Idaho Medical Association

Table of Contents:
In this Issue...

IMA Wire

December 1, 2019

IMA Billing Practices Survey

IMA has recently learned that there could be legislation in early 2020 impacting physician billing practices, which could impose a 30-day window for medical practices to submit their claims to insurance or else forfeit their ability to use outside collection services to pursue past due accounts. This is obviously very troubling. IMA would like to gather some data about current billing practices around the state to understand the existing environment and learn how such legislation might impact physician practices in our state.

Please take a few moments to fill out our brief survey by clicking HERE

Submit your survey by Friday, December 6th

[Back to Top]

Renew Your IMA Membership For 2020!

Easily renew your membership online by following these steps:

1. Visit www.idmed.org
2. Select the 'Membership' tab
3. Select 'Join / Renew' and follow the prompts

Questions? Please contact IMA Membership at 208-344-7888

The CO*RE/ASAM Pain Management and Opioids: Balancing Risks and Benefits

115 Americans die every day to opioid-related overdose. Are your patients among them?

Attend this FREE CME Pain Management and Opioids course hosted by IMA and ACMAC

When: December 11 from 8 AM to 10 AM MST.

Where: St. Luke's Boise Anderson Center, 5th Floor, Ada 1
100 E. Idaho Street, Boise, ID 83712

Please RSVP **HERE**

Newly Updated Curriculum

This newly updated comprehensive course incorporates all six units outlined in FDA blueprint for safe opioid prescribing and provides necessary context for safe opioid prescribing by discussing biopsychosocial aspects of pain, the newest clinical guidelines on the treatment of chronic pain, and state policies about prescribing opioids.

The intended audience is all prescribers of ER/LA opioids which includes: pain specialists, primary care physicians, physician assistants, nurse practitioners, advanced practice nurses, dentists, addiction medicine physicians, psychiatrists and other physicians and clinicians.

Learning Objectives

- Accurately assess patients with pain for consideration of an opioid trial.
- Establish realistic goals for pain management and restoration of function.
- Initiate opioid treatment (IR and ER/LA) safely and judiciously, maximizing efficacy while minimizing risks.
- Monitor and re-evaluate treatment continuously; discontinue safely when appropriate.
- Counsel patients and caregivers about use, misuse, abuse, diversion, and overdose.
- Educate patients about safe storage and disposal of opioids.
- Demonstrate working knowledge and ability to access general and specific information about opioids, especially those used in your practice.

[Back to Top]

Code Changes Coming for Evaluation and Management – Start Preparing Now for 2021

Change is coming to office or other outpatient Evaluation and Management (E/M) services. The good news is that there's a year to prepare, allowing time for a smooth transition. These revisions apply only to office or outpatient CPT E/M codes 99201-99215.

When are CPT E/M guidelines changing? January 1, 2021. Changes to the E/M office or other outpatient services subsection are quickly approaching while updating coding systems and training staff will take a significant effort.

What is changing and why? The process to revise the CPT E/M office visit guidelines and code descriptors was driven by four primary objectives:

- To decrease administrative burden or documentation and coding
- To decrease the need for audits, through the addition and expansion of key definitions and guidelines
- To decrease unnecessary documentation in the medical record that may not be pertinent to the patient's care
- To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties

These changes will affect:

- Physicians and qualified health professionals need to understand the changes in how to document patient encounters. Focus can be on taking care of patients, rather than performing potentially unnecessary documentation. Clarity in definitions may lower audit risks. Practice managers will also need to prepare for technology changes and training.
- Coders and health information managers need to know how to properly select the correct E/M office visit CPT code based on new selection requirements. Clarity in definitions will ensure accurate coding.
- Payers need to determine changes that need to be made in systems to support shared adoption and understanding for all clinical and administrative staff. Streamlined time reporting and Medical Decision Making (MDM) requirements will lead to administrative simplification.
- Health systems and hospitals need to determine changes that directly affect their coding/billing business model. Reduced administrative burden with reduction in physicians time documentation and increase in time for patient care.
- Tech vendors need to revise software to ensure new documentation requirements are supported and legacy requirements are retired.

Summary of Proposed Revisions: By providing improved definitions for MDM and consistency in documentation for all payers, the revisions approved by the CPT Editorial Panel and CMS will provide significant and lasting burden reductions.

- Eliminate history and physical as elements for code selection
- While the work in capturing the patient's pertinent history and performing a relevant physical exam contributes to both the time and MDM, these elements alone should not determine the appropriate code level.
- The revised code descriptors state a "medically appropriate history and/or examination" is required.

Physicians and other Qualified Healthcare Professionals (QHP) choose whether documentation is based on MDM or total time

- MDM: the approved revisions did not materially change the three current MDM elements, but did provide extensive edits to the elements for code selection and revised/created numerous clarifying definitions in the E/M guidelines.
- Time: the definition of time is minimum time, not typical time, and represents total physician or other QHP time on the date of service. The use of date-of-service time builds on the movement over the last several

years by Medicare to better recognize the work involved in non-face-to-face service like care coordination. These definitions only apply when code selection is based on time and not MDM.

Modifications to the criteria for MDM:

- The current CMS Table of Risk was a foundation for designing the revised required elements for MDM. Current CMS Contractor audit tools were also consulted to minimize disruption in MDM level criteria.
- Removed ambiguous terms (e.g. “mild”) and defined previously ambiguous concepts (e.g. “acute or chronic illness with systemic symptoms”).
- Defined important terms, such as “Independent historian.”
- Re-defined the Data MDM element to move away from simply counting tasks to focusing on tasks that affect the management of the patient (e.g. independent interpretation of a test performed by another provider and/or discussion of test interpretation with an external physician/QHP.

Deletion of CPT code 99201: The CPT Editorial Panel deleted CPT code 99201 as the MDM is the same as 99202, only differentiated by history and exam elements.

Creation of a shorter Prolonged Service code: The Panel created a shorter prolonged services code that would capture physician/QHP time in 15-minute increments. This code would only be reported with 99205 and 99215 and be used when time was the primary basis for code selection.

Link to 2021 AMA CPT Evaluation and Management Guidelines HERE

Link to Revision to Medical Decision Making – effective 2021 HERE

Give $220 Today to Make a Difference in 2020!

Make your IMPAC donation today!

TEXT "IMPAC" to (208)996-8776

Or click HERE to contribute

The 2020 election is just around the corner and the Idaho Medical Political Action Committee (IMPAC) needs your support! In order to pass laws that protect patients and support the medical profession, physicians need strong allies at the Capitol. When you donate to IMPAC, you make Idaho a better place to practice medicine by helping our Friends of Medicine get elected and keep their seats in the Legislature. Your donation ensures that physicians have a voice in the Idaho Legislature, which is vital in passing pro-medicine legislation and defeating harmful bills.

Give $220 or become an IMPAC Diamond Club member!

There are three Diamond Club membership levels—Silver/$250; Gold/$500; and Gem/$1,000. Diamond club members receive special IMA recognition.

[Back to Top]

Appropriate Use Criteria (AUC) Require New Modifiers and G Codes

Starting January 1, 2021 – the Protecting Access to Medicare Act (PAMA) requires referring physicians and other qualified healthcare providers to consult Appropriate Use Criteria (AUC) prior to ordering advanced diagnostic imaging services. For Medicare patients, advanced imaging includes:

• Computed tomography (CT)
• Magnetic resonance image (MRI)
• Nuclear medicine
• Positron emission tomography (PET)

January 1, 2020, marks the start of the AUC program educational and operations testing period, at which time Medicare Administrative Contractors (MACs) will begin accepting AUC - related modifiers on claims for advanced diagnostic imaging services furnished to Medicare Part B patients. The voluntary participation period ends December 31, 2020.

What ordering physicians and other qualified healthcare providers need to know:

In 2020, the Centers for Medicare & Medicaid Services (CMS) expects ordering professionals to begin consulting qualified Clinical Decision Support Mechanisms (CDSMs) prior to ordering advanced imaging services in applicable settings for Medicare patients and providing information to the furnishing professionals for reporting on their Medicare Part B claims.

Who Must Comply with AUC Program Requirements?

Ordering physicians or practitioners will be required to consult a qualified CDSM when ordering an advanced imaging service for a Medicare patient. CDSMs are the electronic portals to access AUC during the patient workup. The CDSM will provide the ordering professional with a determination of whether the order adheres, or does not adhere, to AUC, or if there is no AUC applicable. Response from CDSM should be immediate real-time.

The applicable settings (where the imaging service is furnished) include:
• Physician offices
• Hospital outpatient departments (including emergency departments)
• Ambulatory surgical centers (ASCs)
• Independent diagnostic testing facilities

The applicable payment systems include:
• Physician Fee Schedule
• Outpatient Prospective Payment System
• ASC

Exceptions to the CDSM requirement include:
• The ordering professional has a significant hardship
• The patient has an emergency medical condition
• The patient is an inpatient and the service will be billed under Part A

Which Codes and Modifiers?:

During the test phase of the program, MACs will not deny claims for failing to include AUC - related information or for misreporting AUC information on non-imaging claims. Full AUC program implementation is expected January 1, 2021. For a complete list of the new HCPCS Level II modifiers established for the AUC program and the corresponding HCPCS Level II G code(s) to identify the qualified CDSM consulted, click **HERE**

[Back to Top]

IMA Education Webinar Series
CPT Changes 2020 - 2 hour session (2 CEU)

Wednesday, December 4

12:15 – 2:30 pm (MT)

Register today to join IMA Reimbursement Director Teresa Cirelli, CPC, CPMA and Reimbursement Specialist Pam McCord, CPC, COC, CPMA on Wednesday, December 4 for the next webinar, CPT Changes 2020 – 2 hour session (2 CEU)

Don't miss this valuable webinar! A registration form is available on the IMA website. Questions? Contact the IMA at 208-344-7888 or rebecca@idmed.org.

This program has the prior approval of AAPC for (1) continuing education hours.

Granting of prior approval in no way constitutes endorsement by AAPC of the program content or the program sponsor.

[Back to Top]

BYU- Idaho to Accept Medicaid Again for Student Coverage

The Brigham Young University-Idaho campus says it will once again accept Medicaid as health insurance that meets its coverage requirement after the school was criticized for adopting a different policy.

Campus officials apologized Monday “for the turmoil caused by our earlier decision.”

“We have decided that Medicaid, as it has in previous years, will meet the health coverage requirement at BYU-Idaho,” the campus said in a news release. “Because of its limited capacity and scope of services, our Health Center has not been a Medicaid service provider. This will not change.”

The university noted that pushback from students and the health care community were among the reasons for the reversal.

Earlier this month, BYU-Idaho announced plans to stop accepting Medicaid as coverage.

The change meant students would have to buy a university-backed plan costing at least $81 a month for single students and up to $678 a month for a family, officials said.

The change came one day after Idaho received approval letters from the federal government for its Medicaid expansion plan, officials said.

The university had cited concerns that Medicaid health care providers would be overwhelmed, but several providers disputed that possibility. Some students argued the school plan was expensive and had limited coverage.

“It feels like a huge weight off the shoulders,” Kaleigh Quick, a senior at BYU-Idaho, said about the school accepting Medicaid. “We can go to school and not worry about the burden of health insurance.” [*Associated Press*, 11/26]

[Back to Top]

New AMA/AHA Blood Pressure E-learning Module

The American Medical Association (AMA) alongside the American Heart Association (AHA), has launched a blood pressure (BP) measurement e-learning module called *Achieving Accuracy: BP Measurement.*

As you are aware, hypertension is a leading risk factor for heart attacks, strokes, and preventable death in the U.S. And we know that inaccurate BP readings can lead to diagnostic errors, which means getting an accurate reading is vital to treating the condition.

This new module, which is available on the AHA’s e-Learning platform and TargetBP.org, as well as the AMA’s Ed Hub platform starting in December, supports AMA’s commitment to provide ongoing support to physicians and care teams in implementing quality improvement efforts that enhance the standard of care and safety for the patients they serve.

Reducing cardiovascular disease starts with accurate BP measurements.

Visit **HERE** to access the course now and sharpen your skills.

[Back to Top]

Burnout Prevention: Tips of the Month

It can often be difficult to notice a struggling colleague when you feel like you’re barely staying above water yourself.

Quick tip
Changes in attitude or personality are the greatest signal that a colleague is struggling to stay afloat. Physicians who are exhausted physically and mentally often become cynical, rushed and indifferent or lack empathy for their patients.

Professional satisfaction and the passion from purpose may be the antidote for burnout. Physician leaders are better equipped to manage stress and rediscover joy in medicine.

Quick tip
Taking a leadership course could be the best thing you could do for your career and your wellbeing. Leadership training gives physicians the resilience, mastery and support needed to create a workplace that is more flexible, satisfying and efficient.

For more information about burnout management, tune into AMA's Moving Medicine podcast
http://movingmedicine.libsyn.com/

[Back to Top]

Office of Inspector General (OIG) Work Plan

Office of Inspector General (OIG) updated its website with audit projects that were added in November. The IMA encourages practices to monitor this website monthly to view recently added projects. These are the projects that the OIG plans to review:

1. Medicare Advantage Risk-Adjustment Data - Payments to Medicare Advantage (MA) organizations are risk-adjusted on the basis of the health status of each beneficiary. MA organizations are required to submit risk-adjustment data to CMS and inaccurate diagnoses may cause CMS to pay MA organizations improper. In general, MA organizations receive higher payments for sicker patients. CMS estimates that 9.5 percent of payments to MA organizations are improper, mainly due to unsupported diagnoses submitted by MA organizations.

2. Medicare Payments for Stelara - Since 2016, Medicare Part B payments to physicians for Stelara-an expensive drug used to treat certain autoimmune diseases that is often self-injected by patients in their home-have increased substantially. Such a large increase in payments for a drug that would not typically be covered under Part B raises questions about what is driving the growth, including the possibility of improper billing. In this study, OIG will (1) determine whether versions of Stelara that are typically self-injected meet the criteria for Medicare Part B coverage, (2) identify factors that may be causing the substantial growth in payments, and (3) determine whether claims for Stelara show evidence of improper billing by physicians.

[Back to Top]

Need a Surgery? An Ambulatory Surgery Center is a Great Low-Cost, High-Quality Option
By Gregory S. Feltenberger, PhD, MBA, FACMPE, FACHE - CEO, Urologic Institute & Surgery Center of Idaho

Do you often have patients who need surgery? What if you could save the patient and the healthcare system money and still be confident the patient would experience high-quality care? Today's healthcare environment has become extremely complicated for patients (and medical offices). In addition, patients are paying more out-of-pocket (high deductible plans) for their healthcare so it has become more consumer-driven (shopping for care).

Therefore, if you need a surgery, there can be many options that include an ambulatory surgery center (ASC), hospital outpatient department (HOPD), or a physician clinic. An ASC is a distinct and independent facility that provides surgical services for patients that do not require hospitalization and the expected duration of services will not exceed 24 hours. A HOPD is similar to an ASC, but it is considered part of a hospital.

Medicare pays ASCs less than it pays HOPDs. This difference between reimbursements, in part, is because a HOPD has greater overhead due to its connection with a larger organization so it can charge hospital-based rates (which are always higher than an ASC). An ASC, however, is an independent entity with inherent efficiencies and cost controls. In general, each of these options have different out-of-pocket costs, capabilities, and insurance coverage limitations. For reimbursement, ASCs often receive about 55% to 60% of what a HOPD is paid and these savings reduce the out-of-pocket cost to patients. For example, a cataract surgery under Medicare might pay an ASC $964 but will pay a HOPD $1,670. And the patient's out-of-pocket is $192 in an ASC but $350 in a HOPD. And finally, ASCs are associated with several advantages given their independent nature: (1) greater patient

convenience in location and scheduling, (2) coinsurance is lower (out-of-pocket), (3) specialized and more consistent staff, (4) a more personalized patient experience, and (5) the same (or better) high-quality care. And for surgeons, the OR turnaround time (the time between surgical cases) is significantly less so “your” time is maximized resulting in more time for quality of life.

What can you do? Educate your patients on the differences and ensure they know they have a choice.

[Back to Top]

Value Based Health Care

The United States health care system is experiencing rapidly rising costs, uneven access to health care services and poor patient outcomes when compared to other nation’s health care systems. Unnecessary services and inefficient care are two areas of health care waste as defined by the National Academy of Medicine.

What is Value-Based Care?

Best care for the patient including high quality outcomes, safety and service delivered at a reasonable cost. High value care is not simply a formula for cost containment but rather a recipe for improved patient health care.

Essentially, value-based care models revolve around the patient's treatment and how well healthcare providers can improve their quality of care based on certain metrics, such as reducing hospital readmissions, improving preventative care, and using certified health technology.

Fee-For-Service Care

Fee-for-service is the more traditional healthcare reimbursement model, based on the amount of services a healthcare provider performed. Another common term for this model is pay-for-performance. This system incentivized providers to order batteries of tests and procedures and increase their total number of patients in order to bring in more money.

That's the key difference with value-based care vs. fee-for-service care; the former provides incentives for quality, while the latter emphasizes quantity.

Defining Value

Six health system goals under acronym STEEEP from the National Academy of Medicine provides a vision for value-based care:

- **S**afe
- **T**imely
- **E**ffective
- **E**fficient
- **E**quitable
- **P**atient-Centered

Value equation

A way to measure high quality of care, including outcomes, safety and service, divided by the total cost over a span of time.

- Outcomes reflect patient health and may include patient mortality, complications, functional status, consistent school or work attendance.
- Safety is a measure of how well health systems protect patients such as: infection rates, accidental falls, medication errors, preventable deaths.
- Service refers to how health care is experienced by the patient and may include measures of patient satisfaction, waiting times to be seen, access to a physician or treatment, access to affordable insurance.

Cost component includes several ways: per line item of service, per visit, per episode, per disease, per year. Long-term view is essential since higher costs in the short term may lead to lower overall costs of treatment. Therefore, total cost is defined as the total amount spent per patient over time.

The definition of health care value can vary widely depending on whose perspective is being considered.

- Physicians and other health care professionals provide a high quality of care timely, without complications and with high level patient satisfaction. Minimize preventable morbidity and mortality.
- Patients want a quick return to normal activity at an affordable cost
- Payers control costs by focusing on short-term benefits to the organization. Keep employees satisfied and return to work rapidly.

Health care professionals are uniquely positioned to lead transformation on a systemic level.

Key components of an ideal high-value health care system

- Clear, shared vision with the patient at the center to deliver highest value care. Barriers include poor integration and coordination of care.
- Leadership and professionalism of health care workers with corresponding training to emphasis teamwork.
- Robust IT infrastructure designed around both physician and patient centered homes. Lack of a national health data infrastructure to study outcomes and published results. An ideal structure would include all the patient's health care data that can be securely accessed by any health care professional.
- Broad access to care individuals have means to choose an access to appropriate medical care. Uninsured individuals have limited access.
- Reimbursement models that remove incentives for volume-based care and instead promote integration, coordination, prevention and health. Payers do not reward physicians to invest in keeping patient's healthy at a younger age to prevent the higher costs as the patient ages.

Five-step framework for high-value care delivery

- Understand the benefits, harms and relative costs of intervention
- Decrease or eliminate the use of interventions that provide no benefit and/or cause harm
- Choose interventions and care settings that maximize benefits, minimize harms and reduce cost
- Customize care plans with patients that incorporate their values and address their concerns
- Identify system-level opportunities to improve outcomes, minimize harms and reduce health care waste

Click HERE to view the AMA Value-Based Care Module Summary

[Back to Top]

Idaho Medical Association
P.O. Box 2668, 305 West Jefferson, Boise, ID 83701
Phone: (208) 344-7888 - Fax: (208) 344-7903 - Email: mail@idmed.org