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All Medicare fees are par, office, national unless otherwise noted.

Meaningful use

Meaningful use attestation deadline looms Feb. 28; prepare as if for an audit

Review your meaningful use data to make sure you haven't misplaced reportable data such as patient smoking status, and get ready not only to attest but also to testify should Figliozzi and Company pick you for a meaningful use audit.

Medicare providers need to get their attestations for 2016 in by Feb. 28 for any continuous 90-day period via their attestation page (*see resources, p. 7*). CMS estimates 171,000 eligible providers (EPs) will have negative payment adjustments in 2017 because of meaningful use non-compliance in 2015; those who fail to meet requirements for 2016 will get

*(see **Meaningful use**, p. 4)*

Compliance

New rules loosen safe harbors but increase penalties for non-compliance

You can offer patients transportation to and from your office for appointments and more items for free or at a discount now that the HHS Office of Inspector General (OIG) has softened some of the harshness of the anti-kickback statute and the civil monetary penalties law in a series of rules and announcements released Dec. 7.

A new rule, published in the Federal Register, updates the anti-kickback statute and civil money penalty law to reflect the evolution from fee-for-service medicine to value-based care.

*(see **Anti-kickback**, p. 7)*

MIPS: An opportunity to grow revenue

Now that it's 2017, MIPS is officially here. While your peers may be easing into the transition year, you can surpass their efforts and position your practice for a pay bonus in 2019. Take the right steps and gain a clear roadmap to succeed under MIPS during the webinar **Maximize MIPS incentives: Your 2017 game plan for payment bonuses** on Feb. 21. Learn more: *http://decisionhealth.com/conferences/A2719/index.html*.

Billing

Liven up your CPAP treatment protocol to avoid pervasive billing errors

Don't sleepwalk through your encounters with patients needing referrals for continuous positive airway pressure (CPAP) treatment — the complex coverage requirements for CPAP might easily be leading to unintended denials.

That could mean patients are on the hook for expensive equipment or they'll be denied coverage for much-needed treatment.

In 2016, errors in billing for CPAP devices, monitoring and treatment were tied to an estimated $414 million in improper payments, according to a CMS report, released Dec. 12, on fee-for-service payment accuracy (*see resources, p. 3*).

The report pinpoints a small number of referring specialties — internal medicine, family practice, nurse practitioners and neurology — that were tied to the lion's share of improper payments. Internal medicine accounted for nearly 60%, or $246 million, of the $414 million of erroneous payments, states the report.

Yet CMS' estimates on improper payments related to CPAP don't immediately suggest untoward activity on behalf of providers, surmises Lawrence Epstein, M.D., president and CEO of Welltrinsic Sleep Network in Chestnut Hill, Mass.

The payment errors are "less likely to be a function of fraud than the complexity of the documentation that's required [for CPAP coverage]," says Epstein. Indeed, in an improper payments report released the previous year, CMS noted that most of the improper payments for CPAP were tied to "insufficient documentation to support the medical necessity of the devices."

Untangle the complex CPAP web

CPAP devices are commonly used to treat obstructive sleep apnea (OSA), a condition that results in obstructed airflow during sleep and is characterized by varying degrees of complexity. OSA is a "potentially lethal condition," notes a local coverage determination (LCD) from Noridian, a Medicare administrative contractor (MAC) covering California and a dozen other states.

For example, a patient must have "high enough severity" of OSA to warrant the use of CPAP and Medicare has specific definitions of severity, explains Atul Malhotra, M.D., a sleep medicine specialist and professor of medicine with UC San Diego Health in San Diego, Calif.

Another factor at play that's contributing to Medicare's focus on CPAP treatment is the "increased recognition of sleep problems by the medical community," suggests Epstein. While CMS may be concerned about fraud and abuse, a general "increase in demand" of the services related to CPAP and sleep testing is driving the fee-for-service numbers upward.

Medicare covers CPAP and other sleep-apnea devices only when specific criteria are met, explains Epstein. Specifically, a patient must undergo a "face-to-face

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clinical evaluation by the treating physician prior to the sleep study test," notes a Medicare Learning Network on documentation and coverage requirements for CPAP devices (*see resources, below*).

During a Medicare-covered sleep test, the patient must meet specific clinical criteria to be approved for CPAP. That's generally five sleep-apnea events per hour plus the documentation of other symptoms, such as impaired cognition, daytime sleepiness, mood disorders or high blood pressure or heart disease.

Additionally, providers must conduct further evaluations for the patient to meet eligibility for continued coverage. Pay close attention to your calendar because the treating physician must conduct a face-to-face clinical re-evaluation between the 31st and 91st day after therapy begins. Also, the provider must show that the patient is compliant with treatment.

3 billing tips for treatment, referral

1. Document encounters to Medicare's standards. Given the number of moving parts required to support medical necessity, providers may simply be leaving some boxes unchecked. Some providers may be "prescribing CPAP when diagnostic testing wasn't done," warns Malhotra. Also, because Medicare coverage is contingent upon patients continuing to use CPAP on a regular basis, ensure your documentation reflects the patient's continued use, advises Malhotra. Check with your MAC's LCD on OSA and CPAP treatment because your local payer will likely have nuanced documentation criteria.

2. Report an E/M code — unless you're directly involved in CPAP supervision. Some internal medicine providers and other specialists may directly oversee CPAP treatment. In that case, you can report **94666** (Initiation and management of continued pressured respiratory assistance by mask or breathing tube), which pays about $64. "Check with your payers first to make sure they will reimburse when this code is used for management of sleep apnea in the outpatient setting," advises Epstein.

But unless you're doing the full extent of the work related to CPAP treatment — that is, you're not referring the patient to a sleep specialist for monitoring and treatment — then you should bill a normal office E/M code, advises Epstein.

3. Watch place of service. The Noridian LCD restricts the place of service for the sleep study to a "facility-based sleep study laboratory and not in the home or a mobile facility." Check with your MAC because other Medicare payers have issued recent guidance on the topic of sleep studies (*PBN 11/7/16*).

Resources:

- Supplementary appendices, Medicare FFS Improper Payments Report: *http://go.cms.gov/2iVtlr1*
- CPAP documentation and coverage requirements: *http://go.cms.gov/2j9LMeE*
- Noridian LCD: *http://bit.ly/2iVNAdB*

Quality reporting

Take part in CMS' MIPS study to fulfill one slice of 2017 reporting

Practices gearing up for the first year of the merit-based incentive payment system (MIPS) may want to take part in a CMS study assessing the segment of MIPS that's brand new to reporting entities — the clinical practice improvement activities (CPIAs) performance category.

Participating in the study will give practices a chance to gain feedback on reporting challenges associated with the CPIA category, says CMS in a request for study applicants.

Also, all practices that successfully participate in the study will receive full credit for the CPIA reporting category regardless of their actual performance. In 2017, the CPIA category accounts for 15% of the total MIPS performance score (*PBN 10/24/16*).

How to get involved

The study, open to all MIPS-eligible clinicians in 2017, is intended to clarify data collection procedures among various reporting mechanisms and understand providers' challenges "when you collect and report quality data," says CMS.

In addition to assessing reporting challenges, the study will also "recommend ways to ease clinician burden, simplify quality data collection and reporting and strengthen clinical care" for study participants.

Practices that are interested in participating in the study must fill out a one-page enrollment form (*see resources, p. 4*). To successfully participate, practices will

be required to fulfill several requirements during 2017 — specifically, they're required to fill out at least three surveys; take part in three focus groups; and report at least three CPIA measures during 2017.

The application deadline is Jan. 31. After filling out the enrollment form, interested practices should submit the form via email to *CMSCPIAStudy@ketchum.com*. — *Richard Scott (rscott@decisionhealth.com)*

Resources:

- CPIA Measurement Study: *www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-Feedback.html*
- Enrollment application form: *www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/CPIA-Study-Application.pdf*
- CPIA 2017 measures: *https://qpp.cms.gov/measures/ia*

Ask Part B News

Use modifier 62 for surgeon duos using same code, but make sure you can justify it

Question: *When two surgeons are working a patient, when is modifier* **62** *(Two surgeons) appropriate and when is modifier* **80** *(Assistant surgeon) appropriate?*

Answer: If you're going to bill 62, the procedure must "really need the individual skills of two surgeons to even perform — a complex nature, like certain spine or heart transplant procedures," says Corina Marquardt, CPC, CPMA, senior consultant with the Haugen Consulting Group in Denver.

CMS helps you figure out whether these modifiers are appropriate by listing co-surgery and assistant-at-surgery status indicators in the relative value file of the Medicare physician fee schedule. For modifier 62, 0 means no payment, 1 means payment with "supporting documentation" for the medical necessity of the four-hander and 2 means payment with no extra documentation needed; for modifier 80, 1 means no payment, 0 means payment with supporting documentation and 2 means payment with no extra documentation needed.

Note: For some CPT codes associated with transcatheter aortic valve replacement (TAVR) **— 33361-33365** and **0318T** — CMS requires the 62 modifier and that the procedure be performed by an interventional cardiologist and a cardiothoracic surgeon.

Nonetheless, says Marquardt, make sure you note the necessity of the second surgeon in case you get challenged.

For "two surgeons" billing for Medicare, each surgeon must have a different specialty, but both surgeons must bill the same CPT code. "Each surgeon must perform an individual, intricate portion of the surgery," Marquardt says. Take **63090** (Vertebral corpectomy [vertebral body resection], partial or complete, transperitoneal or retroperitoneal approach with decompression of spinal cord, cauda equina or nerve root(s), lower thoracic, lumbar, or sacral; single segment). A co-surgeon would be justified if the corpectomy has several segments, says Marquardt; for example, the operation may require a thoracic surgeon to perform the opening, gain access and approach, while an orthopedic surgeon might perform the corpectomy, interbody fusion and instrumentation.

Another example would be **61580** (Craniofacial approach to anterior cranial fossa; extradural, including lateral rhinotomy, ethmoidectomy, sphenoidectomy, without maxillectomy or orbital exenteration), in which a thoracic surgeon would provide similar services for a neurosurgeon, says Valerie Fernandez, MBA, CCS, CPC, CIC, CPMA, manager of coding client program development for H.I.M. ON CALL Inc. in Allentown, Pa.

But supposing the thoracic surgeon were also asked to perform another procedure on the patient that has its own code — for example, secondary repair of dura for a cerebrospinal fluid leak (**61618**)? Then she would bill the code with 80 as the assistant surgeon. Thus she could have both 80 and 62 lines on the claim.

For 61580-62, each surgeon would also do his or her own operative note, says Fernandez. For 61618-80, "the assistant merely needs to be documented in the primary surgical op note," says Marquardt; the assistant doesn't need to do a note. However, the primary surgeon must indicate the services the assistant surgeon provided in documentation, she adds.

The difference in compensation between the two modifiers is large. While surgeons each get 62.5% of their rate on 62, the assistant only gets 16% for 80; if a physician assistant, nurse practitioner or certified nurse specialist assists at surgery, the **AS** modifier is used, and their compensation is 13.6% (85% of 16%)**.** — *Roy Edroso (redroso@decisionhealth.com)*

Resources:

- PFS Relative Value Files: *www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html*

Benchmark of the week

Primary care, cardio, other specialties tied to massive E/M billing errors

Some specialty groups may want to take a closer look at their coding and billing processes for office visit codes **99201**-**99215** after a new report from CMS details a more than billion-dollar blunder.

A dozen specialty groups are linked to more than $1.2 billion in improper payments in 2016 for the 10 E/M office codes, according to The Supplementary Appendices for the Medicare Fee-for-Service 2016 Improper Payments Report.

The top three groups – internal medicine, family practice and cardiology – account for nearly half, or 49%, of the total improper payments, even though their percentage of improper payments is lower than other groups. For instance, neurology leads the way with an 18% improper payment rate, compared with 8% for internal medicine and family practice, though improper payments for neurology, at $62 million, were dwarfed by internal medicine ($262 million), family practice ($223 million) and cardiology ($146 million).

Remember that not all improper payments mean that you're overbilling Medicare. In fact, significant underpayments, which occur when a practice downcodes a service to a lower level E/M than warranted, also prevail (*PBN 1/18/16*). In 2016, CMS estimates that providers downcoded about $342 million worth of E/M office visits. In the same year, upcoding office visits accounted for $426 million in erroneous payments.

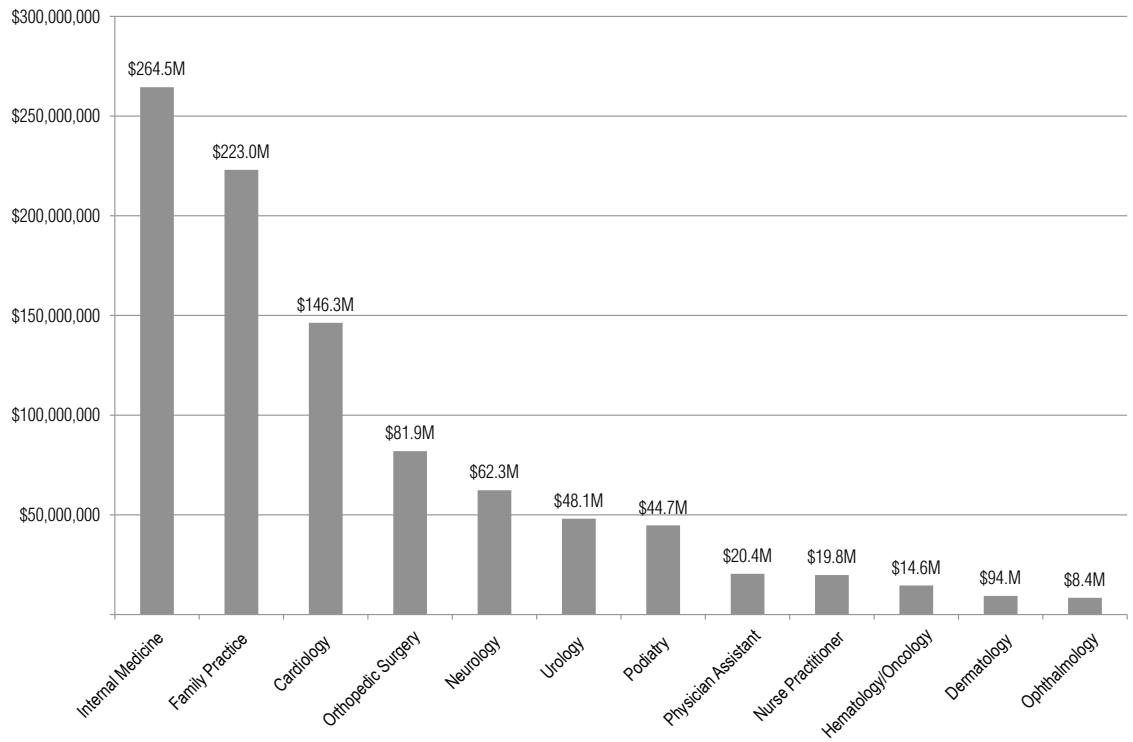
Orthopedic surgery, urology and podiatry also made the list with sizable improper payments. Hematology/oncology, dermatology and ophthalmology had smaller amounts and lower rates.

The report compels practices to take a closer look at their coding – CMS estimates that 59% of the billing errors for established office codes occur because of incorrect coding; 32% are attributed to insufficient documentation; and just 2% relate to errors in medical necessity. A greater portion, or 83%, of billing errors for new office visit codes are a result of incorrect coding. – *Richard Scott (rscott@decisionhealth.com)*

Resource:

- Appendices: *www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/AppendicesMedicareFee-for-Service2016ImproperPaymentsReport.pdf*

Improper payments for office visits (99201-99215) in 2016, per specialty



Source: Part B News *analysis of Medicare claims data*

Meaningful use

(continued from p. 1)

2% lopped off their Medicare payments in 2018. For the 2017 performance year, meaningful use transforms into the advancing care information piece of the merit-based incentive payment system [MIPS], and related payment adjustments will be made in 2019.

The attestation process is simple — see the worksheet in "Resources" for examples — but electronic health record (EHR) company executives say they've been getting panicky clients calls. "We're swamped from everyone calling in," says Stefan Ferreira, meaningful use and product support specialist at Amazing Charts in Boston. "Very few practices are actually self-sufficient with meaningful use. They don't use the educational materials we provide as much as they could because they're doctors — they're busy!"

"Practice Fusion receives nearly as many requests to help reproduce the supporting documentation from prior attestation periods as requests to help with the attestation process for the current attestation period," says Jay Ross, vice president for product management at Practice Fusion in San Francisco.

If you've been trying to comply, chances are you've cooperated with your EHR vendor to make sure your data are being tabulated correctly for attestation purposes and probably have a dashboard or other tools for following your progress against measures. But the actual attestation remains your job, not theirs. "We make sure we're collecting data, but ultimately it's the provider's responsibility to look at their requirements," says Ida Mantashi, senior product manager at EHR company Modernizing Medicine in Boca Raton, Fla.

Where's the data?

The major difficulty providers have is squaring the data they think they have with the data their EHR reports.

One big thing is incorrect or missing data, says Daniel Kivatinos, cofounder and COO at EHR company drchrono in Mountain View, Calif. "You want to make sure the data you enter is in the right field," he says. "For example, take smoking status: A lot of the time a provider has noted smoking status but in the wrong field, and it only shows up as a measure met if all the data is entered into the right field."

If you have less of some data element than you think you should, you may need to do some sleuthing. "One likely place the text 'non-smoker' could be entered is in an unstructured free-text field in part of the note," says Kivatinos. "At times a physician uses medical speech-to-text [by] talking into an iPad or iPhone. The text is placed into one field and the doctors task themselves with parsing the text for meaningful use later... There are times when a physician hires a new physician assistant (PA) or staff member who isn't properly trained on the EHR." Also, data can be dropped when providers switch systems. When you find the data, you have to do some

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"cleanup." But make sure to do it right, says Kivatinos; have the doctor make a properly notated amendment, as CMS requires (*PBN 11/2/15*).

Prepare for audits

While you're collating your meaningful use data for attestation, gear up for an audit by CMS contractor Figliozzi and Company because the auditors will be around long after meaningful use is over (*PBN 5/11/15*). "They still have a six-year lookback [period]," says Susan Clark, BS, RHIT, CHTS-PW, CHTS-IM, and HIT solutions executive with eHealthcare Consulting in Fishers, Ind. "Why would they stop now?"

All documentation related to an attestation should be filed in preparation for a potential audit. You should keep printouts from the EHR report you're working from with the vendor logo as well as provider name and reporting period displayed, says Clark. "If it simply appears typed into an Excel spreadsheet, I would expect it to be questioned."

Ross suggests you also include:

- A printed copy of each EP's meaningful use objectives, with the reporting period for attestation;
- Any letters of agreement with your EHR vendor, such as an adopt, implement, upgrade (AIU) letter;
- Any documentation regarding exceptions that are being claimed for any of the meaningful use objectives.

Also keep evidence relevant to any meaningful use disputes or issues with your EHR vendor that might be needed if Figliozzi questions you on a measure and, despite your best efforts, you don't have dispositive documentation. Clark mentions a client who had incomplete summary-of-care measure information because her vendor counted only electronic transitions. "I advised she keep the email/tickets correspondence she had with the vendor about the issue to demonstrate her level of effort to address the discrepancy in interpretations of transition of care," she says.

3 more attestation prep tips

1. Check your meaningful use registration data. CMS reminds EPs to make sure that data is correct when they attest.

2. Remember Y/N isn't in the EHR. While some measures are depdendent on numerators/denominators, others are just did-you-or-didn't-you, such as clinical decision support. Don't get confused if you don't see them on your dashboard. Providers should be able to attest based on their own records.

3. Watch for the eCQM glitch. "At one stage, you go from submitting meaningful use measures to submitting electronic clinical quality measures (eCQM)," says Ferreira. "In one section, they have to say whether they're submitting [eCQMs] electronically or manually — option 1, option 2." Some EHRs, like Amazing Charts, counterintuitively require manual submission — and if users mistakenly enter option 1 and finish the submission, "CMS will not allow them to change the submission format and therefore it will lead to a failure," says Ferreira. "I have been as far as the appeal process to try and reverse/resolve this with some of my clients, to no avail." — *Roy Edroso (redroso@decisionhealth.com)*

Resources:

- CMS registration and attestation portal: *www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/registrationandattestation.html*
- Eligible professional attestation worksheet for modified stage 2 of the Medicare Electronic Health Record (EHR) Incentive Program in 2016: *www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EP_AttestationWorksheet2016.pdf*
- 2016 meaningful use program requirements: *www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/2016ProgramRequirements.html*

Anti-kickback

(continued from p. 1)

The rule contains a number of provisions that will directly affect physicians, including:

- **A local transportation safe harbor.** The rule allows certain providers to offer free or discounted local transportation services to established patients between the provider's office and the patient's home or another provider's office so they can obtain medically necessary services. Physicians, hospitals, home health agencies and others that provide services are eligible to offer this transportation; providers that sell items, such as pharmaceutical manufacturers, are not.

The transportation cannot be used as a tool to recruit new patients, but a patient is "established" once an appointment is made. The safe harbor excludes air, luxury or ambulance-level transportation. OIG did relax the distance criteria from that of the proposed rule: The limit for "local" transportation is 25 miles in urban areas,

but 50 miles in rural areas. Previously the limit was going to be 25 miles for everyone.

- **Incentives that promote access to care.** The civil money penalty law bars providers from providing patients with incentives to help with their treatment. However, the rule implements an exception in the Affordable Care Act (ACA) that allows incentives that promote access to care and carry a low risk of harm to patients and the federal health care programs because the incentives are unlikely to interfere with clinical decision-making or increase costs.

For instance, if a patient makes an appointment with a doctor, the practice may send the patient a monitoring device like a purchase code for a smartphone app or pressure cuff to collect health data before the appointment. Note that the incentives are limited; the rule does not allow rewards for receiving care, and the remuneration cannot be cash or cash equivalents, such as gift cards.

- **Benefits to financially needy patients.** This change, also required by the ACA, allows remuneration of items for free or below fair market value to patients who can't afford them. The items can't be advertised, they can't be tied to the provision of other reimbursed services and there needs to be a reasonable connection between the items or services and medical care the patient is receiving. So a physician can't give sporting equipment to a patient on the basis that the patient needs more exercise or a toy to a child, but can give an injured or developmentally delayed child a therapy tool to help with fine motor skills that resembles a toy.

Practices will need to assess whether and how they may want to avail themselves of these relaxed rules. For instance, they may want to evaluate whether it's financially feasible to contract with a taxi service to provide transportation or to participate in more coordination of care efforts with hospitals.

Other changes in the rule include safe harbors for pharmacies and ambulances waiving copayments in certain instances, certain arrangements between Medicare Advantage organizations and federally qualified health centers, a reduction of copayments for certain hospital outpatient department services and retailer rewards, such as coupons or rebates.

Gainsharing dropped in final rule

The proposed rule would have narrowed the prohibition on gainsharing, whereby hospitals pay physicians to induce them to reduce or limit Medicare or Medicaid services. The prohibition bars physicians from aligning with hospitals to share savings — for example, in collaborating to increase efficiencies and reduce costs within a hospital unit. The proposed rule would have changed the prohibition to allow such payments if the physicians are reducing or limiting services that were medically unnecessary. Because the Medicare Access and CHIP Reauthorization Act (MACRA) made that change, the OIG no longer needed to address it.

OIG expands ability to impose CMPs

A separate rule outlines new conduct that would subject a person to penalties, assessments and or exclusion from the federal health care programs under the law. The OIG can now impose penalties and exclude providers from federal programs for the following conduct:

- Failure to grant OIG timely access to records.
- Ordering or prescribing services while excluded.
- Making false statements, omissions or misrepresentations in an enrollment application.
- Failure to report and return an overpayment.
- Making or using a false record or statement that is material to a false or fraudulent claim.

All of these changes were effective Jan. 6.

Nominal gift amounts increase 50%

The civil monetary penalty can be triggered if a provider offers or transfers to a Medicare or Medicaid beneficiary any remuneration that is likely to influence the beneficiary's selection of a provider, practitioner or supplier of Medicare or Medicaid payable items or services. An exception exists for gifts of "nominal value." The definition of nominal value, last set in 2000, was $10 per item and $50 in the aggregate per patient per year. The OIG announced that the definition of nominal value would increase to $15 per item and $75 in the aggregate and the rule would go into effect immediately. — *Marla Durben Hirsch (pbnfeedback@decisionhealth.com)*

Resources:

- Revisions to safe harbors and civil monetary penalty rules regarding beneficiary inducements: *www.gpo.gov/fdsys/pkg/FR-2016-12-07/pdf/2016-28297.pdf*
- Revision to civil monetary penalty rules: *www.gpo.gov/fdsys/pkg/FR-2016-12-07/pdf/2016-28293.pdf*
- Policy statement on gifts of nominal value: *oig.hhs.gov/fraud/docs/alertsandbulletins/OIG-Policy-Statement-Gifts-of-Nominal-Value.pdf*

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