Idaho Medical Association

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IMA Wire

June 1, 2018

AMA Report Shows National Progress Toward Reversing Opioid Epidemic

The American Medical Association (AMA) issued a new report (www.end-opioid-epidemic.org) documenting how physician leadership is advancing the fight against the opioid epidemic.

The report, which is being released as the U.S. Department of Health and Human Services Pain Management Best Practices Inter-Agency Task Force meets for the first time, found a decrease in opioid prescribing and increases in the use of state prescription drug monitoring programs (PDMPs), number of physicians trained and certified to treat patients with an opioid use disorder, and in access to naloxone.

“While this progress report shows physician leadership and action to help reverse the epidemic, such progress is tempered by the fact that every day, more than 115 people in the United States die from an opioid-related overdose,” said Patrice A. Harris, MD, MA, Chair AMA Opioid Task Force. “What is needed now is a concerted effort to greatly expand access to high quality care for pain and for substance use disorders. Unless and until we do that, this epidemic will not end.”

The report found:

- Opioid prescribing decreases for fifth year in a row. Physicians have decreased opioid prescriptions nationwide for the fifth year in a row. Between 2013 and 2017, the number of opioid prescriptions decreased by more than 55 million — a 22.2 percent decrease nationally. Decreases occurred in every state, including a 17.1 percent decrease here in Idaho.
- PDMP registration and use continues to increase. In 2017, health care professionals nationwide accessed state databases more than 300.4 million times – a 121 percent increase from 2016. States with and without mandates to use the PDMP saw large increases. In Idaho, 2017 PDMP queries numbered 1,113,840, approximately a 70 percent increase from 2016.

- Physicians enhancing their education. In 2017, nearly 550,000 physicians and other health care professionals took continuing medical education classes and other education and training in pain management, substance use disorders and related areas. Many of these resources are offered by the AMA, state, and specialty societies, and more than 350 of these resources can be found on the AMA opioid microsite, www.end-opioid-epidemic.org.
- Access to naloxone rising. Naloxone prescriptions more than doubled in 2017, from approximately 3,500 to 8,000 naloxone prescriptions dispensed weekly. So far in 2018, that upward trend has continued; as of April, 11,600 naloxone prescriptions are dispensed weekly - the highest rate on record.
- Treatment capacity increasing. As of May this year, there were more than 50,000 physicians certified to provide buprenorphine in office for the treatment of opioid use disorders across all 50 states — a 42.4 percent increase in the past 12 months.

“We encourage policymakers to take a hard look at why patients continue to encounter barriers to accessing high quality care for pain and for substance use disorders,” said Dr. Harris. “This report underscores that while progress is being made in some areas, our patients need help to overcome barriers to multimodal, multidisciplinary pain care, including non-opioid pain care, as well as relief from harmful policies such as prior authorization and step therapy that delay and deny evidence-based care for opioid use disorder.”

To further address the opioid epidemic, the AMA and the Idaho Medical Association urges policymakers and insurers to remove barriers to care for pain and substance use disorders. These steps include:

- All public and private payers should ensure that their formularies include all FDA-approved forms of medication assisted treatment (MAT) and remove administrative barriers to treatment, including prior authorization.
- Policymakers and regulators should increase oversight and enforcement of parity laws for mental health and substance use disorders to ensure patients receive the care that they need.
- All public and private payers—as well as pharmacy benefit management companies—must ensure that patients have access to affordable, non-opioid pain care.
- We can all help put an end to stigma. Patients with pain or substance use disorders deserve the same care and compassion as any other patient with a chronic medical condition.

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2018 IMA Annual Meeting
August 3-5, 2018

Sun Valley

Make your room reservations now! Now's the time to make your reservation and take advantage of conference rates at the Sun Valley Resort. Reserve your room online at https://www.sunvalley.com/lodging#/groups/IMAM2018 or call 1-800-786-8259 and reference IMA room block code IMA7888. Our room block will be released July 2 and the resort tends to sell out during the summer months.

Registration and meeting details are available on the IMA website and registration brochures were recently mailed to members. Register online today at www.idmed.org!

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Idaho Healthcare Advocates Summit
Monday, June 18, from 2:30-5:30 pm
The Linen Building,1402 W Grove Street, Boise

As the new campaign to expand Medicaid at the ballot takes off this summer, this event will bring healthcare advocates working in a variety of settings together to discuss:

- Messaging for the new campaign
- Details about lessons learned during the signature gathering effort
- The fiscal case for expanding Medicaid in Idaho

A panel discussion and group work will run from 2:30 – 4:30 pm. A volunteer appreciation reception for those who worked to collect signatures will run from 4:30 – 5:30 pm. Food and drink will be provided by Idaho Voices for Children.

You can RSVP for the event, or register to attend remotely via webinar, here.

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Insurance Department Issues Administrative Order

On May 30, 2018, the Director of the Idaho Department of Insurance issued a consent order regarding Montana Health Cooperative dba Mountain Health Co-Op (MHC) effective May 30, 2018, imposing an administrative penalty of $10,000 for violation of Idaho Code § 41-1304, and IDAPA Rule 18.01.24.

These violations stem from inaccurate and misleading information that MHC admitted to providing to its agents and to placing on its website in November of 2017. MHC had represented to agents and posted on its website that certain medical providers at a regional medical facility in Idaho were within the MHC network when in actuality those providers were not.

Idaho Code § 41-1304, *False information and advertising with respect to insurance business*, prohibits the making and publishing of any advertisement or statement containing any assertion or representation with respect to the business of insurance that is untrue, deceptive or misleading. MHC violated this statute by misstating and by posting to its website that certain medical providers were available through its network when they weren't.

IDAPA 18.01.24, *Advertisement of Disability (Accident and Sickness) Insurance*, provides for minimum standards and guidelines of conduct in the advertising of disability insurance by means of printed and published material and that such advertisements shall be sufficiently clear and complete to avoid deception or to avoid being misleading. MHC's publication on its website that certain medical providers were available through MHC's network was untrue and was a form of advertisement that was misleading and deceptive, in violation of IDAPA Rule 18.01.24.

Director Dean Cameron noted that, "agents assisting consumers and the insurance-buying public need to be able to rely upon information from insurance companies, including which providers are in-network." Director Cameron added, "We appreciate MHC's willingness to acknowledge this mistake and its commitment to correct it going forward."

A copy of the order is available on the Department's website, doi.idaho.gov.

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Aligning the Merit-based Incentive Payment System (MIPS) with Health Equity

By: Qualis Health

Year one of the Quality Payment Program (QPP) is now behind us, and practices are gearing up for year two. In 2017 we heard about many challenges that practices face, such as: time, resources, lack of a certified electronic health record, and the need for intensive technical assistance. And yet others have found purpose and meaning in the QPP program by aligning it with meaningful measures that match organizational goals and high priority topics. One national high priority area is the opportunity to advance health equity.

What is Health Equity?

Health equity is a shared goal for clinicians and partners working to improve the quality of healthcare. Health equity is the state in which every person has the ability to be their "healthiest self." Disparities are present when vulnerable persons have more difficulty achieving their healthiest self, due to interacting factors present in their communities. People may be vulnerable to disparities when they do not have access to clean drinking water, fresh quality food, safe and secure housing, reliable and accessible transportation, adequate educational and healthcare services, and/or have communication, accessibility, or other societal challenges (e.g., bias or discrimination). To achieve health equity, action beyond providing usual quality medical care is required to address these underlying issues.

Health disparities are differences in health outcomes closely linked with social, economic and environmental disadvantages. Disparities are often driven by the social conditions in which individuals live, learn, work and play. Characteristics including race, ethnicity, disability, sexual orientation or gender identity, socio-economic status, geographic location, and other factors historically linked to exclusion or discrimination are known to influence the health of individuals, families and communities[1]. Work to advance health equity can start with collecting and reporting data aligned with the CMS Health Equity Plan Priorities.

Three Steps to Align Your QPP Reporting Plan with Health Equity

The QPP offers clinicians new tools, models, and incentives to help provide their patients with the best possible care. It also presents an opportunity to leverage complementary goals, by selecting measures that align, such as health equity. Here are three steps you can take to align your Quality Payment Program reporting plan with health equity.

Step 1: Choose Health Equity-related Improvement Activities (IAs): In 2018, Improvement Activities will account for 15 percent of your MIPS Final Score and should be performed for a minimum of 90 days. Most practices will select up to four IA's to report, and small practices, defined as having 15 or fewer clinicians, will select up to two IA's to report. In 2018, you will find four Improvement Activities that are listed under the subcategory of Achieving Health Equity.

- Engagement of new Medicaid patients and follow-up (IA_AHE_1). This is a high weighted activity that is defined as: Seeing new and follow-up Medicaid patients in a timely manner, including individuals dually eligible for Medicaid and Medicare.
- Leveraging a Qualified Clinical Data Registry (QCDR) for use of standard questionnaires (IA_AHE_4). This is a medium weighted activity that is defined as: Participation in a QCDR, demonstrating performance of activities for use of standard questionnaires for assessing improvements in health disparities related to functional health status (e.g., use of Seattle Angina Questionnaire, MD Anderson Symptom Inventory, and/or SF-12/VR-12 functional health status assessment).
- Leveraging a QCDR to promote use of patient-reported outcomes tools (IA_AHE_3). This is a medium weighted activity and is defined as: Participation in a QCDR, demonstrating performance of activities for promoting use of patient-reported outcome (PRO) tools and
    - corresponding collection of PRO data (e.g., use of PQH-2 or PHQ-9 and PROMIS instruments).
    - Leveraging a QCDR to standardize processes for screening (IA_AHE_2). This is a medium weighted activity and is defined as: Participation in a QCDR, demonstrating performance of activities for use of standardized processes for screening for social determinants of health such as food security, employment and housing. Use of supporting tools that can be incorporated into the certified EHR technology is also suggested.

Step 2: Choose Quality Measures that Align with Health Equity: The Quality Category is

worth 60 percent of your MIPS final score in 2018. Clinicians will report six Quality Measures on at least 60 percent of all patients for the 12 month performance period. With nearly 300 measures to choose from, MIPS eligible clinicians will need to report on six Quality Measures, with one being an outcome measure. Many MIPS Quality measures align with the goals set out in six Health Equity Plan priorities that are outlined in the CMS Health Equity. Out of the measure set below, nine are considered as "high priority" measures, which yield additional bonus points, and can contribute significantly to your MIPS final score.

			CMS Health Equity Plan Priorities					
Quality ID	Quality Measure	High Priority	1-Standardized Demographic Data	2 - Evaluate Disparities Impacts/ Solutions	3 - Develop/ Disseminate Promising Approaches	4 - Vulnerable Populations	5 - Communications Access	6 - Physical Accessibility
288	Dementia: Caregiving Education and Support	•			•		•	
286	Dementia: Counselling Regarding Safety Concerns	•			•		•	
19	Diabetics Retinopaphy: Communication with the Physicians Managing Ongoing Diabetes Care	•			•	•		
155	Falls: Plan of Care	•			•			•
325	Adult Major Depressive Disorder (MDD): Coordination of Care of Patienets with specific Comorbid Conditions	•			•	•		
134	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan			•			•	
317	Preventive Care and Screening: Tobacco Use: Screening for High Blood Pressure and Follow-Up Documented		•	•		•	•	
226	Preventive Care and Screening: Tobacco Use: Screening and Brief Counselling				•		•	
431	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counselling				•	•	•	
326	Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy (appropriate use of)				•			
236	Controlling High Blood Pressure	•		•	•	•		
117	Diabetes: Eye Exam		•		•			
163	Diabetes: Foot Exam		•		•			
1	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)	•	•		•			
373	Hypertension: Improvement in Blood Pressure	•			•			
438	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease				•	•		
32	Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy				•			
130	Documentation of Current Medications in the Medical record	•	•	•	•	•	•	

Step 3: Use your Certified Electronic Health Record to Optimize Patient Care for All Patients, and Report Advancing Care Information (ACI). The ACI category is worth 25 percent of your MIPS final score in 2018. Clinicians will report on a minimum of 90 days during the performance period. There are many opportunities to use the Electronic Health Record to promote health equity. For example, you can use the patient portal to send patient reminders for milestones, such as reminding them that it's time to receive an immunization or a wellness exam. Providing access to screenings for all patients eliminates health disparities. The information below aligns ACI objectives and measures with the CMS Health Equity Plan.

		CMS Health Equity Plan Priorities					
Objective Name	Performance Score Weight/ Required for Base Score	1-Standardized Demographic Data	2 - Evaluate Disparities Impacts/Solutions	3 - Develop/Disseminate Promising Approaches	4 - Vulnerable Populations	5 - Communications Access	6 - Physical Accessibility
Clinical Data Registry Reporting	0/NO			•		•	
e-Prescribing	0/YES			•		•	
Electronic Case Reporting	0/NO			•	•		
Immunization Registry Reporting	0 or 10%/NO			•			•
Patient-Specific Education	Up to 10%/ NO			•	•		
Provide Patient Access	Up to 10%/ YES		•			•	
Public Health Registry Reporting	0/NO	•	•		•	•	
Request/Accept Summary of Care	Up to 10%/ YES			•		•	
Secure Messaging	Up to 10%/ YES			•	•	•	
Send a Summary of Care	Up to 10%/ NO			•			
Syndromic Surveillance Reporting	0/NO		•	•	•		

Bringing it All Together: MIPS creates an opportunity to find purpose and meaning in the program by aligning it with organizational goals and national high priority topics, such as health equity. As your practice selects and tracks health equity aligned measures throughout the year in 2018, your efforts can result in up to a 5 percent incentive on Medicare Part B payments for the 2020 payment year.

Qualis Health provides practices in Idaho with customized technical assistance that includes regular office hours and webinars, monthly program updates, strategic MIPS planning and access to a QPP helpdesk at no cost to you. In addition to technical assistance, the Qualis Health QPP online resource center is designed to be a comprehensive destination for all QPP needs. It includes a variety of helpful tools and resources, quick links to important QPP websites and information, and a curated list of upcoming QPP learning events.

Featured Webinar - Using Data and Strategy to Succeed in MIPS Year 2: Advice for Solo and Small Group Practices

This event will help all understand how to use data and strategies for enhancing their MIPS scores in each of the four performance areas.

June 12, 2018, 3:30 p.m. - 4:30 p.m. ET
June 14, 2018, 11:00 am - 12:00 p.m. ET

Register today.

For a full list of technical assistance offerings, and to view tools and resources, visit the QPP online resource center at www.Medicare.QualisHealth.org/QPP. To contact Qualis Health's team of QPP experts, email QPP@qualishealth.org or call 877-560-2618.

[1] *Braveman, Public Health Reports / 2014 Supplement 2 / Volume 129 What are disparities and Health Equity? We need to be clear*

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OIG Efforts to Prevent Opioid Overutilization and Misuse in Medicare and Medicaid

The mission of the Office of Inspector General (OIG) is to protect the integrity of Health and Human Services (HHS) programs and the health and welfare of the people they serve through prevention, detection, and enforcement. OIG investigators have identified and charged physicians in various states with opioid-related convictions. The convictions range from patient harm, prescription fraud to treatment-related fraud.

Data analysis is used to identify questionable prescribing, dispensing and utilization of opioids. In 2016 data, one in every three Medicare Part D beneficiaries received opioids, 14.4 million people. Approximately 500,000 beneficiaries received high dosages of opioids, excluding cancer diagnoses and those enrolled in hospice. Within this group, 90,000 beneficiaries were identified at serious risk of opioid misuse or overdose.

Although some patients may legitimately need high amounts of opioids, questionable prescribing can indicate that prescribers are not checking state databases that monitor prescription drugs, or that they are ordering medically unnecessary drugs that may be diverted for resale or recreational use.

OIG will be releasing a new data brief utilizing 2017 data and will include an analysis toolkit that provides detailed steps for using prescription drug data to analyze patients' opioid levels and identify those at risk of opioid misuse or overdose, such as those who receive extreme amounts of opioids or appear to be doctor shopping. (https://oig.hhs.gov/testimony/docs/2018/dixon-testimony052918.pdf)

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Coding Corner: Diagnosis Coding Question

The IMA recently received a question, "What diagnosis is needed to get a service paid?" The reimbursement team found that a local coverage determination was in place and the diagnosis codes did not support medical necessity.

Coding should always clearly match the services provided and the condition treated, regardless of insurance coverage. To understand the importance of diagnosis coding, look beyond what it takes to get a claim paid and consider the importance of the data diagnosis codes represent. When a physician sees a patient, he/she sees the "whole person." But for anyone viewing the medical record - including payers, other healthcare providers, medical coders, and billers - the patient is reduced to the data within that record. To give a complete view of the patient's condition, as well as the medical necessity of treatment(s) provided, the data must be complete and accurate.

For example, if a practice attributes a diagnosis to a patient that he/she does not have, this could affect the individual's insurance rates (as in the case of life insurance or health insurance for non-ACA plans). A non-existent diagnosis also makes healthcare more expensive as other providers are trying to treat a condition they assume exists when in fact it does not. Experienced coding and billing staff members should help others in the practice understand various insurance coverage policies to ensure effective communication regarding when a procedure is covered by insurance, or if a patient will be responsible for payment.

Patients are often told their insurance is a contract between the insurance company and the patient. While that is true, the patient is often unfamiliar with medical procedures and relies heavily on the physician and their staff to help them understand what will happen and how that will affect their health and their finances. The physician also holds a contract with insurance companies. As part of that contract the physician agrees to bill accurately for services provided, including the most accurate diagnosis codes based on documentation.

For any questions related to this article or reimbursement in general, IMA Director of Reimbursement Teresa Cirelli, CPC, CPMA and IMA Reimbursement Specialist Kim Burgen, CPC, CPMA are available to help. Teresa and Kim can be reached by phone at 208-344-7888 or by email, teresa@idmed.org or

kim@idmed.org. If your office is struggling with this issue or any reimbursement issues, the IMA provides outreach and education in many forms. Contact us today to see if we have a solution for your needs.

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Noridian Medicare Draft LCDs

Noridian Medicare posted four draft Local Coverage Determinations (LCDs) that will be open for comments through August 14, 2018. The Idaho Carrier Advisory Committee will meet on June 20 to discuss concerns from committee members.

To submit comments on any of the draft LCDs, copy the IMA and send to:

Noridian Healthcare Solutions, LLC JF Part B Contractor Medical Director(s)
Attention: Draft LCD Comments
PO Box 6781
Fargo, ND 58108-6781

IMA
Attention: Teresa - Draft LCD Comments
PO Box 2668
Boise, ID 83701

Submit comments by email:
policydraft@noridian.com
teresa@idmed.org

Draft LCDs – Comment period ends August 14, 2018:

- Magnetic-Resonance-Guided Focused Ultrasound Surgery (MRgFUS) for Essential Tremor (DL37738)
- MolDX: DecisionDx-Melanoma (DL37748)
- MolDX: Oncotype DX AR-V7 Nucleus Detect for Men with Metastatic Castrate Resistant Prostate Cancer (MCRPC) (DL37744)
- MolDX: Pigmented Lesion Assay (PLA) (DL37740)

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TRICARE Changes

As of January 1, 2018, Health Net Federal Services took over claims processing for beneficiaries enrolled in the TRICARE military program. Prior to January 1, 2018, claims for Idaho were processed by United Healthcare. As with any new claims processor, there are changes that physicians and their offices need to be aware of. Healthnet has a very robust website that they direct physicians to often. Since procedures needing prior authorizations may have changed, or co-pay amounts or other changes that may affect practices reimbursement, take a moment and click here. The link will take you to the Health Net Federal Services website for TRICARE West.

Veterans Choice Program

Recently Congress passed legislation that included funding for the Veterans Choice program. Services provided through the Veterans Choice Program are supplemental to the TRICARE benefits and meant to fill the gap between long wait times at VA medical centers and needed care for veterans. As a reminder to physician offices, the VA Choice Program is billed first, and claims are processed by TriWest Health Alliance. The website can be found here for more information. President Trump has expressed his intention to sign the bill once it reaches his desk.

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Medicare Comprehensive Error Rate Testing (CERT) in Idaho

Noridian Medicare released preliminary CERT numbers for 2018. The national CERT error rate is 9.0 percent, down from 10.2 percent in 2017. Idaho's CERT error rate dropped almost by half from 8.4 percent in 2017 to the current error rate of 4.7 percent. Idaho's recent error rate represents accurate documentation for services submitted to Medicare and moves us down from the high error range shown in last year's numbers.

Two categories identified through CERT review are insufficient documentation and incorrect coding. Missing

the intent or supportive documentation for ordering services seems to be an area that needs improvement. When ordering tests, images or other services, the documentation should indicate the reason for the order and the specific service. For example, “Run labs” or “check blood” by itself does not support intent.

- Insufficient Documentation
  - Missing physician order/intent and supportive documentation
  - Documentation submitted does not adequately describe the service defined by the CPT/HCPCS code billed
  - Missing or illegible signature; missing attestation or signature log
- Incorrect Coding
  - Documentation does not support CPT/HCPCS code, unit of service or use of modifier

If you have questions regarding your documentation or would like to have an audit performed by an outside entity, IMA offers audits by certified auditors at a reduced rate for members. Contact the reimbursement team, Reimbursement Director Teresa Cirelli, CPC, CPA at teresa@idmed.org or Reimbursement Specialist Kim Burgen, CPC, CPMA at kim@idmed.org, or call 208-344-7888.

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OIG May 2018 Update to Work Plan

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

In the month of May, the OIG has chosen to look at state stewardship of federal funds, Indian Health issues and:

- Examining Healthcare Coalitions' Partnerships With Non-Hospital-Based Facilities in Community Preparedness Efforts - Healthcare Coalitions (HCCs) are groups of public and private health care organizations, emergency preparedness planners, responders, and other types of health officials in specified jurisdictions. Many vulnerable populations depend on non-hospital-based facilities, such as community mental health centers, for monitoring and care during and after disasters. OIG will examine the extent to which HCCs ensure "a successful whole community response" by integrating non-hospital-based facilities into their emergency preparedness activities and technological strategies.
- Medicare Part B Outpatient Cardiac and Pulmonary Rehabilitation Services – Previous OIG audits found requirements for rehabilitation services were not medically necessary and didn’t meet requirements. Reviews will continue to verify requirements are met.
- Noninvasive Home Ventilators - Compliance With Medicare Requirements - For items such as noninvasive home ventilators (NHVs) and respiratory assist devices (RADs) to be covered by Medicare, they must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Prior OIG work identified significant growth in Medicare billing for NHVs in the years since they reached the market. OIG will determine whether claims for NHVs were medically necessary for the treatment of beneficiaries' diagnosed illnesses and whether the claims complied with Medicare payment and documentation requirements.

Physicians and their practices will want to book mark this website and monitor issues monthly.
https://oig.hhs.gov/reports-and-publications/workplan/index.asp

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