Idaho Medical Association

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IMA Wire

February 1, 2019

Measles Outbreak in Clark County, Washington The Idaho Immunization Program is alerting Idaho healthcare providers that Clark County Public Health in Washington State continues to investigate an expanding measles outbreak, with 22 confirmed cases of measles reports as of January 22, 2019. For information on this outbreak and possible exposure locations in Washington and Oregon, see https://www.clark.wa.gov/public-health/measles-investigation.

No measles cases have been reported yet in Idaho; however, healthcare providers are encouraged to assess measles vaccination status of their patients and issue appropriate reminders or recalls. Recommended immunization schedules can be found at https://www.cdc.gov/vaccines/schedules/hcp/imz/child-adolescent.html and https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html.

Healthcare providers should consider measles in patients presenting with febrile rash illness and clinically compatible measles symptoms, especially if the patient recently traveled internationally or to locales in the United States experiencing a measles outbreak (see https://www.cdc.gov/measles/index.html), including Clark County, WA. For information about diagnosis, vaccination, isolation, and treatment of measles for healthcare professionals, including a link to a five-minute video from the Centers for Disease Control and Prevention, see https://www.cdc.gov/measles/hcp/index.html. Healthcare providers should obtain BOTH a serum sample for IgG and IgM antibody testing and a throat or nasopharyngeal swab for PCR testing of patients suspected to have measles, at first contact with the patient. The Idaho Bureau of Laboratories (IBL) can offer PCR testing on specimens from patients with compatible symptoms only. There may be an associated fee for testing. Contact Virology/Serology at IBL at 208-334-0589 prior to shipping any specimens, and see the IBL sampling and submission guideline at http://healthandwelfare.idaho.gov/Portals/0/Health/Labs/SSG/Clinical_Measles_RT-PCR.pdf.

Suspected measles is reportable to your local public health district (see map and links at https://healthandwelfare.idaho.gov/Health/HealthDistricts/tabid/97/Default.aspx) or

the Bureau of Communicable Disease Prevention, Epidemiology Program (phone 208-334-5939; FAX 208-332-7307) within one working day. Prompt reporting will facilitate rapid public health investigation to initiate appropriate control measures for this highly contagious disease.

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New Medicare Part D Opioid Overutilization Policies for 2019

The Centers for Medicare and Medicaid Services (CMS) finalized new policies for Medicare drug plans to follow starting on January 1, 2019. These policies involve further partnership with providers and prescription drug plans. Providers are in the best position to identify and manage potential opioid overutilization in the Medicare Part D population. Medicare prescription drug plans can assist providers by alerting them about unusual utilization patterns in prescription claims.

The new policies include improved safety alerts when opioid prescriptions are dispensed at the pharmacy, and drug management programs to better coordinate care when chronic high-risk opioid use is present.

Real-Time Safety Alerts at the Time of Dispensing

Part D plans commonly implement safety alerts (pharmacy claim edits) for pharmacists to review at the time of dispensing the medication to prevent the unsafe utilization of drugs. These alerts are typically for drug-drug interactions, therapeutic duplication, or a potentially incorrect drug dosage (for example, doses above the maximum dosing in the Food and Drug Administration (FDA)-approved labeling).

Specific to prescription opioids, beginning in January 2019, Medicare Part D plans will employ the following new safety alerts at the pharmacy:

- 7 day supply limit for opioid naïve patients: Part D plans are expected to implement a hard safety edit to limit initial dispensing to a supply of 7 days or less. A hard safety edit stops the pharmacy from processing a prescription until an override is entered or authorized by the plan. This policy will affect Medicare patients who have not filled an opioid prescription recently (for example, within the past 60 days) when they present a prescription at the pharmacy for an opioid pain medication for greater than a 7 day supply.
- Opioid care coordination alert: This policy will affect Medicare patients when they present an opioid prescription at the pharmacy and their cumulative morphine milligram equivalent (MME) per day across all of their opioid prescription(s) reaches or exceeds 90 MME. Regardless of whether individual

prescription(s) are written below the threshold, the alert will be triggered by the fill of the prescription that reaches the cumulative threshold of 90 MME or greater. It is the prescriber who writes the prescription that triggers the alert who will be contacted by the pharmacy even if that prescription itself is below the 90 MME threshold.

Drug Management Programs
The Comprehensive Addiction and Recovery Act of 2016 included provisions that give Part D plans important new tools to use in 2019 to address opioid overutilization. To implement this law, CMS adopted a regulation so that Part D plans may implement a drug management program that limits access to certain controlled substances that have been determined to be "frequently abused drugs" for patients who are considered to be at-risk for prescription drug abuse. Limiting access means that the patient might only be able to obtain these medications from a specified prescriber or pharmacy. For 2019, CMS has identified opioids and benzodiazepines as frequently abused drugs.

Additional information including frequently asked questions is available in MLN Matters SE18016.

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Burnout Management Tip-of-the-Week Emails More than half of U.S. physicians experience burnout. Subscribe to the American Medical Association's Burnout Tip-of-the-Week for expert-driven insights to manage burnout, quick tips to streamline workflows and resources to improve professional satisfaction.

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Recent Updates from CMS

Guidance on Coding and Billing Date of Service. The Centers for Medicare and Medicaid Services (CMS) re-issued guidance SE17023 from 2017 on January 24, 2019 to reiterate current Medicare policy on correctly submitting the date of service. The guidance specifies this is not a new or changed policy.

DME Documentation

1. CMS provided guidance through SE19003 indicating that physicians and suppliers billing for Durable Medical Equipment (DME) must maintain proof of delivery documentation for seven years.
2. DME Competitive Bidding contracts expired at the end of 2018, MM11097. CMS will have a temporary gap in contracts that will last through the end of 2020. Patients will not be required to obtain DME supplies from specified suppliers during the next two years.

Total Knee Arthroplasty. On January 24, 2019, CMS clarified through SE19002 the removal of a total knee procedure from the inpatient-only list along with the application of the two-midnight rule.

Medicare Compliance Tips. CMS has several topics listed by date order for compliance tips that could be shared with office staff. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications.html?DLSort=0&DLEntries=10&DLPage=1&DLSortDir=descending&DLFilter=venip

New App Displays What Original Medicare Covers. On January 28, 2019, CMS announced the new "What's Covered" app that lets people with original Medicare, caregivers, physicians, and others quickly see whether Medicare covers a specific medical item or service. You can now use your mobile device to more easily get accurate, consistent original Medicare coverage information in your office, the hospital, or anywhere. The free app is available in Google Play and the Apple App Store.

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Understanding Incident-to Services Most practices utilize incident-to services sometimes, whether it is an encounter where a nurse or MA takes a blood pressure or gives an injection, or it can expand all the way to a non-physician practitioner (NP, PA, etc.) providing a full evaluation and management (E/M) service in the office and billing it under a physician's NPI. Failing to bill for incident-to services can cost a practice thousands of dollars. When billing incident-to, a practice can be reimbursed at 100 percent of the physician fee schedule for non-physician provider services.

What makes a service incident-to is that someone other than the supervising physician is providing the service, but the service is billed out under the supervising physician's NPI. The actual provider of the service such as a nurse, medical assistant or NPP is invisible to the payer on the claim. There is no modifier to indicate that a service is being provided incident-to, so the claims all appear as if the physician whose NPI was used was the provider who provided the services.

Medicare has very specific rules as to when you can use incident-to and how to bill under a supervising physician's NPI. However, practices cannot assume that non-Medicare payers follow Medicare's rules without finding out from each of the payers specifically and asking them for their rules for billing incident-to services in writing.

Medicare's guidelines for billing incident-to can be found in the Internet Only Manual (IOM) in Chapter 12 of Publication 4, in section 30.6.4 and Evaluation and Management and CMS Internet Only Manual Chapter 15 of Publication 2. These guidelines outline very specific Medicare rules. In order to bill under the supervising physician's NPI, the service must:

- Be part of the physician's plan of care for the patient.
- The supervising physician must be onsite, providing "*direct supervision*" in the office suite (does not need to be in the room) while the service is rendered by the incident-to personnel.
- The incident-to personnel must either be a W-2 or contracted employee.

This means that incident-to cannot be billed by a NPP seeing a new patient or a new problem where there is no plan of care and bill it incident-to. The NPP can bill the above services under their own NPI and the practice will be allowed 85 percent of the Medicare fee schedule.

It also means that the physician's NPI that is used must represent a doctor that is onsite, in the office suite at the time of the incident-to services. The doctor whose NPI is used does not have to be the patient's doctor, does not have to be the doctor who established the plan of care and does not have to be the doctor who ordered the service, but the doctor whose NPI is used does have to be the doctor who was onsite with the nurse, MA or NPP when the service was rendered. Using the NPI of another doctor in the group, who was not in the office suite, who may have been doing surgery, was in another office or was off that day is considered *"billing for services not rendered"* because that doctor was not onsite and did not supervise the incident-to services.

Location, Location, Location - Watch Out for Place of Service Rules
The place of service is important in incident-to billing. In most cases, services must occur in a physician's office or clinic. However, there may be cases where NPPs can bill incident-to services for homebound patients in medically underserved areas where home health services are not available. As CMS delineates in MLN Matters article SE0441, in these cases, physician providers do not have to be physically present in the home when the NPP performs the service. However, the doctor still must order the service, stay in contact with the NPP, and be professionally responsible for the service, CMS says.

So, please take away the following: Incident-to billing to Medicare is acceptable if:

- There is a plan of care for the patient for what is being treated;
- The NPI being billed is the NPI of the physician who is onsite when the incident-to service is performed, and;
- It would be advantageous for the incident-to personnel to document at the beginning of their note: *"Doctor A in office supervising today"* so that when and if the incident-to services are audited, the documentation exists that the billed doctor, Doctor A, was onsite.
- For non-Medicare, inquire from each payer and ask what their rules (written) are for billing incident-to as well as for billing for NPP services.

More information can be found at the link below: https://med.noridianmedicare.com/web/jfb/topics/incident-to-services

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Qualis Health Offering MIPS Coffee Talk

Do you have a MIPS question or concern? Qualis' MIPS Coffee Talks can provide answers. The next session is February 27 at 10:30 am (MT). Check Qualis' upcoming events page for more information.

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Noridian Medicare LCD Articles

Noridian Medicare is making changes to how Local Coverage Determinations (LCDs) can be viewed. LCDs will indicate the coverage and corresponding articles will provide any coding guidance.

Every LCD or National Coverage Determination (NCD) may not have a corresponding article to provide coding guidance. Noridian is in the process of developing coverage articles as new LCDs or NCDs include coding information.

Articles address local coverage, coding or medical review related billing and claims considerations, and may include any newly developed educational materials, coding instructions or clarification of existing medical review related billing or claims policy.

Share this link with your coding staff and know when coverage may be limited on a procedure or service you are providing. https://med.noridianmedicare.com/web/jfb/policies/coverage-articles

If you have questions regarding any of the coverage articles or LCDs, please contact Reimbursement Director Teresa Cirelli, CPC - teresa@idmed.org or Reimbursement Specialist Pam McCord, CPC - pam@idmed.org; or call 208-344-7888.

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HHS Just Released New Cybersecurity Practices for the Entire Health Care Industry, Including Medical Practices Large and Small

A two-year project to create a set of voluntary cybersecurity practices for health care organizations of all sizes has been released by the U.S. Department of Health and Human Services (HHS).

Titled *Health Industry Cybersecurity Practices (HICP): Managing Threats and Protecting Patients,* the document is in response to requirements set forth in the Cybersecurity Act of 2015.

The extended publication explores five leading cybersecurity threats to the field, including phishing and ransomware attacks, and ten ways to mitigate those risks. It also includes tailored advice for small and large practices.

The publication consists of four parts:

- The main document, exploring the five most relevant cybersecurity threats and highlighting ten actions to help mitigate these threats.
- Volume 1, discussing cybersecurity practices for small health care organizations.
- Volume 2, discussing cybersecurity practices for medium and large health care organizations.
- Resources and templates, including links to resources to assist practices in assessing their "cyber hygiene" and developing appropriate policies and procedures.

To access all parts of the report, click here.

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Office of Inspector General (OIG) Work Plan

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

1. Medicare Payments for Clinical Diagnostic Laboratory Tests in 2018: Year 1 of New Payment Rates – OIG will release an analysis of the top 25 laboratory tests by expenditures for 2018, the first year of payments made under the new system for setting payment rates.
2. Duplicate Payments for Home Health Services Covered Under Medicare and Medicaid – Looking at dual eligible patients (Medicare and Medicaid) with home health benefits and Medicaid payments received for the same date of service.
3. Utilization and Pricing Trends for Naloxone in Medicaid - The proposed data brief would (1) trend

utilization of and expenditures for naloxone in Medicaid over a 5-year period; (2) determine how the cost-per-dose for naloxone under Medicaid compares to other available prices; and (3) determine the proportion of all naloxone distributed in the U.S. that was paid under Medicaid between 2014 and 2018. This information can help stakeholders determine how to cost-effectively increase naloxone access to affected Medicaid-eligible beneficiaries.

OIG Fraud Risk Indicator

The Office of the Inspector General (OIG) addresses healthcare fraud by using the False Claims Act (FCA) as a primary tool to predict fraudulent conduct.

The OIG assesses the future trustworthiness of the settling parties (which can be individuals or entities) for purposes of deciding whether to exclude them from the Federal healthcare programs or take other action based on information gathered in FCA cases.

The OIG published criteria (***click here***) and the OIG applies this criteria to assess future risk, then places each party into one of five categories on a risk spectrum:

Risk Categories

1. Highest Risk - Exclusion
2. High Risk - Heightened Scrutiny
3. Medium Risk - CIAs
4. Lower Risk - No Further Action
5. Low Risk - Self-Disclosure

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