modifier 25 payment by 50%

Practices in Pennsylvania are facing a sudden, massive pay cut thanks to a move by Independence Blue Cross (IBX) to slash payment by 50% for all E/M services with modifier 25 attached.

Beginning on Aug. 1, IBX is reducing payment by 50% for all E/M services with modifier 25 appended that are reported on the same day as a minor procedure, defined as those CPT codes with a 0-day or 10-day post-operative period. IBX, which offers both commercial HMO, PPO, and Medicare Advantage plans, is a major player in southern Pennsylvania, says Robert Connelly, CEO of Pinnacle Ear Nose & Throat Associates LLC in Wayne, Pa. The practice, which has 17 physicians and 25 non-physician providers spread across 14 office locations, can't afford to simply opt out with IBX over this change.

"Their size is just too significant in this area for us to not participate with them," Connelly says. The impact has already been felt in his practice; he estimates that IBX

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Sept. 14-16	**National Organization of Rheumatology Managers (NORM) Annual Conference,** Kansas City, MO – Sean Weiss
Sept. 18-20	**Association of Otolaryngology Annual Educational Conference,** Las Vegas NV, Sean Weiss, Frank Cohen
Sept. 21	**FREE Webinar, "Risk-based Auditing: It's No Longer an Option,"** 2pm to 3pm ET, Frank Cohen
Oct. 4-6	**Association for Value-Based Cancer Care 2017 Summit,** Washington D.C., Sean Weiss
Oct. 8-11	**MGMA 2017 Annual Conference,** Anaheim CA, Frank Cohen
Oct. 12	**FREE Webinar, "What Next: Documenting, Tracking and Analyzing Your Audit Results,"** 2pm to 3pm, Frank Cohen
Oct. 15-17	H**CCA Clinical Practice Compliance Conference,** Phoenix AZ, DoctorsManagement booth #11
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

represents approximately 25% of their business. Of the roughly 7,500 patients his providers see every month, he estimates that some 600 would receive a medically necessary E/M service in the same encounter as a minor procedure. Based on those figures, "you're talking millions of dollars in lost revenue annually," Connelly says.

What was particularly startling was how quickly IBX implemented the rule; the insurer first announced its plans on May 1, and set Aug. 1 as the effective date. The state medical association, working with physicians across many specialties, immediately reached out to the Pennsylvania Insurance Department to lobby against IBX, but there have been no results thus far.

No room left to maneuever

Another aspect of the IBX policy that made Connelly uncomfortable was how thoroughly the insurer wrote the new rules to ensure practices had little recourse. "It is not eligible for dispute, review, or appeal," IBX writes about the new policy in a FAQ document obtained by *The Business of Medicine*. "Should the claim meeting the coding combination scenarios outlined in the policies, the modifier 25 E/M code will be reduced by 50%. We consider this as payment in full for the service and not eligible for further review."

Practices tempted to split the E/M visit and the procedure by having patients return for one or the other are explicitly prohibited from doing so, IBX states. "Unless medically necessary, providers should treat members on the same day for both services. Independence will consider it a breach of your agreement if you require Independence members to return for services that can be performed on the same date of service ... We will review and audit providers who ask patients to return for second visits."

Another question on the FAQ is posed almost as if by a physician: "In some cases, the payment for E/M services that are being reduced are more involved and complex than the original minor procedure/preventive E/M services. In these cases, how can you justify paying less than half the overall claim?"

IBX answers the question by citing the "overlap in the location, services provided, and resources utilized." Because of these efficiencies, their position is justified, the payer writes.

Practices worry other plans will follow

Currently, *The Business of Medicine* is only aware of IBX and no other payers with such an aggressive policy on modifier 25. But IBX claims that other payers have also "adjusted" their reimbursement for modifier 25, and states that it made the move after examining billing data that showed sky-high modifier 25 utilization in the Philadelphia area.

New DoctorsManagement clients	
Client	**Services provided**
Allergy and asthma group, NY	Monthly practice management
Gastroenterology practice, OH	Monthly revenue cycle management
Urology practice, AZ	Practice assessment
Dentistry practice	Feasibility study
Ophthalmology provider	General consulting
Hospital system, FL	Audiology services audit
Internal medicine group, OH	Monthly human resources management
Allergy and asthma group, NY	Monthly human resources management
3 DMU renewals, 1 DMU CMPM certification program applicant	
12 NAMAS boot camp registrations, 130 total conference registrations, 12 webinar purchases, 10 manual purchases, 26 new memberships, 45 renewals	

"We're concerned that other payers may follow suit, because the Blue Cross plans have a tendency to follow each other if they see a policy they like that can save money," says Rosalie Riley, CPC, CPCO, state coding manager for OrthoVirginia in Lynchburg, Va. Her practice, the largest orthopaedic specialty group in the state, hasn't been affected by the IBX policy yet, but it's threatening enough for the leadership to be preparing, just in case their payers follow IBX.

"This is a payer that's taking a very unusual and very draconian approach," says Karen Simonton, chief administrative officer of OrthoVirginia. "We all know that overuse exists and that poor documentation exists, but this kind of move is unprecedented."

She advises practices to take all the steps possible to ensure they won't stand out from a modifier 25 utilization standpoint. That means implementing regular coding reviews with an eye toward unnecessary usage of modifier 25, or insufficient documentation to support modifier 25.

"Increasingly we are using best practice standards and industry benchmarks to identify where we are outliers in terms of cost of care and utilization," IBX writes. "The use of modifier 25 is considerably more prevalent in Philadelphia as in all 50 states across the country."

The FAQ from IBX doesn't go into detail about its data and methodology, such as whether some of the modifier 25 utilization was the result of providers appending modifier 25 even when it wasn't needed, and thus didn't result in increased payment, only increased utilization of the modifier itself.

Connelly, the CEO at Pinnacle ENT, says that his practice will soon be up to renegotiate their contract with IBX, and hopes that the group's size will give them enough clout to mitigate the impact of the modifier 25 cut. He has seen other physician practices leave IBX, only to return after discovering that the revenue difference was too great. "Going non-par is always an option, but is it a financially reasonable option? Probably not. We'll be trying to negotiate better fees to compensate."

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CONGRESSIONAL ACTION

Repeal efforts: Will Obamacare 'implode' as Trump predicts?

Efforts to replace the Affordable Care Act (ACA) have ended with no clear path to a second attempt, while Congressional Republicans seem uninterested in reviving them. But without any action from Congress, could the ACA "implode" on its own as predicted by President Donald J. Trump?

The president suggested that if Republicans simply waited for various components of the ACA to fail on their own, Democrats as well as more moderate Republicans would be forced to strike a deal that would result in passage of a repeal-and-replace bill. Trump also suggested that his administration could proactively weaken the ACA by cutting off subsidy payments to insurance plans that are currently used to help poorer Americans afford their deductibles, co-payments, and other out-of-pocket costs.

"If a new healthcare bill is not approved quickly, bailouts for insurances companies ... will end very soon," Trump promised in a July 29 Twitter post. The final deadline came and went, with no specific update from the White House on whether Trump's threat would be carried out. The government has continued to pay the subsidies throughout Trump's time in office.

However, if the subsidies were indeed eliminated, premiums would explode by 20% in 2018, according to an analysis

released Aug. 15 by the non-partisan Congressional Budget Office (CBO). "Because they would still be required to bear the costs of [cost-sharing reductions] even without payments from the government, participating insurers would raise premiums of 'silver' plans to cover the costs," the CBO writes.

The "silver" plans represent mid-level coverage plans that many sick Americans rely on regularly. Their premiums would continue to increase after 2018 if the subsidies were stopped, climbing to 25% by 2020, according to the CBO analysis. The change would not have a major effect on the number of uninsured, at least in the short term, the CBO says.

Democrats point to political risks

The opposition was quick to seize on the CBO's predictions, highlighting the political damage Trump could do to himself if he carried out his promise. "Try to wriggle out of his responsibilities as he might, the CBO report makes clear that if President Trump refuses to make these payments, he will be responsible for American families paying more for less care," said Senate Minority Leader Charles Schumer (D-NY), in an interview with *The New York Times*. "He's the president, and the ball is his court."

To complicate matters, it's not clear what mechanism the White House could use to stop the subsidy payments without Congressional action. Currently, House Republicans have a lawsuit in progress that was lodged during the Obama administration to try and stop the subsidy payments. The suit argued that the ACA didn't contain language that secured a formal Congressional appropriation for the cost-sharing subsidies in the law. A district court judge sided with the House GOP and the case moved on to the U.S. appeals court in Washington, where it had been on hold at the request of Republicans after Trump's election victory. At this point, "no final decision" has been made by the president, a White House spokesman told *The New York Times* on Aug. 15.

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