2021 E&M Changes:

Documentation Change or a Scoring Change?

CEO Letter

Typically, around this time of year in this issue's CEO note, I usually ask you all how your New Year's resolutions are going. Now we're three months into the year and you're either going strong or not, so me asking is kind of moot, but good job if you are! It's an admirable quality, sticking to something that challenges you out of your comfort zone. Keep it up!

For those of you who have chosen to spend your time doing something other than what was in your resolution, well, I have no words of wisdom for you, as I too have strayed from the intentions that I started the year with. But of course, I am capable of starting again and I don't need a change of year/decade to do so. I'm doing a reset in March and I'm going to set myself up for success with all the tools that will help me achieve my goals this time. If you want to start over, why not do it? Recent events occurring on the celebrity stage have shown us that time is precious, and we should never take it for granted. Find a way to achieve those goals that you've put on the backburner. Don't wait. Life is far too short.

So, we have a great issue for you again this time, starting with our cover story. Shannon DeConda from NAMAS has written a great article about the upcoming changes to evaluation and management codes. She asks if it's a documentation change or a scoring change and explores that with you. It's a great read and important to understand before the changes are made.

Other highlights include an article from Natalie Tornese about pharmacy prior authorizations. We've seen politicians talking about the high prices of medications and the financial toll that it has taken on patients, so having a great understanding of this time-consuming process is paramount to providing great service and avoiding surprises.

David Jakielo writes about the importance of growth and includes some common-sense tips to help you stay on track to grow. Rachel Rose is back again with a great article about third party risk management and the FTC's new and improved data security orders. Don Self discusses doctors being lied to—or told "untruths." Maxine Lewis discusses risk adjusted coding and MIPS. And Glenn Krauss writes about outpatient CDI. It's another diverse, information-filled issue for you—enjoy!

Until next time, Storm

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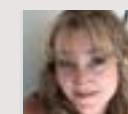
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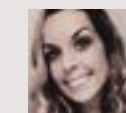
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COVID-19 (2019 Novel Coronavirus) Resource Center for Physicians

As of Feb. 11, 2020, the World Health Organization (WHO) has officially named the 2019 novel coronavirus (2019-nCoV) as COVID-19.

The Centers for Disease Control and Prevention (CDC) is monitoring an outbreak of the virus that began in Wuhan City, Hubei Province, China, in Dec. 2019 and has since spread rapidly, with cases now confirmed in multiple countries.

The WHO and U.S. Department of Health and Human Services have declared COVID-19 a public health emergency. The AMA is continuing to monitor this situation and, in partnership with the CDC, will bring you the most up-to-date resources.

https://www.ama-assn.org/delivering-care/public-health/covid-19-2019-novel-coronavirus-resource-center-physicians

New 2020 CPT Codes Recognize E/M Work that Happens Online

If a separate E/M face-to-face visit or real-time virtual visit occurs within the seven-day period, then this online work is incorporated into the face-to-face visit and not separately reported. However, if the patient initiates an online digital inquiry for the same or a related problem within seven days of a previous E/M service, then the online digital visit is not reported.

The codes to be used for the E/M service are:
99421 for 5–10 minutes of time spent on the inquiry.
99422 for 11–20 minutes.
99423 for 21 minutes or more.

Three other new time-based codes have been created to cover similar work done by qualified nonphysician health professionals: 98970, 98971 and 98972. The Centers for Medicare & Medicaid Services will require the use of G codes for these services.
Source: www.ama-assn.org

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Single-Center Study Raises Larger Issues about Proper Billing

Two CMS codes for advanced care planning — 99497 and 99498 — were used less than 20 times at a tertiary care center in Iowa in a nearly 3-year period, according to findings published in the Journal of the American Board of Family Medicine. Additionally, the center was successfully reimbursed only about one-quarter of the time, potentially resulting in lost revenues.

Billing errors are not limited to advanced care planning, and the findings from the single-center study speak to larger issues about reimbursement, according to Frank Campbell, MHA, MBA, former chief strategic and business planning officer at the University of Mississippi Medical Center.

According to researchers, where the codes were denied, a registered nurse very skilled in advanced care planning conversations correctly documented the conversation and its duration, but due to Medicare billing rules was not considered a licensed provider for these conversations.

"Each of those codes reimburse health systems about $80," Daly told Healio Primary Care. "That's not a huge amount of money. But it's better than nothing, and if you could get that amount for at least 100 patients, that could mean a little extra for your bottom line."

Source: healio.com

D.C. District Court Limits the HIPAA Privacy Rule Requirement for Covered Entities to Provide Access to Records

On January 23, 2020, the D.C. District Court narrowed an individual's right to request that HIPAA covered entities furnish the individual's own protected health information ("PHI") to a third party at the individuals' request, and removed the cap on the fee covered entities may charge to transmit that PHI to a third party.

Specifically the Court stated that individuals may only direct PHI in an electronic format to such third parties, and that HIPAA covered entities, and their business associates, are not subject to reasonable, and cost-based fees for PHI directed to third parties.

The HIPAA Privacy Rule grants individuals with rights to access their PHI in a designated record set, and it specifies the data formats and permissible fees that HIPAA covered entities (and their business associates) may charge for such production. See 45 C.F.R. § 164.524. When individuals request copies of their own PHI, the Privacy Rule permits a HIPAA covered entity (or its business associate) to charge a reasonable, cost-based fee, that excludes, for example, search and retrieval costs. See 45 C.F.R. § 164.524(c) (4). But, when an individual requests his or her own PHI to be sent to a third party, both the required format of that data (electronic or otherwise) and the fees that a covered entity may charge for that service have been the subject of additional OCR guidance over the years—guidance that the D.C. District Court has now, in part, vacated.

Source: natlawreview.com

Surprise Billing Proposal Wins Support of Physician Groups — but Leaders Want "Inadequate" Networks Addressed

A new bill that would establish an arbitration process to settle disputes over "surprise" medical bills has garnered support from the American Association of Orthopaedic Surgeons, the American Medical Association, and the Physicians Advocacy Institute, among other industry groups.

The Consumer Protections Against Surprise Medical Bills Act — which was unveiled by the U.S. House Ways and Means Committee on Feb. 7 — would give providers and insurers up to 30 days to negotiate a payment rate for out-of-network charges.

In the event that they can't agree on a rate, they could enter into an arbitration process. Both parties would submit proposals to an independent mediator, who would make the final decision, in a process lasting up to 30 days.

The mediator would be required to consider the median contracted rate for services in the region and would be prohibited from considering "usual and customary charges." The bill does not include a mediation threshold.

In addition, the bill would require that patients receive an explanation of benefits before their treatment. The EOB would detail the services, costs, and provider network status.

Source: beckersasc.com

Five Changes in CPT® Coding to Know
Before 2021

Busy physicians like you have long been asking CMS to revise and simplify its laborious E/M documentation requirements.

On January 1, 2021, changes in CPT® coding will take effect that grants those requests. The changes don't include the radical overhaul of documenting and reimbursing office and outpatient visits CMS proposed in 2018, but they should dramatically reduce the time doctors spend doing paperwork (physical or digital). Physicians seeing 20 patients a day, for example, should have about 42 minutes more a day for patient care, according to an AAPC report of an AMA study. And the changes should also help you more quickly determine the most appropriate code for your documented work.

Giving physicians the knowledge and tools they need to

properly document and claim the optimal code for their labor is our mission at MDCodePro. We've prepared this brief overview of the changes coming in 2021 so you'll know what to expect and how to maximize their potential to strengthen your practice and grow your revenue.

How the CPT® Changes Aim for Quicker, Clearer Medical Coding

Here's a look at what the CPT® coding changes in 2021 will do:

1. Provide New Choice in Determining Overall Level of Service

Currently, you must determine what CPT® code captures the overall level of service you've provided in an office or other outpatient visit by considering the visit's three key components:

- History
- Exam
- Medical Decision-Making (MDM)

For established patient visits, the code you assign must match the complexity of two of these three elements. For new patient visits, it must match the complexity of all three.

Once the 2021 changes take effect, CPT® coding of all visits covered by codes 99202-99215 (in other words, new or established office visits) will be determined by your choice of either the level of your MDM or the total time (direct and indirect) spent providing service the day of the visit.

You'll still take histories and perform exams, or review them, to establish medical necessity. But you'll have more discretion

regarding their extent. And being free to use either MDM or date-of-service time as your key to code selection should clarify your path to the reimbursement your work is worth.

2. Clarify the Nature of Medical Decision-Making

Because you'll be able to select codes solely on the basis of MDM, it's more important than ever that you document the correct MDM level.

A revised Level of Medical Decision-Making table* will help. It lays out the relationship between CPT® codes, the four MDM levels—straightforward, low, moderate, and high—and MDM's three elements:

- The number and complexity of problems you address
- The amount and/or complexity of data you review and analyze
- The risk of complications and/or morbidity or mortality of patient management

The revised table is simpler than the present MDM table and builds on the 1995 and 1997 E/M guidelines' Table of Risk. It will help you confirm at a glance that you're choosing the CPT® code that most accurately reflects the amount of cognitive labor you must do to properly treat your patient.

The 2021 guidelines also clarify and expand definitions of 22 key MDM terms and concepts. For instance:
- What, exactly, qualifies as "addressing" a problem?
- When should physicians categorize an illness as "stable"?
- Who counts as an "appropriate source" for discussing patient management, and who doesn't?

The new regulations spell out answers to these questions and many more. You'll have greater confidence that you're correctly representing your MDM in reimbursement claims.

3. Redefine Time Spent Providing Services
When you choose CPT® codes based on the factor of time, remember: As of January 1, 2021, "time" no longer refers to typical time spent face-to-face with patients and families, as it does now, but to minimum time spent on the date of service on all tasks related to patient care.

Right now, time can only control your outpatient visit coding when you spend more than 50% of a visit directly counseling patients or their families. Time spent reviewing data, consulting with other healthcare professionals, or even talking with the patient on the phone doesn't count.

In contrast, the new option of using date-of-service time recognizes how much real work physicians must do for the patient outside the visit itself. The AMA states that, "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 services like care coordination."

Other activities that will count toward minimum date-of-service time include:
- Obtaining and/or reviewing a separately obtained history
- Ordering medications, tests, or procedures
- Documenting clinical information in an EHR or other health record
- Independently interpreting results (not separately reported) and communicating results to patients or their families and caregivers

A shorter prolonged services code, to be reported only with codes 99205 and 99215, will capture time in 15-minute increments.

You'll need to keep a close eye on the clock when choosing to document

based on time. But because the new guidelines encompass direct and indirect care, you should be able to meet the minimum time threshold for higher value CPT® codes when warranted because you've appropriately documented all you've done.

4. Reorganize the CPT® Coding Manual
To underscore the fact that the 2021 CPT® coding changes apply only to office or other outpatient visits, CPT® will publish them under their own separate section header.

5. Eliminate Code 99201
You haven't been using it, have you? Neither have your colleagues.

Since both codes 99201 and 99202 involve straightforward MDM and differ only in history and exam elements, 99201 (level 1 new patient office/outpatient E/M visit) will be deleted—the victim of what Becker's ASC Review calls "low utilization."

Despite the CPT® coding changes due in 2021, one thing won't change: Your need to accurately and comprehensively document your work.

Stephanie Cowser www.mdcodepro.com

*A revised level of medical decision-making table can be found at https://www.billing-coding.com/pdf/cpt-revised-mdm-grid.pdf

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Pharmacy Prior Authorization:
Challenges and Solutions

Summary: Getting prior authorization for high-cost medications is burdensome, and costs pharmacies and practices a lot of time and money.

The prior authorization (PA) process can cost pharmacies and physicians' practices a lot in terms of time and money. A December 2018 survey by the American Medical Association revealed that, despite efforts to reduce administrative burdens and provide timely care, Prior Authorizations continue to pose significant challenges for both physicians as well as patients. Up to 88 percent of the 1000 practicing physicians surveyed reported that the number of prior authorizations required for prescription medications had increased over the last five years, with half of the respondents saying they had increased significantly.

Obtaining a prior authorization is a very time-consuming process for physicians and their staff. In an AMA survey, nearly 65 percent of physicians report waiting at least one business day for prior authorization decisions from insurers—and 26 percent said they wait three business days or longer. More than 91 percent said that the PA process delays patient access to necessary care; and 75 percent reported that PA can sometimes lead to patients abandoning a recommended course of treatment. Further delays occur if coverage is denied and must be appealed.

Why Health Plans Require Prior Authorizations

Obtaining a prior authorization is a requirement that insurance plans place on healthcare providers to obtain an advance approval before a specific procedure, service, device, supply, or medication qualifies for payment coverage.

Physicians typically aim to prescribe the best drug for the patient, and this may mean specifying a brand name medication rather than a generic one. The main purpose of the PA process is to control the use of or prevent the overuse of non-preferred brand name or non-formulary medications. Health plans use the PA as a means to ensure that the drug prescribed is truly medically necessary appropriate, as well as economical for the patient's situation.

For example, if the physician prescribes an expensive drug, the insurance company may authorize it only if the physician can show that it is a better option than a less expensive medication for the condition.

The criteria for approval of a drug undergoing the PA process may include:

- The diagnosis codes along with pertinent lab/test values and documentation
- Failure of therapy with certain drugs that are indicated to treat the same disease as the medication requiring the Prior Authorization
- Patient demographics, such as age or gender
- The patient's state or stage of a disease
- Prescriber limits whereas only specific medical specialties are permitted to prescribe certain medications

Medications that Require Prior Approval

According to Consumer Affairs, the following kinds of drugs are subject to requiring a PA:

- Brand name medications that are available in a generic form
- Expensive medications, such as those needed for psoriasis or rheumatoid arthritis
- Drugs used for cosmetic reasons
- Drugs prescribed to treat a non-life threatening medical condition
- Drugs not usually covered by the insurance company, but said to be medically necessary by the prescriber
- Drugs usually covered by the insurance company, but prescribed at doses higher than normal

One of the most recognized names in health insurance, Blue Cross Blue Shield, requires prior authorizations for the following:

- Drugs that have dangerous side effects
- Drugs that are harmful when combined with other drugs
- Drugs that should only be prescribed for certain health conditions
- Drugs that are often misused or abused or are prescribed when less expensive drugs might work better

PA Process and Barriers to Medication Access

The chain of events to obtain a prior authorization starts with the physician prescribing a specific drug. The patient then presents the prescription to the pharmacist. If the medication requires a PA, the pharmacy will contact the physician who prescribed the medication and inform them. At this stage, the patient can either opt to wait for coverage approval from the insurance company or pay for full cost of the prescription themselves. If the patient decides to wait, the physician will contact the insurance company and submit a formal authorization request according to the plan's guidelines, along with the necessary forms. The insurance company may also require the patient to complete some paperwork or sign some forms. The insurance company will then review the request and may either authorize the drug or refuse to cover it.

The common reasons why a patient's PA request may not be approved are:

- The patient did not give the insurance company, physician, and pharmacy enough time to complete the needed steps

(this can take several business days).
- The insurance information was outdated, or the claim was sent to the wrong insurance company.
- The medication was not medically necessary.
- The supporting evidence was inadequate.
- The physician's practice did not contact the insurance company.
- The wrong PA code was used to bill the medication.
- Payer rules changed.
- The physician did not meet payer guidelines.

Sometimes, the approval of the drug is only valid for a limited time, such as one year or one month. In such cases, the authorization process would need to be restarted.

Summing up the PA problem, AMA President Barbara L. McAneny, MD, said, "Physicians must follow insurance protocols for prior authorization that require faxing recurring paperwork, multiple phone calls, and hours spent on hold. At the same time, patients' lives can hang in the balance until the health plan decides if the treatment will qualify for insurance coverage."

Appealing Rejected Claims

If patients believe that their pharmacy PA was incorrectly denied, they can appeal the rejected claim. They would need to first contact the insurance company and ask why the claim was denied. If the insurance company indicates a billing error or missing information, patients can work with their physician to review the paperwork and fix any errors that caused the denial. They can also ask the physician to provide backup evidence or notes that could help prove that the prescription is medically necessary. The chances of success in resolving a prior authorization denial are higher when the physician ensures that all clinical information is included with the appeal, including any data that may have been missing from the initial request.

Insurance Authorization Services to Ease Pharmacy PA

If the healthcare practitioner knows in advance that the drug requires PA, the necessary paperwork to have the drug approved for the patient can be completed before the patient approaches the pharmacy. Problems arise when the patient and physician are unaware of which drugs on the health plan's formulary require PA. Outsourcing the insurance authorization task can address this concern.

How do insurance authorization services work? Insurance authorization companies have experienced personnel who act as a liaison between the physician's practice and the payer. These experts have extensive experience in working with all government and private insurances. They will collect the patient information from the practice and check the PA requirements before services are provided or prescriptions are sent to the pharmacy.

Insurance authorization services cover the following:
- Verifying patients' benefit information before the office visit to ensure clean claim submission
- Contacting payers to obtain pre-authorization quickly
- Ensuring that payer criteria are met before submitting the request
- Submitting all necessary documentation with PA requests
- Tracking requests and managing follow-up, such as getting more information from the physician, for the pre-authorization
- Support for appealing denials

Led by the AMA, physicians, payers, and other stakeholders are working to improve the PA process. With proper documentation and the support of an insurance verification and authorization staff, practices can reduce PA hassles and enhance patient care.

Natalie Tornese, CPC, is a Senior Solutions Manager responsible for Practice and Revenue Cycle Management at MOS. She brings 25 years of healthcare management experience to the company. Natalie has worked in varied leadership roles with practices and specialties. Her primary focus is revenue cycle management with an emphasis on Medical Billing, Coding and Insurance Verification Management. www.outsourcestrategies.com

Demystifying Price Transparency
and Patient Billing

Competitive pricing is one of the most important aspects of a capitalist economy. While the U.S. economy has always had a capitalist structure based on supply and demand, our healthcare system has mostly functioned outside of the norms that keep other industries thriving and in check.

The principles of competitive pricing are simple. By having advanced knowledge of the cost and apparent value of the items they are purchasing, consumers can shop around to find the best prices for the items they want or need. This, in turn, pushes businesses to keep their prices as low as possible or to improve the value of the products or services they're selling.

So what keeps prices in check within the healthcare industry, where almost no one knows the price of care until after diagnosis and treatment? It's a good question without a clear answer.

With the way the U.S. healthcare system has operated in previous decades, few patients knew more than their copay cost when it came to their treatment—they just knew they needed healthcare. Even if the issue was as small as a common cold, with predictable treatment options, the final cost for care remained a mystery for most patients; they paid their copays and left the rest to the insurance companies.

Considering recent challenges with the health insurance market and other alarming trends in the industry, like the continued growth of healthcare spending in the U.S., changing the way we communicate about the cost of care and patient billing is becoming a necessity.

True healthcare price transparency is the first step toward lowering costs and forcing providers to keep their prices competitive. Simply attaching direct and simple prices to certain services and making that information available to the public will help push the healthcare industry into greater efficiency and improve patient control over their own health and well-being.

According to a recent article from the Robert Wood Johnson Foundation, "More and more people are becoming increasingly curious about the price of their healthcare, and understand that more expensive does not necessarily mean better. But people still do not realize that healthcare prices vary significantly between providers for the same services."

As consumers become more informed about the fluctuations in costs between providers, they are going to want more information in order to make the best decisions for their families. With insurance deductibles and premiums on the rise, patients have good reason to become more concerned about insurance payouts and patient billing processes than ever before.

The Kaiser Family Foundation found that the average premium for health insurance coverage in the U.S. has risen by 69 percent in the last decade. At the same time, healthcare spending, though slowing, is still expected to cover roughly a fifth of our country's GDP by 2025. Without healthcare price transparency and a concentrated effort to make the industry more competitive overall, these issues will only grow.

Ultimately, the cost of medical treatment shouldn't be a great mystery to the general public. Patients have a right to know what they're paying in advance, at least in a general sense, and to clearly understand what services those charges entitle them to.

Even more important is the fact that the U.S. was designed to encourage competition between businesses, so that prices would stay reasonable for consumers. Why, then, should the healthcare industry operate any differently?

With the recent trends in the industry and the need to encourage greater competition between providers in order to drive down costs, healthcare price transparency may be the best way to begin making long-term changes to the way our healthcare system is run—changes that will improve the level of care patients can expect at prices they can afford.

Source: ntchealthcare.com

Third Party Risk Management
and the FTC's "New & Improved" Data Security Orders

Cybersecurity and the related technical, administrative, and physical safeguards, which are required under a plethora of law ranging from the Health Insurance Portability and Accountability Act (HIPAA) to the California Consumer Protection Act (CCPA) to the Federal Trade Commission's Data Security Orders (FTC's Data Orders), is receiving heightened attention from regulators. Yet, according to EHRIntelligence, one of the biggest problem areas is risk mitigation associated with a third-party or vendor-related breach.

The purpose of this article is to highlight the July 2019 Ponemon Report, The Economic Impact of Third-Party Risk Management in Healthcare in relation to the well-established privacy and security requirements and its relationship to the FTC's Data Orders. For purposes of the article, the term "risk assessment" is being used in a general context and includes the annual requirement for a risk analysis under HIPAA, which is set forth in 42 C.F.R. § 164.308(a)(1)(ii)(A).

Analysis

According to the EHRIntelligence article, the following findings are disconcerting:

• The indirect and direct costs of third-party risk management for the healthcare industry averages $23.7 billion annually.
• The lack of automation and reliance upon manual risk management processes makes it difficult to keep pace with cyber threats and the proliferation of digital applications and medical devices used in healthcare.
• Vendor risk assessments are time-consuming and costly, so few organizations are conducting risk assessment of all their vendors.
• Critical vendor management controls and processes are often only partially deployed or not deployed at all. If controls and processes are deployed, they are not considered very effective in reducing third-party risks.

The Ponemon Report reached similar conclusions, indicating that healthcare entities are grappling with the prevention or mitigation of a third-party or vendor-related data breach. Of the many findings that are highlighted, there is one in particular that should be pointed out.

Organizations are not requiring remediation or disqualification when an assessment reveals security gaps. Only an average of 21 percent of all assessments result in a requirement to remediate prior to doing business with them and only 11 percent of respondents say they result in disqualification.

Moreover, vendor's security gaps are not addressed following an assessment. Respondents were asked what they do if they determine working with the vendor will put their organization at risk. Only one-third of respondents say they would terminate the relationship with the vendor. These findings indicate that most organizations might not have processes in place to follow-up when such security gaps are revealed.

So, it appears to be a conscience choice. Typically, I advise clients to ask these five basic questions of a vendor/third-party. If the answer to any of these five questions is "No," then the likelihood of a breach and potentially a monetary penalty and/or lawsuit damages is harder to mitigate.

The five questions are:
1. Do you train employees annually?
2. Do you have a Business Associate Agreement or similar Data Privacy and Security Agreement executed between the parties?
3. Is an annual risk assessment conducted and are the gaps corrected?
4. Are policies and procedures adequate and reviewed annually?
5. Is data encrypted at rest and in transit?

The impetus for these five questions stems from reading various U.S. Department and Health and Human Services – Office for Civil Rights (HHS-OCR) resolutions of admitted and non-admitted breaches of protected health information, class action law suits, and FTC Orders. These five areas comprise the highest dollar recovery. Therefore, if there are gaps in any of these, mitigating liability is slim.

That brings us to the FTC's Orders in data security cases, "Since the early 2000s, our data security orders had contained fairly standard language. For example, these orders typically required a company to implement a comprehensive information security program subject to a biennial outside assessment. As part of the FTC's Hearings on Competition and Consumer Protection in the 21st Century, we held a hearing in December 2018 that specifically considered how we might improve our data security orders. We were also mindful of the 11th Circuit's 2018 LabMD decision, which struck down an FTC data security order as unenforceably vague."

In light of these outcomes, the FTC curtailed data security practices in three major ways. First, the orders have greater specificity, which are similar to those disseminated by HHS-OCR. Second, the orders place more of an onus on third-party assessor accountability. Finally, the orders consider the data security compliance of C-Suite and Board level members, such as training and being briefed on a company's information security program. This enterprise risk management approach correlates to mitigating the risks found in the EHRIntelligence article and Ponemon Report.

Conclusion

In sum, the FTC's revisions to its orders should serve as a reminder that ignoring either conducting an annual risk assessment or failing to address the gaps can have consequences. With renewed emphasis at the Board and C-Suite levels, organizations should assess their corporate culture and risk tolerance, as well as what assets are available to pay for fines, damages, legal costs, and reputational damage. By asking five simple questions and choosing not to ignore the answers, organizations can improve the overall industry as those with inadequate technical, administrative, and physical safeguards will be left behind.

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Risk Adjusted Coding:
Improvement Activities and Promoting Interoperability Performance Measures of MIPS 2020

MIPS is the program that will determine Medicare payment adjustments. Using a composite performance score, eligible clinicians (ECs) may receive a payment bonus, a payment penalty, or no payment adjustment. Improvement activities account for 15% of the total MIPS score and promoting interoperability accounts for 25%. Both proportions are unchanged from 2019.
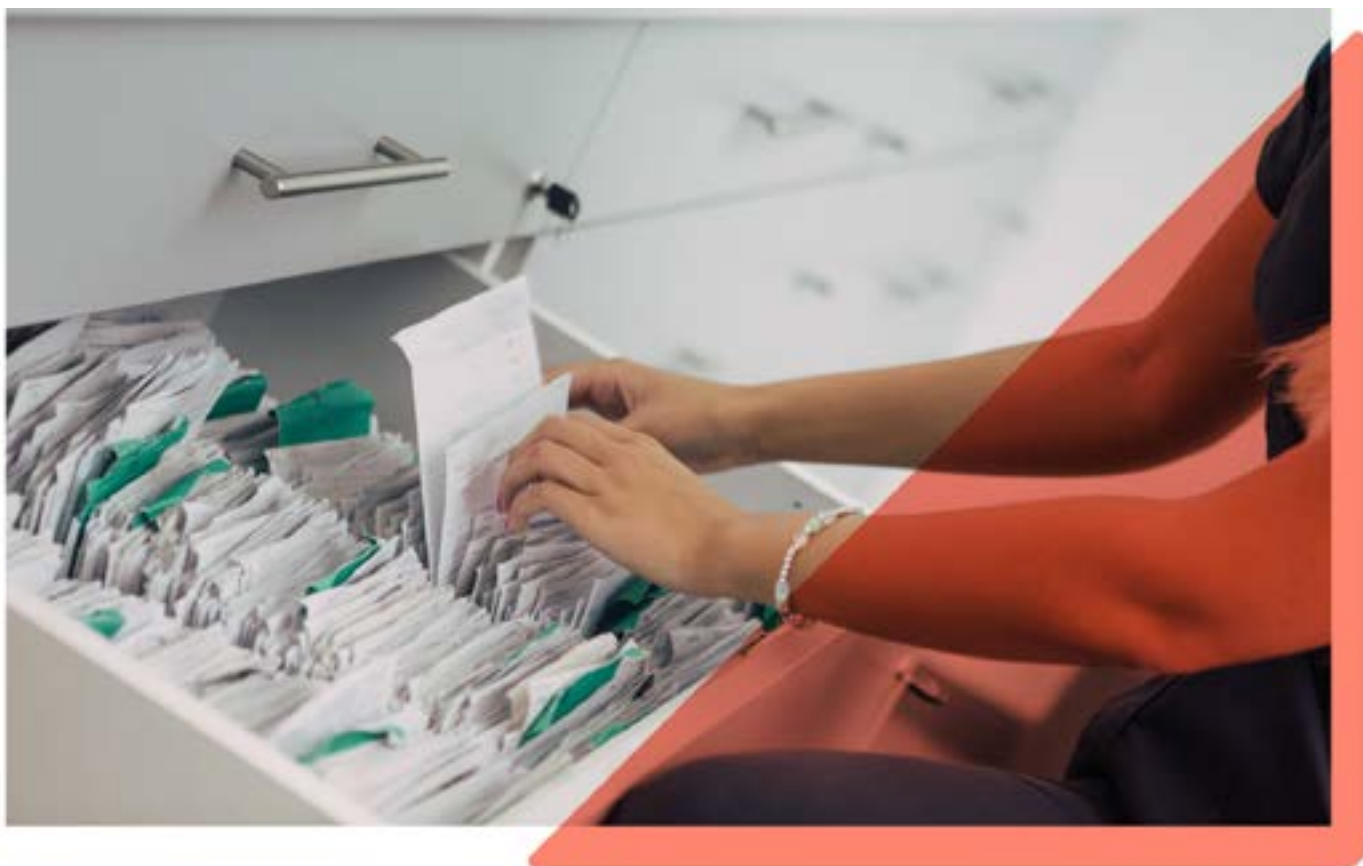
I f a group is identified as hospital-based, it is eligible when more than 75% of the NPIs in the group meet the definition of hospital-based MIPS eligible clinicians (100% in 2019). The maximum incentive/penalty for 2020 is +9% or -9% applied in 2022. In the Final Rule, the Negative Adjustment Threshold (points scored) is 45 points (up from 30 in 2019) and the performance bonus threshold is 85 points (up from 75 in 2019.) One can earn up to 40 points in improvement activities and up to 100 points in promoting interoperability.

CMS confirmed that they did not propose any changes to the following policies for MIPS in 2020:
- MIPS eligibility: low-volume thresholds; i.e., if one does not bill more than $90,000 in covered Part B professional services and see more than 200 Part B patients and provide 200 or more covered professional services to Part B patients; and opting out of the program, eligible clinician types, opt-in policy, MIPS determination period
- Data collection and submission: MIPS performance period, collection types, submitter types, submission types, CEHRT requirements
- Quality Measures: topped-out measures, measures impacted by clinical guideline changes
- Facility-based clinicians: definition and determination, scoring methodology, and policies.

Of the 105 improvement activities for 2020, 15 were deleted, seven changed, and two added. There was no change to the weights associated with each activity; medium is worth 10 points and high weight is worth 20 points. One must earn 40 points, which could be a combination of four medium, two high, or one high and two medium worth activities. There were some improvement activities which only require attestation with a "yes" when completed. For an activity to count for a group, there must be at least 50% of the clinicians participating in the same activity for > 90 days.

For the promoting interoperability category, participants must use the 2015 Edition Certified EHR Technology (CEHRT). There is no change to e-prescribing, health information exchange, provider to patient exchange, public health and clinical data exchange (Note: If your state cannot exchange data through their public health system, you must have proper evidence of this), and the five mandatory performance measures. Participants must perform the security risk analysis. There is still a 90-365-day performance period and removal of the verification of opioid treatment agreement measure, which was optional in 2019.

Changes to improvement activities include the expansion of the choice of patient centered medical home recognition. It can now be any certifying body with national scope and at least >500 certified entities. Two additional activities and 15 activities were removed. For an activity to be counted, there must be at least 50% of clinicians in the group participating in the same activity, each for > 90 days. CMS has also established criteria for removal of activities. There are two new improvement activities: IA_BE_25 Drug Cost Transparency (High Weighting) and 20 tracking the clinician's relationship to and responsibility for patient reporting by reporting MACRA patient relationship codes (high weighting); this requires modifiers to be submitted with HCPCS codes. CMS modified 7 improvement activities:

1. Completion of an accredited safety or quality improvement program
2. Anticoagulant management improvements
3. Additional improvements in access as a result of QIN/QIO TA
4. Implementation of formal quality improvement methods, practice changes, or other practice improvement processes
5. Participation in a QCDR, that promotes use of patient engagement tools
6. Use of QCDR data for ongoing practice assessment and improvements
7. Completion of Collaborative Care Management Training Program

Participation in Systematic Anticoagulation Program:
1. Implementation of additional activity as a result of TA for improving care coordination
2. Participation in Quality Improvement Initiatives
3. Annual Registration in the Prescription Drug Monitoring Program
4. Initiate CDC Training on Antibiotic Stewardship
5. Unhealthy alcohol use
6. Participation in a QCDR, that promotes use of processes and tools that engage patients for adherence to treatment plan
7. Use of QCDR to support clinical decision making
8. Use of QCDR patient experience data to inform and advance improvements in beneficiary
9. Participation in a QCDR, that promotes implementation of patient self-action plans

10. Use of QCDR to promote standard practices, tools and processes in practice for improvement in care coordination
11. Leveraging a QCDR for use of standard questionnaires
12. Leveraging a QCDR to standardize processes for screening
13. Use of QCDR data for quality improvement, such as comparative analysis reports across patient populations
14. CPI Participation

Promoting Interoperability had two significant changes: one bonus measure was removed and the definition of a hospital-based group changed. CMS removed the verification of opioid treatment agreement measure in MIPS 2020. However, CMS kept the Query of Prescription Drug Monitoring Program (PDMP) measure as an optional bonus measure. There are changes to Hospital Based MIPS Eligible Clinicians in groups. For inpatient hospital (POS 21), on campus outpatient hospital (POS 22), off campus outpatient hospital (POS 19), and Emergency room (POS 23), only 75% of NPIs in TIN are defined as hospital based. For these clinicians, CMS will use either the favorable facility-based score or the NPI score.

Reporting is still a 90-365-day performance period. Starting next year, groups earn credit for an improvement activity if at least 50% of clinicians fulfill the activity during a 90-day period within the performance year.

E-prescribing is now worth 10 points. Other highlights include exclusions for sending electronic health data.

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Objectives	Measures	Maximum Points
e-Prescribing	e-Prescribing Bonus: Query of Prescription Drug Monitoring Program (PDMP)	10 points 5 points bonus (Attestation)
Health Information Exchange	Support Electronic Referral Loops by sending Health Information Support Electronic Referral Loops by receiving & incorporating health information	20 points
Provider to Patient Exchange	Provide Patients Electronic Access to their health information	40 points
Public Health & Clinical Data Exchange	Choose two of the following: Immunization Registry Reporting Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Syndromic Surveillance Reporting	10 points

2021 E&M Changes:

Documentation Change or a Scoring Change?

Recently while doing a provider training event at a large health system, a provider asked, *"What advice do you have for us regarding the 2021 E&M AMA CPT Changes to the office E&M codes?"* My response was short, simple, and merely one sentence. "Just keep documenting the way you have been documenting these services for the past 25 years." I know this may make you pause and ponder, "But wait, these changes were provided to ease the documentation burden, but yet your advice is to stay the course?" Again, my resounding answer is yes, because the changes made impact the scoring process of the encounter, not the purpose of documentation.

Below are the most significant changes in a nutshell.

- History and exam will no longer be scored. Please note, this does not say providers can exclude history and exam, but rather it should be documented as medically appropriate.
- **Scoring** the documentation to assign a level of service will be based on time or MDM. We will no longer be required to "bean count" HPI, ROS, PFSH, or Exam, but rather focus on the new requirements of MDM only. AMA has redesigned the Marshfield Scoring Process with a new consolidated MDM table for this purpose.
- Time **scoring** guidelines change. A provider can bill any visit on time that they choose as opposed to only those visits consumed with counseling and coordination of care.

Noting these most significant changes, we see that scoring is the common denominator. There are a few other updates, such as AMA defining some of the gray areas that Marshfield Guidance created within the MDM. Again, noting these changes also impact the scoring process and have no impact on the fundamental purpose for documentation. So, the purpose of documentation and demonstrating complexity of each encounter has **not** changed—just the scoring of it.

By Shannon Deconda, CPC, CPC-I, CPMA, CEMC, CMSCS, Partner, Founder, and President of NAMAS

In 25 years, has the true purpose of documentation changed? Well, the answer would depend on who you asked, and quite frankly, if we cannot point to an answer in black and white published guidance, then there is a chance that the answer is an opinion or interpretation. Do we have published guidance that identifies the true purpose (not requirements) of documentation? The answer is yes, we do. It just gets passed over by so many of us, all the while it has been there for 25 years staring us in the face. 1995 & 1997 Documentation Guidelines (DG) include an introduction that answers two very important questions: *What is Documentation and Why is it Important?*

As we consider the 2021 changes to the documentation scoring process, we as coding professionals, audit reviewers, and provider educational experts, our resounding message to providers should be *Don't change a thing!* Because the purpose of documentation has not changed, but rather, your job as the coder and auditor has.

Let's consider the answers the DG provided to the questions of the "what" and the "why" for documentation and compare them to the most significant changes for 2021:

1. *The ability of the physician and other healthcare professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her healthcare over time.* Best summoned up by saying one of the purposes of documentation is to chronicle the patient's health history, telling the patient's specialty specific story about their presenting problem. Keep in mind that regardless of age, patients are not always the best and/or most forthright about their health history and therefore the medical record can help prevent and avert conflicts in patient care.

   2021 Impact: None. Each encounter will still be expected to chronical the patient's plan of care for each presenting problem for which the provider assumes care

2. *Communication and continuity of care among physicians and other healthcare professionals involved in the patient's care.* The inclusion of this information ensures that any other provider rendering care to the patient is well informed. Whether they are treating the same presenting problem or a different problem that could be impacted by other health issues or treatment plans associated with other problems. Documentation ensures each care plan from provider-to-provider can best align.

   2021 Impact: None. Patient care should be the number one consideration of each provider-patient interaction.

3. *Accurate and timely claims review and payment.* This goes beyond the mere collection of documentation elements formerly included in history and exam and rather focuses on demonstrating the medical complexity associated with each patient encounter. This means that documentation of each encounter will still have an obligation to explain the **why** of each service rendered and the **complexity** of each patient encounter, as once again, this is the underlying reason for documenting the patient encounter. Why did the provider walk into the room to see the patient? Why were the diagnostic or procedural services indicated for this specific patient during this encounter? Documentation of complexity includes the provider identifying any factors that contribute to more work. According to CGS Medicare, medical necessity is expressed in terms of physical and/or mental effort as well as identifying conditions that may cause increased risk and complications to treating the presenting problem. This is already an epic problem in the healthcare documentation process, and we must ensure that the relaxing of documentation requirements does not lead to a further rise of encounters that do not demonstrate the medical appropriateness and reasonableness, not to mention necessity.

2021 Impact: None. Providers will still be expected to file claims timely and have documentation to support the services rendered.

4. *Appropriate utilization review and quality of care evaluations.* A Utilization Review (UR) varies from a coding and documentation audit in that a UR is a clinical focused review standardly using at minimum nurse trained reviewers. The UR is evaluating clinical treatment based on medical reasonableness and clinical indications of care. In contrast, audits are more focused on the coding and documentation as the guidelines mandate focusing on component counting (i.e., HPI, ROS, PFSH, Exam, and MDM). Therefore, UR helps by focusing on the quality of care provided to patients, which again, is not impacted by the volume of documentation requirements met, but rather on quality of the documentation of each service provided to any given patient.

2021 Impact: None. UR and the validation of quality care will not change as we move into 2021, and therefore becomes reason 4 for our providers to maintain their current documentation process.

5. *Collection of data that may be useful for research and education.* Many may read #5 and say, "I am not in an academic environment and therefore this has no relevance to my documentation," but that would be incorrect. Remember that one of the reasons we convert documentation into codes includes the advantages that numbers provide in consideration of data analytics. The codes we bill are the catalyst for the data of healthcare provided in the U.S. and beyond. Our CPT coding provides the footprint of the service performed while the ICD-10 codes reveal the problem for which the service was provided. This information can only be abstracted from a live event through a culmination of documentation, and most of the time, this documentation is best demonstrated beyond the mere documentation components listed in 1995 and 1997 Documentation Guidelines. Analyzing data as it relates to disease onset and comorbidity

management impacts all healthcare consumers as it becomes a predictive modeling based on our physiological and geographic pointers. Researching disease, injuries, illness, and comorbidities empowers advances in improvements of quality and quantity of life and would certainly be hindered with the mere documentation of MDM or the amount of time spent being the only entries made for patient encounters.

2021 Impact: None. We all recognize that healthcare is progressively advancing in technology and patient care/interactions. Documenting less information is counter-productive of advancement.

The above has been our directive on the purpose of documentation for the past 25 years, and while the guidelines and level of service requirements may not have worked well, the **purpose** of documentation has.

I think that what we can all agree on has changed over the past 25 years is twofold; the value of documentation which has increased the requirements of documentation.

- The value of documentation has dramatically shifted as we have seen carriers place higher emphasis and demand on what is documented. Carriers are not only wanting DG met, but also the thought process behind all decisions, therefore placing a higher value on documentation.
- Providers are trained that documentation should be their communication tool from provider to provider, so they find the level of documentation demanded by carriers and DG ridiculous; therefore, the result is they undervalue documentation. This has led to a transition of the value of documentation. Providers are disparaged by the burden of documentation, which has been the focus of documentation relaxation initiatives.

Oftentimes, we jump to say that this didactic shift was the product of the use of EMR in healthcare, and while it may have fanned the flame, we were already there way before that. Prior to an electronic template, we had

a paper template that prompted a provider to do merely more than check yes/no, WNL (within normal limits), or an abnormal finding. Personally, since my initial exposure into the world of E&M documentation (nearly 25 years ago), the focus was on counting the components and adding them together to find the score for each patient encounter. Then we would identify the counted findings in that famous "up-code/down-code report," which would lead to our plea to providers to always document 4 HPI, 10 ROS, 3 PFSH, and 8 organ systems on the exam to ensure the maximum documentation components were met. Such teachings led our providers into migrating their focus from the true reasons for documentation and why it is important to a "bean-counting" conglomeration of words that checked audit boxes but didn't necessarily show the complexity of the encounter.

All EMR did was come behind our mantra for max documentation components and say, "Hey, if that is all that is expected, then we can create efficiencies by making your paper templates electronic, instead of using a photocopier (copy/paste), instead of using transcription (talk-to-text), and instead of flip-flip sign dictation (electronic signatures)." See, we are doing the same thing we have been doing for years, only the technology advanced, and here we are with much of the same without a focus on the core purpose of what it is and why it's needed.

Medical necessity audits by carriers have soared over the past few years, but the concept has been an integral part of E&M for 16 years. In 2004, Medicare changed the Claims Processing Manual (CPM) to reflect that medical necessity is the overarching factor. That was way before EMRs were dominating our practices.

The Point: Medical necessity is **not** impacted by the 2021 E&M Changes. It will still be the overarching criteria, answering why the patient was seen and how complex was the interaction. Therefore, changes in how we score an E&M will have no impact on medical necessity, because it **never** had an impact on medical necessity.

As we work our way through the rest of 2020 with the existing rules, it is important that we understand how E&M DG components work to convey the complexity of the interaction to naturally demonstrate medical necessity. The documentation components, if used appropriately, should work together to communicate the complexity of each encounter. The more complex the patient is, the more physical/mental work is involved, and more documentation is needed to communicate this. Review the chart below which shows medical necessity in conjunction with the documentation components naturally increasing as the patient's presenting problem increases in complexity.

This chart reflects the requirements from 1995 through December 31, 2020 for 99203 – 99205 new patient E&M code set.

New Patient		Level 3	Level 4	Level 5
Medical Necessity	Acute Problem	Uncomplicated	Complicated	Threat
	Chronic problem	Stable	Exacerbated or 2+ Stable	Severe Exacerbation
Documentation	HPI	4	4	4
	ROS	2	10	10
	PFSH	1	3	3
	Exam	2+	8	8

Established Patient		Level 3	Level 4	Level 5
Medical Necessity	Acute Problem	Uncomplicated	Complicated	Threat
	Chronic problem	Stable	Exacerbated or 2+ Stable	Severe Exacerbation
Documentation	HPI	1	4	4
	ROS	1	2	10
	PFSH	0	1	2
	Exam	2	2+	8

New & Established Patients		Level 3	Level 4	Level 5
Medical Necessity	Acute Problem	Uncomplicated	Complicated	Threat
	Chronic problem	Stable	Exacerbated or 2+ Stable	Severe Exacerbation
Documentation	HPI	Not Applicable	Not Applicable	Not Applicable
	ROS	Not Applicable	Not Applicable	Not Applicable
	PFSH	Not Applicable	Not Applicable	Not Applicable
	Exam	Not Applicable	Not Applicable	Not Applicable
	MDM	Low	Moderate	High

This chart clearly shows big change noted in the documentation requirements, but notice the correlation between medical necessity and the new MDM requirements for each level of service. Also noteworthy is that there is no variation from new to established patient for documentation content, medical necessity, or medical decision making.

Preparation and Training
These E&M changes are much less intrusive than the implementation needs that were associated with ICD-10; however, if your providers have been using MDM to define their levels of service, or documentation only, then there is training and prep that needs to begin now. Medical necessity in conjunction with documentation requirements has been the rule since 2004, and since it does not change in 2021, all training and prep work that is done now should be implemented in 2020 as well.

The following is a Training Prep Step-by-Step Guide

to help implement these changes.

Step One: This step is recommended for implementation February 2020.
Most providers have only been taught documentation requirements since residency. The best way to approach this change is to first conduct training identifying this requirement by Medicare in the Claims Processing Manual *(link available in our website noted below)*.
- Be sure to define the difference in medical necessity and clinical decision for medical intervention. Inform the providers that complexity of care as demonstrated by the medical necessity is based completely on the documentation of each patient encounter.
- Use the medical necessity tool found on the reverse side of the comparison chart to identify how to use medical necessity to select the appropriate level of service.
- Integration of current sample charts (HIPAA com-

pliant) should be used as a hands-on session to practice what is learned.

Step Two: Shadowing is an extension of the hands-on application of Step One. This step should begin within 9-12 weeks of the completion of Step One. Completion should be approximately April 30, 2020, but may vary based on the size and difficulty of scheduling within your organization.

While most providers are not as receptive to shadowing during clinic, this exercise can be quite effective in another hands-on learning technique. Discussing the encounter, the complexities or the lack thereof, and identifying the best approach to documentation content focuses not on maxing out the requirements, but rather purposeful documentation to demonstrate complexity to support the most appropriate medical necessity.

Step Three: Review of documentation vs. coding. Upon maintaining the above pace for training, this step should begin around May 2020 and should be conducted over the following 4 months. Again, this may vary on sample size and organization size.

Now it is time to evaluate the return on the training investment from Steps One and Two. Review 5, 10, or 15 records per provider. The sample size should be encompassing enough, but keep in mind this is validation of education and not meant to take the place of your annual compliance review. It may be prudent to show four main findings of each encounter for this review:
1. The level of service the provider selected
2. The level of service supported by the volume of documentation only
3. The level of service supported by the medical necessity only
4. The overall level of service that should have been billed to the carrier

Including each one of these will provide a basis for educating in proficiencies and deficiencies on selecting the level of service. Note that if your organization has been requiring MDM as the key indicator for the level of service, we would recommend having it as a main finding as well to educate on this difference.

Step Four: Feedback
No review (i.e., audit) is complete without feedback and education on any noted changes, why the changes were needed, and efficient strategies to implement for documentation improvement while maintaining patient care as the focus of each encounter. 65% of the population are visual learners, and

by nature, many providers are analytical thinkers. Therefore, a combination of the two should lead to an effective educational approach.
- Of the records review, pull 2-3 samples and be sure to include examples of both incorrect and correct leveling of the E&M service.
- Handwrite on these HIPAA compliant records direct feedback by encouraging additional elaboration with key points and noting streamlining in areas in which over-documentation of the required components were noted.
- Be clear and confident in your findings and keep reminding the provider that the patient should look as sick or as stable as they appeared at the time of the encounter.

Step Five: Continue the review cycle and integrate 2021 changes. Every 6-8 weeks, continue to provide spot reviews on the providers who need additional training for better compliance. During each 6-8-week period, begin the push toward 2021 prep. Using a HIPAA compliant office-based encounter, audit one of the notes using the current 2020 documentation requirements and medical necessity guidelines. Now, take the same encounter, and using 2021 rules, audit the same note for a cross comparison of the new guidelines.

We are 9 months away and if your providers see an average of 4 patients an hour, in an 8-hour clinic day, for 3 clinic days a week, then they still need to create billable documentation for approximately 4,608 patients utilizing existing 2020 guidelines. This recommendation of phasing in the training will have your providers set and ready to go come January 1, 2021.

Visit our website for free resources and tools to help train your providers.

We have created a one-page comparison of the changes between 2019, 2020, and 2021 that can be downloaded for free at www.namas.co/2021-comparison.

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Global Surgical Period

On January 2nd, 2020, John Smith is at home when he experiences a heart attack. Thankfully, John has excellent health insurance benefits with ABC Insurance, so when his doctor, Dr. Smith, tells him that he needs to have open heart surgery, he has one less concern going into it. John's surgery was a success, and after a week, he is discharged to go home and undergo his recovery. John is given an appointment card to see Dr. Smith to have the surgical wound examined, and in a week, John can have the staples removed from his chest and down both of his legs.

When John returns for his follow-up appointment, he is handed a medical bill for a 99245 office visit. During this appointment, Dr. Smith is wearing green surgical scrubs, looks at John's staples, and says that his surgery is healing fine. His visit with Dr. Smith takes less than 30 seconds when John is given another appointment card for the staples to be removed. The appointment is for a home health nurse (who has never treated John) to come to his home and remove the staples. The nurse does so with an everyday staple remover from the local office supply store. Afterward, John receives another bill in the mail. This bill is also for a 99245 consultation from Dr. Smith. With another appointment card from the home health nurse, John goes back to see Dr. Smith again, but this time, Dr. Smith isn't wearing surgical scrubs, instead he is wearing a black suit. Dr. Smith tells John that his post-surgical healing is progressing well. John is handed another appointment card to see Dr. Smith, as well as a third medical bill, another 99245 consultation. As in the TV shows, the stories are real, John Smith is a real person, but his name is changed to protect his innocence.

When John had his open heart surgery, what Dr. Smith didn't know is that when he billed John for a consultation, the bill was wrong. The visit should have cost John nothing, and the reason for this is because the surgery falls into what is called the Global Surgery Period, also known as the Global Surgical Package.

The Global Surgical Package includes all the necessary services normally furnished by a surgeon before, during, and after a procedure. Under the Global Surgical Package, there is a 0-day post-operative period. Under the 0-day period, a visit on that day is not payable to the doctor, so he cannot bill the patient for this. For some surgeries/procedures, there is a 10-day post-operative period. Under the 10-day post-operative period, the total period is 11 total days (the actual day of surgery is counted plus 10 days immediately following the surgery). For other procedures/surgeries, there is a 90-day post-operative period with the total global period being 92 days (count one day before the day of the surgery, the day of surgery, and the 90 days immediately following the day of surgery).

John's open-heart surgery is deemed to have a 90-day period, which means that Dr. Smith cannot charge John for the office visits within 90 days following the surgery. Under the global surgery package, follow up visits are included, and therefore, not payable separately. Miscellaneous services, such as dressing changes, local incision care, removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes are also not payable.

So, the charges for all the consultations surrounding the date of surgery plus 90 days are not payable and any payments (outside of any co-payments/co-insurances/deductibles) made by John are to be returned to him.

When I had my open heart surgery, the surgeon tried to charge me for all of his 99215 office visits that were included in the global surgery period. All of his bills were disputed, and his payments were denied and refunded to me and I never went back to see him again. About a year later, I unfortunately began having chest pains again and my primary care provider sent me to a cardiology practice where the cardiologist was the same doctor who had billed me for the office visits during the global period (he was now dismissed from the practice), so I ended up in a new practice with a brand new doctor. To give this a happy ending, both the original surgeon and I terminated our patient-provider relationship, which is a story for another article to be published at a later time.

Steve Verno, CMMC, CMMB, NREMT-P, CEMCS, CMSCS, was a Professor of Medical Coding and Billing Instruction at Florida Metropolitan University.
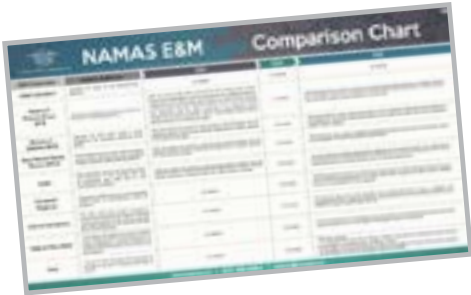
E&M Comparison Chart - Download the .PDF version for FREE!

Clear the confusion! This easy-to-understand chart will detail all the upcoming E&M changes. Each component of E&M is defined and all changes are explained in depth. Or, order a full size laminated version for yourself or your providers for only $7.99 each! Included with the laminated comparison chart is our medical necessity leveling charts for E&M services.

Download: http://shop.namas.co/EM-Comparison-Chart_p_494.html

Outpatient CDI: Follow the Money

Moving from the inpatient to the outpatient setting is gaining momentum.

Outpatient clinical documentation improvement (CDI) programs are becoming more prevalent in the healthcare sector, as the value and benefit to the revenue cycle have become readily apparent. Consulting companies are developing service lines and software to grow their position in the outpatient CDI consulting marketplace. I am excited to see the CDI profession migrate into the outpatient arena, as more and more patient care services are moving into the outpatient setting, including many of the surgical procedures traditionally performed in the inpatient setting.

A ccording to Deloitte Insights, hospital inpatient stays have declined 6.6 percent over the past decade, despite population growth and demographic shifts (such as an increasingly older, sicker Medicare population). In contrast, between 2005 and 2015, visits to outpatient facilities increased by 14 percent, from 197 visits per 100 people in 2005 to 225 visits per 100 people in 2015.

The pace of services migrating from inpatient to outpatient will continue to accelerate, accompanied by the increased volume of outpatient office visits, with the baby boom generation reaching their 60s and more patients electing Medicare Advantage plans. Enrollment in Medicare Advantage plans has nearly doubled in the past decade. One-third (34 percent) of all Medicare beneficiaries, 22 million people, are currently enrolled in Medicare Advantage plans. Between 2018 and 2019, total Medicare Advantage enrollment grew by about 1.6 million beneficiaries or 8 percent. The Congressional Budget Office (CBO) projects that the share of beneficiaries enrolled in Medicare Advantage plans will rise to about 47 percent by 2029.

Following the Reimbursement

As the movement to outpatient continues and more and more Medicare beneficiaries elect for Medicare Advantage coverage, wherein the plan reimburses providers through severity scores consisting of risk adjustment factors, calculated in part through capture of HCC diagnoses, most outpatient CDI programs primarily will focus upon capture of these diagnoses that qualify as HCCs impacting the risk adjustment factor scores. HCCs are synonymous with CC/MCC diagnoses to the extent that they increase reimbursement under the MS-DRG system.

However, there is one distinct difference in that under the MS-DRG system, the CC/MCC diagnoses captured and documented by the physician will have a material impact upon reimbursement as part of the DRG system, provided that the payer does not refute the assigned DRG in the interests of cost containment and reduction in provider payment on the case. Compare this to the HCC system, risk adjustment factor scores, and reimbursement under the Medicare Advantage payment system. Any and all HCCs documented in a calendar year potentially impact reimbursement the following year, provided that the plan shares the additional revenue it receives under the per-member, per-month payment from Medicare. It seems more than logical that hospitals and health systems should be focusing upon and directing their energies on areas of clinical documentation integrity that best communicates patient care, including all relevant diagnoses and accurate depiction and reporting of the clinical facts, clinical information, context (as well as the physician's clinical judgment), medical decision-making, and thought processes that support medical necessity for all work performed or services ordered.

Medical Record Documentation: Fuel for Healthcare

Clear, concise, consistent, and contextually correct clinical documentation is analogous to fuel for an automobile. Without gasoline, the car does not run. Without accurate and complete medical record documentation, all provisions of healthcare come to a grinding halt. Every service ordered by a clinician, aside from a screening mammogram, requires a clinician order. This order is the first step in the process of rendering patient care. The order must be complete and contain all the necessary information required to fulfill the provisions governing an order for care. Besides the patient name, date of order, ordering physician patient date of birth, service ordered, and diagnosis or diagnoses, at a minimum, the order must establish medical necessity for the service. The diagnosis must be considered a covered benefit, as determined by the payer.

More is to come on medical necessity. The clinician order is the first step in the revenue cycle process, which continues with the actual providing of the service, such as an X-ray, CT scan, IV infusion, wound care, etc. What transpired next are the providing and charting/documentation of the service, charge entry, and coding and billing for the service, resulting in expected reimbursement from the payer. The interrelated steps in the revenue cycle can be likened to a subway system. If there is any problem at any of the stations along the route, then the entire subway system is impacted. Similarly, if any of the pieces of the revenue cycle (spanning from the time the order is placed to when the patient is registered, and the service provided, charged, coded, and billed) presents an issue, then the entire revenue cycle is negatively impacted. At a minimum, any process breakdown in the revenue cycle contributes to rework, delays in payment, and increases in cost to collect, a key performance indicator that is tracked and trended as part of the revenue cycle.

Fundamental to the Revenue Cycle

Fundamental to the entire revenue cycle is clinical documentation that serves as a communication tool. Effective communication of patient care supports the patient's clinical needs, adequately reports and the clinical condition of the patient, describes why the patient requires the level of service rendered, outlines any conservative treatment received or contraindicated, and clearly depicts the clinician's clinical judgment, medical decision-making, thought processes, and clinical rationale that supports the services ordered. The latter is traditionally found in the clinician's office notes, ED documentation, or urgent care documentation, necessitating that outpatient CDI programs consider extending the initiative of documentation integrity into the clinician's office, ED, or urgent care.

Outpatient CDI: A Powerful Driving Force

As is clearly evident, outpatient CDI programs can be a powerful driving force in sufficiently ensuring the completeness, accuracy, and integrity of clinical documentation, well beyond diagnosis capture. Medicare's hospital insurance trust fund will become insolvent by 2026 unless something is done to slow down the spending curve. Data shows that hospitals are by far the biggest cost in our $3.5 trillion healthcare system, where spending is growing faster than the gross domestic product, inflation, and wage growth. Spending on hospitals represents 44 percent of personal expenses for the privately insured, according to the Rand Corp.

Inarguably, the emphasis of outpatient CDI programs should be placed upon enhancing the value and usefulness of documentation, from the perspectives of communication of patient care, medical necessity, and value cost effectiveness. To do otherwise is offering lip service to efforts of improving the integrity of documentation, foregoing the opportunity to contribute in a positive way to patient care as well as the revenue cycle. Increasing

medical necessity standards, coupled with more stringent documentation requirements and limitations of coverage imposed by third-party payers, are contributing to continued medical necessity struggles, denials, and resulting rework by hospital staff.

I submit to those in the CDI profession working with current outpatient CDI initiatives, or those contemplating starting a program, give strong consideration to expanding the deeply established ingrained vision to include processes that are designed to improve actual quality and effectiveness of clinical documentation that best communicates patient care on behalf of the patient. Laser focus upon achieving a reasonable standard of clinical documentation serves as a major benefactor to the patient, first and foremost. A byproduct of solid and complete documentation is optimal reimbursement that is less subject to third-party payer scrutiny, prone to unnecessary medical necessity denials, and clearly supported and aligned with the revenue cycle. Diagnosis capture and reporting is the final chapter of patient care, and other critical elements of the revenue cycle prior to diagnosis charting must not be overlooked, under the theory of limited constraints. The healthcare delivery process is only as strong as the sum of its parts.

Glenn Krauss, RHIA, BBA, CCS, CCS-P, CPUR, CCDS, C-CDI, PCS, FCS, C-CDAM, is the president and CEO of Core-CDI.com and is a nationally cognized CDI/revenue cycle expert and speaker.
Source: ICD10monitor, a division of MedLearn Media, Inc., is an online news and information service created to help healthcare providers in all settings make informed decisions relative to coding, clinical documentation integrity (CDI), value-based purchasing, and other new payment methodologies. ICD10monitor reports on current issues including population health, physician engagement, and the patient experience.

5 Ways to Improve Patient Retention Rates
in the Digital Age

As we enter 2020, providers are struggling now more than ever to maintain their patient retention rates. Millennials are transitioning into a stage in life where finding a quality physician is important to them. The problem that many providers are running into is that what is important to the upcoming generations is not the same as what is important to the ones that came before them. Contributing factors like the digital age of technology and the impact an online presence has on a practice are causing many patients to search for providers who understand what they want. Keep reading to understand how to improve your patient retention rates among these new realities in healthcare.

mprove Patient Retention Rates

1. Improve Patient Trust
Patient trust is one of the top contributors to improving patient retention rates in today's environment. When a patient does not trust their physician, they are less likely to remain compliant with their treatment plans and they feel more inclined to search for another provider. Your practice can improve patient retention rates and patient trust by communicating with them openly and with compassion, answering all of their questions directly, and providing every opportunity to stay involved in their care. Providers can also improve patient trust by keeping patients updated on what's happening at your practice and how your practice interacts with the community.

Patient Portal
The patient portal is the number one tool for patient engagement in 2020. Patients are eager to understand their care and avoid health concerns if possible. Offering a patient portal will improve patient retention rates by giving your patients access to their medical history and up-to-date health information so they can stay in the loop. It is also the quickest way to contact their physician should they have any questions. With quality software, physicians can quickly respond, improving patient trust and patient engagement to better their overall healthcare experience.

2. Intelligent Intake
Intelligent intake may not seem like the obvious method to increase patient retention rates at your practice, but it is one of the many ways to give patients what they want in the digital age. Intelligent intake enables patients to check in and complete their forms from a computer at home or at the office on a tablet. This enables them to input the most accurate information directly into their chart, available to update at any time. This helps your patients stay involved in their care process while also improving the integrity of patient data and reducing wait times.

3. Improve Online Presence
A provider's online presence is everything in 2020. If you have a negative online presence, you will find it hard to improve your patient retention rates. Younger patients go straight to the internet to find reviews on physicians in their area and determine who is the best fit for them. This is also where angry patients turn to if they have a poor experience at your practice. Providers can improve their online presence and patient retention rates by asking patients who they think had a positive experience to leave a review about them online. If your practice is noticing a lot of negative feedback online, it may be time for some internal changes.

4. Appointment Reminders
Sometimes patients do not intentionally leave their physician, rather they let their medical care get away from them. This is referred to as a patient lapse, where a patient does not seek medical attention for over 18 months, impacting your patient retention rates. Appointment reminders can be a very effective method for reminding patients to stay on top of their care. It not only reminds patients who have already scheduled appointments to show up, but it also makes patients aware when it is time for their yearly check-up or important labs and testing. By reminding the patients who may forget, you will prevent patient lapses and improve your patient retention rates.

Kimberly Von Feldt writes for iSalusHealthcare.com.
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Who Knew?
There are Three Types of Add-On Codes

Using add-on codes with HCPCS/CPT is not as simple as 1-2-3! Although there are three different groups of add-on codes assigned by CMS, these are used to identify code edits. It is easy to see the add-on code with some codes; we can see the instructional notes and phrases, such as "Use Additional." Add-On codes are updated with their primary procedures each year in January. Quarterly updates may be posted as well.

When are they used?

- Add-on codes must be reported in conjunction with another primary service.
- Add-on codes are only reported if the primary procedure is performed by the same practitioner.

Identifying an Add-on Code

- Identified as a Type I, Type II, or Type III, add-on code.

- The Medicare Physician fee schedule database generally has a global period of "ZZZ."
- Designated by the symbol "+" on Find-A-Code's code page and by the CPT manual.
- Coding instructional notes generally include phrases such as, "each additional" or "(List separately in addition to primary procedure)."

How does CMS process Add-On Codes?

- Type I add-on codes are never paid unless a listed primary procedure code is also paid.
- See CMS Pub-100-04, Chapter 12, Section 30.6.12(I).
- According to CMS, the add-on codes are in three groups to distinguish the payment policy for each group.

Groups of Code Types

1. **Type I -** A Type I add-on code has a limited number of identifiable primary procedure codes. The CR lists the Type I add-on codes with their acceptable primary procedure codes. A Type I add-on code, with one exception, is eligible for payment if one of the listed primary procedure codes is also eligible for payment to the same practitioner for the same patient on the same date of service. Claims processing contractors must adopt edits to assure that Type I add-on codes are never paid unless a listed primary procedure code is also paid.

2. **Type II -** A Type II add-on code does not have a specific list of primary procedure codes. The CR lists the Type II add-on codes without any primary procedure codes. Claims processing contractors are encouraged to develop their own lists of primary procedure codes for this type of add-on codes. Like the Type I add-on codes, a Type II add-on code is eligible for payment if an acceptable primary procedure code as determined by the claims processing contractor is also eligible for payment to the same practitioner for the same patient on the same date of service.

3. **Type III-** A Type III add-on code has some, but not all, specific primary procedure codes identified in the CPT Manual. The CR lists the Type III add-on codes with the primary procedure codes that are specifically identifiable. However, claims processing contractors are advised that these lists are not exclusive and there are other acceptable primary procedure codes for add-on codes in this Type. Claims processing contractors are encouraged to develop their own lists of additional primary procedure codes for this group of add-on codes. Like the Type-I add-on codes, a Type III add-on code is eligible for payment if an acceptable primary procedure code as determined by the claims processing contractor is also eligible for payment to the same practitioner for the same patient on the same date of service.

Chris Woolstenhulme, MBRA, CMRS, is a Certified Billing Guru (CBG) for Find-A-Code. For more information about ICD-10-CM, ICD-10-PCS, and medical coding and billing please, visit FindACode.com where you will find the ICD-10 code sets and the current ICD-9-CM, CPT, and HCPCS code sets, plus a wealth of additional information related to medical billing and coding.

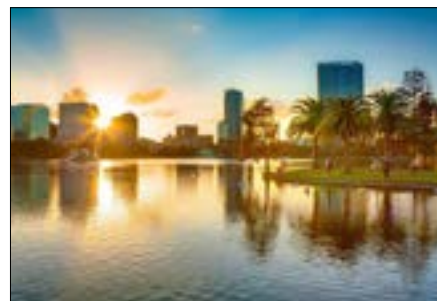www.billing-coding.com/events

40th OHIMA Annual Meeting & Trade Show

When: March 16th - 18th, 2020
Location: Columbus, OH
ohima.org/annmtg/annmtg.html

31st Annual HIP Week

When: March 22nd - 28th, 2020
Location: Online
ahima.org/events?tabid=hipweek

Healthcon 2020

When: April 5th - 8th, 2020
Location: Coronado Springs. FL
http://www.healthcon.com/

HIPAA Training Camp

When: April 29th - 30th, 2020
Location: Las Vegas, NV
www.aihc-assn.org

Corporate Compliance Camp

When: November 11th - 12th, 2020
Location: Tampa, FL
www.ahcae.org

Corporate Compliance Camp

When: November 11th - 12th 2020
Location: Tampa, FL
www.aihc-assn.org

View more conferences and events at www.billing-coding.com/events

The Importance of Growth

It goes without saying that these are turbulent times in the healthcare industry and even well-established companies who have enjoyed a stable client base for decades find themselves traveling in unfamiliar waters.

For the first time ever, even Medical Billing companies who are experts at turning charges into cash and are providing excellent client service are losing clients due to various factors, many of which are beyond their control.

Some common causes for client attrition are:

- The providers' decision to abandon their practices and become an employee of the hospital or another larger group. Essentially, they are throwing in the towel, saying that they want security versus uncertainty, given what the new healthcare legislation may have in store for the future of medicine.
- New physician graduates seem to be content to seek employment versus wanting to start up their own practice. The thought of adding to their college debt by funding a new practice isn't something at the top of their list. Plus having to deal with the other aspects of an independent practice like staffing doesn't seem very attractive.
- A competitor is offering a lower price, and your clients' loyalty to your firm, after you have helped them to be successful for many years, flies out the window.

So, what measures do you need to take to combat your shrinking client base? You need more than ever to dedicate a substantial amount of your time and resources to networking, marketing, and enhancing your selling skills.

Keep in mind that you can't hit a target unless you can see it, so you must decide what types of prospect to chase. Nobody has an unlimited amount of resources. You must determine the specialty, size of the practice, and geographical location of the prospects you'd like to turn into clients. Defining your market will allow you to build and implement a focused plan, and the more focused your plan, the better chance for success. You can't chase all the rabbits in the field at the same time.

There are three components that will help you grow. They are networking, marketing, and selling skills. The following outlines some ideas as to how to accomplish each component.

Networking involves interacting with people either in person at association meetings or via some other medium—email, phone, etc. Remember that networking isn't about you; it's about them. Your goal when meeting people is to see how you can help them, not how they can help you. When you help others succeed, they will eventually help you to succeed.

Marketing can take on many facets and varying degrees of economic investment. Start with a dynamic website; not having an excellent website today is like not having a fax machine 10 years ago. I haven't found advertising to be very effective; instead, I recommend that you write articles for trade journals that your prospects read, or speak at meetings that they attend. Remember that when you are speaking at a trade show, your goal is to tell, not to sell. Share information about a topic that is relevant to your audience, but never promote yourself or your company. When they perceive that you are an expert, they will seek you out.

Selling Skills is the final important component to help you grow, though I doubt you took classes in high school or college attending how to sell—but thank goodness we all had calculus since we use calculus every day. While we might not need calculus, if we want to stay in business, we definitely need selling skills. And it's not true that some people are born to sell; selling is a learned skill and requires development and practice just like every other skill. To improve, you can read or listen to some of the thousands of books written on the subject, attend training seminars, listen to podcasts from various sales experts, and more.

People often ask me what book on selling they should buy; I remind them that it isn't what they buy, but rather, it's what they read.

The key is that you can't just sit by your phone and hope that prospects will call you begging to use your services. You need to develop a plan, acquire the necessary skills, and then most importantly, execute your plan. You can have an excellent strategy, but if it is not implemented, you are no better off than a person without a plan.

Dave Jakielo is an International Speaker, Consultant dedicated to the Medical Billing Industry, Executive Coach, and Author, and is President of Seminars & Consulting. Dave is past President of Healthcare Business and Management Association and the National Speakers Association, Pittsburgh. Sign up for his FREE weekly Success Tips at www.Davespeaks.com. Dave can be reached via email Dave@Davespeaks.com; phone 412-921-0976.

Title: Annual Wellness Visit and Initial Preventive Physical Exam Everything You Need to Know
Format: eBook (Your order confirmation email will include a link(s) to this downloadable product.)
Price: $125.00
**Where:** https://shop.doctors-management.com

This comprehensive eBook provides practice managers, coders, auditors, and other medical professionals with detailed information on the regulations surrounding Annual Wellness Visits. It is delivered immediately as a downloadable eBook (PDF).

The annual wellness visit or AWV is a new benefit introduced as part of the ACA and is a potential revenue booster for practices, as well as helpful to patients. Unfortunately, this is a very complex service due to restrictive federal guidelines that define what it must include. Providers also confuse it with the much older but similar benefit called the initial preventive physical exam or IPPE.

This product explains precisely the regulations governing both services, including the exact list of required elements, documentation, supervision, etc. Also included is a comprehensive suite of forms that can be used to guarantee the service is performed correctly, with all needed information gathered and tests done. Finally, there is a 10-question quiz with clinical examples, a decision tree explaining which service a patient is eligible for, and a quick reference sheet for both services. To conclude is a long list of federal source documents and regulatory memos that back up their interpretation of the rules.

Features:
* 25-page guide explaining the AWV and IPPE + 80 pages of supporting source documents
* Complete set of forms for the AWV, IPPE, and the HRA (health risk assessment that is a mandatory component of the AWV)
* Decision tree to determine whether patient gets IPPE, initial AWV, or subsequent AWV
* Quick reference cards for each service to understand requirements at a glance
* 10 clinical example quizzes to test your knowledge of the rules
* Use the ready-made forms or customize them, ensuring your providers never miss any required elements
* Also included are nationally recognized mental health screening instruments in the forms, unlike many free AWV forms or templates

Title: Fundamentals of Human Resource Management for Physician Practices and Ambulatory Health Service Organizations
Price: $119 Pahcom Members, $149 non-members
Where: www.pahcom.com
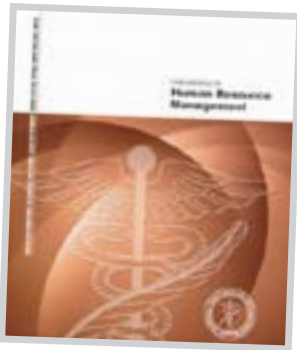
A comprehensive manual for the development and refinement of skills necessary for effective employee management and productivity within physician practices and ambulatory surgical centers.

There are 7 chapters in this book, and it starts out with an overview of the practice managers role in human resources management and moves quickly into a breakdown of federal employment laws. You will also be taken through the rules of record keeping (think employment applications, contracts, and even immigrant documentation), as well as retention requirements. The book has several chapters devoted to the traditional functions of management, the planning and organizing functions of management, and the staffing and directing functions of management. It concludes with a chapter focusing on discipline, dealing with misconduct, and terminating an employee. Some handy forms in the appendix round out the book.
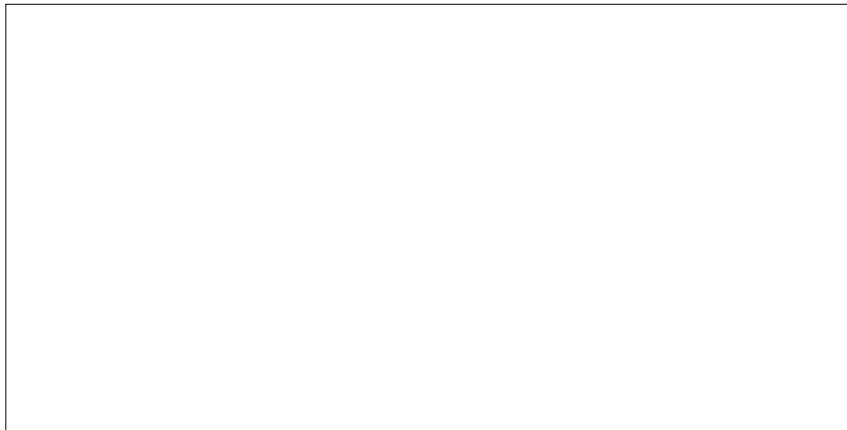
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