Welcome to PMI’s Webinar Presentation

Brought to you by:
Practice Management Institute®
pmiMD.com

Meet the Presenter…

Linda D’Spain, CMPE, CMC, CMIS, CMOM, CMCO

On the topic:
Highlights of Medicare & Compliance Changes for 2019
Welcome to Practice Management Institute’s Webinar and Audio Conference Training. We hope that the information contained herein will give you valuable tips that you can use to improve your skills and performance on the job. Each year, more than 40,000 physicians and office staff are trained by Practice Management Institute. For 30 years, physicians have relied on PMI to provide up-to-date coding, reimbursement, compliance and office management training. Instructor-led classes are presented in 400 of the nation’s leading hospitals, healthcare systems, colleges and medical societies.

PMI provides a number of other training resources for your practice, including national conferences for medical office professionals, self-paced certification preparatory courses, online training, educational audio downloads, and practice reference materials. For more information, visit PMI’s web site at [www.pmiMD.com](http://www.pmiMD.com)

Please be advised that all information in this program is provided for informational purposes only. While PMI makes all reasonable efforts to verify the credentials of instructors and the information provided, it is not intended to serve as legal advice. The opinions expressed are those of the individual presenter and do not necessarily reflect the viewpoint of Practice Management Institute. The information provided is general in nature. Depending on the particular facts at issue, it may or may not apply to your situation. Participants requiring specific guidance should contact their legal counsel.

CPT® is a registered trademark of the American Medical Association.
Highlights of Medicare & Compliance Changes for 2019

Presented by
Linda D'Spain, CMPE, CMC, CMIS, CMOM, CMCO

Brought to you by
Practice Management Institute®

Overview

This course will provide important physician reporting and reimbursement updates to Medicare’s Physician Fee Schedule (PFS) and the Quality Payment Program (QPP) including changes to Merit-based Incentive Payment Systems (MIPS), and Alternative Payment Models (APMs) in addition to updated details for healthcare compliance.
Objectives

Upon the completion of this course, the participants will be able to:

– Prepare for new non-face-to-face codes for Telemedicine
– Understand what additional types of providers will have to participate in MIPS in the new year
– Be informed of additional QPP exemption criteria
– Learn about the implementation of wholesale acquisition cost-based payment for some Part B drugs
– Be prepared for shifts in Practice Expense RVUs for some codes
– Gain clarity on the relaxed documentation standards for Evaluation and Management (E/M) services
– Learn the latest additions to the OIG Work plan affecting healthcare providers

Acronyms

• APM - Alternative Payment Model
• AAPM - Advanced Alternative Payment Model
• CDC - Centers for Disease Control and Prevention
• CMS - Centers for Medicare & Medicaid Services
• CPT - Current Procedural Terminology
• eCQM - Electronic Clinical Quality Measure
• EHR - Electronic Health Record
• ESRD - End-Stage Renal Disease
• FQHC - Federally Qualified Health Centers
• GAO - Government Accountability Office
• GPCI - Geographic Practice Cost Index
EVALUATION AND MANAGEMENT (E/M)
Evaluation and Management

• The massive changes to Evaluation and Management (E/M) that the Centers for Medicare & Medicaid Services (CMS) originally proposed do not appear in the final 2019 physician fee schedule.

• For 2019, CMS has relaxed documentation requirements to reduce the burden on providers.

• Providers will not be required to re-enter information about the patient’s chief complaint and any part of the history entered by the patient or a staff member, but must indicate in the patient record that the information was “reviewed and verified.”

• For established patient office/outpatient visits, providers may simply document changes (or pertinent items that have not changed) since the last visit when relevant information is already contained in the medical record. They will no longer be required to re-record the defined list of required elements if there is evidence they have reviewed the information previously recorded and updated it as necessary and indicated they have done so.

• Providers will no longer be required to document the medical necessity of a home visit in lieu of an office visit when reporting codes 99341 – 99350.

• Teaching physicians will no longer need to duplicate notations in the medical record that have been previously entered by residents or other members of the medical team.
E/M Beyond 2019

• E/M documentation burdens will continue to be reduced in 2021.
• Providers will be able to choose to document office/outpatient visits Levels 2 through 5 using medical decision-making or time as the key documentation requirement instead of the 1995 and 1997 documentation guidelines for Evaluation and Management services.
• For E/M office/outpatient level 2 through 4 visits, when using Medical Decision Making or current 1995 and 1997 documentation guidelines framework to document the visit, CMS will also apply a minimum supporting documentation standard associated with level 2 visits.

Documenting Using Time

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Required Time (minutes)</th>
<th>Estimated Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212</td>
<td>10</td>
<td>$90</td>
</tr>
<tr>
<td>99213</td>
<td>15</td>
<td>$90</td>
</tr>
<tr>
<td>99214</td>
<td>25</td>
<td>$90</td>
</tr>
<tr>
<td>99215</td>
<td>40</td>
<td>$148</td>
</tr>
</tbody>
</table>
Documenting Using Time (cont.)

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Required Time (minutes)</th>
<th>Estimated Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212 extended (99212 + GPRO1)</td>
<td>34-69</td>
<td>$157</td>
</tr>
<tr>
<td>99213 extended (99213 + GPRO1)</td>
<td>34-69</td>
<td>$157</td>
</tr>
<tr>
<td>99214 extended (99214 + GPRO1)</td>
<td>34-69</td>
<td>$157</td>
</tr>
<tr>
<td>99215 prolonged (99215 + 99354-5)</td>
<td>70+</td>
<td>$281+</td>
</tr>
</tbody>
</table>

E/M Beyond 2019

- CMS believes these policies will allow practitioners greater flexibility to exercise clinical judgment in documentation, so they can focus on what is clinically relevant and medically necessary for the beneficiary.
- In 2021 CMS will implement the major revision proposed for 2019 - collapsing E/M payment rates for office visit levels 2 through 4 to a single payment rate structure for both established patient visit codes 99212 – 99214 and new patient visit codes 99202 – 99204.
### Estimated Payment Beginning 2021 for Office/Outpatient E/M Visits

<table>
<thead>
<tr>
<th>Level</th>
<th>Current Payment* (established patient)</th>
<th>Estimated Payment beginning 2021**</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$22</td>
<td>$24</td>
</tr>
<tr>
<td>2</td>
<td>$45</td>
<td>$90 ($103 for primary care and non-procedural care)</td>
</tr>
<tr>
<td>3</td>
<td>$74</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>$109</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>$148</td>
<td>$148</td>
</tr>
</tbody>
</table>

---

### Estimated Payment Beginning 2021 for Office/Outpatient E/M Visits (cont.)

<table>
<thead>
<tr>
<th>Level</th>
<th>Current Payment* (new patient)</th>
<th>Estimated Payment beginning 2021**</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$45</td>
<td>$44</td>
</tr>
<tr>
<td>2</td>
<td>$76</td>
<td>$130 (or $143 for primary care and non-procedural care)</td>
</tr>
<tr>
<td>3</td>
<td>$110</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>$167</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>$211</td>
<td>$211</td>
</tr>
</tbody>
</table>

* Current Payment for CY 2018
New Primary Care Complexity Code:
Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services (Add-on code, list separately in addition to level 2 through 4 office/outpatient evaluation and management visit, new or established)

New Non-procedural Specialty Care Complexity Code:
Visit complexity inherent to evaluation and management associated with non-procedural specialty care including endocrinology, hematology/oncology, urology, obstetrics/gynecology, allergy/immunology, otolaryngology, interventional pain management, cardiology, neonatology, infectious disease, psychiatry, and pulmonology. (Add-on code, list separately in addition to level 2 through 4 office/outpatient evaluation and management visit, new or established)

New Extended Visit Code:
Extended time for evaluation and management service(s) in the office or other outpatient setting, when the visit requires direct patient contact of 34-69 total face-to-face minutes overall for an existing patient or 38-89 minutes for a new patient (List separately in addition to code for level 2 through 4 office or other outpatient Evaluation and Management service)

Existing Prolonged Services Code:
Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service)
NOTE: CMS intends to engage in further discussions with the public to potentially further refine the policies for CY 2021. After consideration of concerns raised by commenters in response to the proposed rule, CMS is not finalizing aspects of the proposal that would have:

1. reduced payment when E/M office/outpatient visits are furnished on the same day as procedures;
2. established separate coding and payment for podiatric E/M visits;
3. standardized the allocation of practice expense RVUs for the codes that describe these services.

©2018 Practice Management Institute®
Advancing Virtual Care

CMS is interested in recognizing changes in healthcare practice that incorporate innovation and technology in managing patient care and aims to increase access for Medicare beneficiaries to these services that are routinely furnished via communication technology by clearly recognizing a discrete set of services that are defined by and inherently involve the use of communication technology.

CMS has finalized policies to:

- Pay clinicians for virtual check-ins – brief, non-face-to-face assessments via communication technology
- Pay clinicians for remote evaluation of patient-submitted photos or recorded video.
- Pay Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for these kinds of services - outside of the RHC all inclusive rate and the FQHC Prospective Payment System rate
New Non-Face-to-Face Codes

- G2012 Brief communication technology-based service (i.e., virtual check-in)
- G2010 Remote evaluations of pre-recorded patient information submitted by an established patient (i.e., photo or video)

Requirements for Use

- These services are for established patients only.
- The patient must consent to the service.
- The service cannot lead to an E/M visit within the next twenty-four (24) hours or the earliest appointment available.
- The service must not be related to an E/M visit that occurred up to seven (7) days prior.
Requirements for Use

• The service must be performed by the clinician who can report E/M services and will bill for the non-face-to-face service(s).
• When a clinician cannot perform an evaluation because the quality or the image or recording is not adequate, the practice may not bill G2010.
• The follow up portion of the remote evaluation service may be performed by phone or HIPAA-compliant electronic method (i.e., via text, email, or patient portal).

New Coding Describing Chronic Care
Remote Physiologic Monitoring and Interprofessional Internet Consultation

99453  Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment

99454  Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days

99457  Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month
CMS will also pay for interprofessional internet consultation (CPT codes 99451, 99452, 99446, 99447, 99448, and 99449). CMS will cover consults performed by phone, internet or electronic health record (EHR):

99446  Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient’s treating/requesting physician or other qualified health care professional, and involves 5 to 10 minutes of medical consultative discussion and review

99447  11 to 20 minutes of medical consultative discussion and review

99448  21 to 30 minutes of medical consultative discussion and review

99449  31 minutes or more of medical consultative discussion and review

Furthermore, CPT codes 99451 and 99452 (new for 2019) include time devoted to preparing written reports.

99451  Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient’s treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time

99452  Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes

Requirements for billing these codes

- Must have patient’s consent for each consult and referral billed
- Time-based codes – review guidance in CPT codebook
CMS adds the following codes to the list of telehealth services:

- **G0513** Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service)

- **G0514** (Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code g0513 for additional 30 minutes of preventive service)

CMS is finalizing policies to implement the requirements of the Bipartisan Budget Act (BBA) for telehealth services related to beneficiaries with end-stage renal disease (ESRD) receiving home dialysis and beneficiaries with acute stroke effective January 1, 2019.

CMS is finalizing the addition of renal dialysis facilities and the homes of ESRD beneficiaries receiving home dialysis as originating sites, and to not apply originating site geographic requirements for hospital-based or critical access hospital-based renal dialysis centers, renal dialysis facilities, and beneficiary homes, for purposes of furnishing the home dialysis monthly ESRD-related clinical assessments.

CMS is also finalizing policies to add mobile stroke units as originating sites and not to apply originating site type or geographic requirements for telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.
Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder and Other Substance Use Disorders

• CMS is implementing a provision from the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act that removes the originating site geographic requirements and adds the home of an individual as a permissible originating site for telehealth services furnished for purposes of treatment of a substance use disorder or a co-occurring mental health disorder for services furnished on or after July 1, 2019.

• Additionally, the SUPPORT for Patients and Communities Act establishes a new Medicare benefit category for opioid use disorder treatment services furnished by opioid treatment programs (OTP) under Medicare Part B, beginning on or after January 1, 2020.

Recognizing Communication Technology-Based and Remote Evaluation Services for Rural Health Clinics and Federally Qualified Health Centers

• For CY 2019, CMS finalized payment for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for communication technology-based services and remote evaluation services that are furnished by an RHC or FQHC practitioner when there is no associated billable visit.

• These services will be payable for medical discussions or remote evaluations of conditions not related to an RHC or FQHC service provided within the previous 7 days or within the next 24 hours or at the soonest available appointment.
QUALITY PAYMENT PROGRAM (QPP)

Merit-based Incentive Payment System (MIPS)

• CMS will now require MIPS-eligible clinicians to use a 2015 Edition certified EHR so patients can more easily access their data and that clinicians can more easily share medical information.
Additional provider types will be required to participate in MIPS in 2019 including:

- Physical therapists
- Occupational therapists
- Clinical psychologists
- Speech-language pathologists
- Audiologists
- Registered dieticians
- Nutrition professionals
Small Practices

- Small practices with 15 or less eligible clinicians will get a six (6) point bonus in the Quality category. In addition, small practices will continue to be allowed to report quality measures via claims.
- In 2020, measures submitted by small practices will continue to receive three (3) points even if they fail to meet data completeness (falling below the required 60% threshold of their patients for the period), while larger practices in the same situation will receive zero (0) points.

To be excluded from MIPS, providers or groups will need to meet at least one of the following conditions:

1. $90,000 or less in Medicare Part B allowed charges for covered services
2. 200 or less patients enrolled in Part B annually
3. 200 or less covered professional services provided under the Physician Fee Schedule annually
Performance Year 2019

- Performance year 2019 under the QPP will dictate MIPS payment adjustments and eligibility for QP incentive payments for 2021.
- MIPS payment adjustments for 2021 can range from +/-7 percent.
- The Balanced Budget Act of 1997 (BBA) narrowed the scope of MIPS payment adjustments.
- Adjustments will apply only to covered professional services paid through the PFS instead of to all items and services under Medicare Part B.
- As a result, MIPS payment adjustments will not be applied to payments for Part B drugs.
Performance Year 2019

- CMS finalized changes to twenty-three (23) measures and removed twenty-six (26). Four (4) patient-reported outcome measures and seven (7) high-priority measures were added to the available MIPS Quality measures.
- MIPS participants will be required to choose from nine (9) Promoting Interoperability measures, complete six (6) and finish two (2) bonus measures. The final rule establishes a new methodology to score each MIPS eCQM individually and then add them together to receive up to 100 possible points (weighted to account for 25% of the MIPS composite score in 2019).

Six (6) new Improvement Activities are added to the Clinical Practice Improvement Activity (CPIA) MIPS performance category for 2019:

1. Comprehensive Eye Exams
2. Financial Navigation Program
3. Completion of Collaborative Care Management Training Program
4. Relationship-Centered Communication
5. Patient Medication Risk Education
6. Use of CDC Guideline for Clinical Decision Support to Prescribe Opioids for Chronic Pain via Clinical Decision Support
• Performance in the cost category is measured using a retrospective analysis of claims across Medicare Part A and Part B and does not require additional reporting by clinicians.

• For 2019, the cost performance score will be based on performance in Medicare Spending per Beneficiary (MSPB), Total Per Capita Cost (TCPC), and eight new procedural episodes of care.

<table>
<thead>
<tr>
<th>Measure topic</th>
<th>Measure type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Outpatient Percutaneous Coronary Intervention (PCI)</td>
<td>Procedural.</td>
</tr>
<tr>
<td>Knee Arthroplasty</td>
<td>Procedural.</td>
</tr>
<tr>
<td>Revascularization for Lower Extremity Chronic Critical Limb Ischemia</td>
<td>Procedural.</td>
</tr>
<tr>
<td>Routine Cataract Removal with Intraocular Lens (IOL) Implant</td>
<td>Procedural.</td>
</tr>
<tr>
<td>Screening/Surveillance Colonoscopy</td>
<td>Procedural.</td>
</tr>
<tr>
<td>Intracranial Hemorrhage or Cerebral Infarction</td>
<td>Acute inpatient medical condition.</td>
</tr>
<tr>
<td>Simple Pneumonia with Hospitalization</td>
<td>Acute inpatient medical condition.</td>
</tr>
<tr>
<td>ST-Elevation Myocardial Infarction (STEMI) with Percutaneous Coronary Intervention (PCI)</td>
<td>Acute inpatient medical condition.</td>
</tr>
</tbody>
</table>

©2018 Practice Management Institute®
The weighting of the final score of the cost and quality categories has changed:

- Cost increases from 10% to 15% of the total score
- Quality decreases from 50% to 45% of the total score
- Promoting Interoperability (formerly Advancing Care) remains 25%
- Improvement Activities remains 15%
The performance threshold is thirty (30) points. To be eligible for a bonus, the threshold is seventy-five (75) points.

Clinicians whose MIPS performance scores meet or exceed the exceptional performance threshold will qualify for an additional payment adjustment.

The MIPS threshold score is the score between 0 and 100 points that CMS uses to determine which clinicians participating in MIPS will receive a negative, neutral or positive payment adjustment.

For the 2017 and 2018 performance years, CMS set the threshold score at 3 points and 15 points, respectively, in an effort to limit the application of negative payment adjustments while MACRA’s QPP is implemented.
Advanced Alternative Payment Model (APM)

- In 2019 the percentage increases from 50% to 75% of clinicians in an APM must use up-to-date certified electronic health records technology (CEHRT). The revenue-based nominal amount for entry into the program will remain at 8% through 2024.
Quality Payment Program: Advanced Alternative Payment Models (APMs) Year 3 (2019) Final

General:

• Increased the Advanced APM CEHRT threshold so that an Advanced APM must require that at least 75% of eligible clinicians in each APM Entity use CEHRT
• Extended the 8% revenue-based nominal amount standard for Advanced APMs through performance year 2024
• Streamlined the definition of a MIPS comparable measure

MIPS APMs and the APM Scoring Standard:

• Reordered the wording of the criterion to state that the APM "bases payment on quality measures and cost/utilization" to clarify that the cost/utilization part of the policy is broader than specifically requiring the use of a cost/utilization measure
• Updated the MIPS APM measure sets that apply for purposes of the APM scoring standard

Advanced Alternative Payment Model (APM)

• Most Advanced APMs are also MIPS APMs so that if an eligible clinician participating in the Advanced APM does not meet the threshold for sufficient payments or patients through an Advanced APM in order to become a Qualifying APM Participant (QP), thereby being excluded from MIPS, the MIPS eligible clinician will be scored under MIPS according to the APM scoring standard.
• To be considered QPs in Advanced APMs (AAPMs) for payment year 2021 under the Medicare-only Option, clinicians in the 2019 performance period must receive at least 50 percent of Medicare Part B payments, or see at least 35 percent of Medicare Part B beneficiaries through a Medicare AAPM.
Advanced Alternative Payment Model (APM)

- Clinicians can achieve QP status if they receive at least 50% of payments from all payers, or see at least 35% of patients through a combination of Medicare AAPMs and Other Payer APMs.
- For the payment standard, at least 25% of Medicare Part B payments will have to come through Medicare AAPMs.
- For the patient count standard, at least 20% of Medicare Part B beneficiaries will have to be seen through a Medicare AAPM.
ADDITIONAL CHANGES IN 2019 PHYSICIAN FEE SCHEDULE

Conversion Factor

• With the budget neutrality adjustment to account for changes in RVUs, all required by law, the final 2019 PFS conversion factor is $36.04, a slight increase above the 2018 PFS conversion factor of $35.99.

• Note: The 0.50% increase approved by MACRA was reduced to 0.25% through a provision of Bipartisan Balanced Budget Act of 2018.
Outpatient Physical Therapy and Occupational Therapy Services Furnished by Therapy Assistants

The Bipartisan Budget act of 2018 requires that these services now be paid at 85% of the Medicare allowable rate. This is also the law that repealed the therapy caps.

CQ Outpatient physical therapy services furnished in whole or in part by a physical therapy assistant

CO Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant

NOTE: These modifiers will be required in 2020.

DEMONSTRATION PROJECTS
Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration

- The final rule moves ahead with this demonstration project that exempts clinicians from MIPS if they “participate to a sufficient degree” in Qualifying Payment Arrangements with Medicare Advantage organizations (MAOs).
- The demonstration will apply requirements for Qualifying Payment Arrangements that are consistent with the criteria for Other Payer APMs.
- This demonstration project begins with 2018 performance data and will continue for five years.

CMS is currently continuing the Paperwork Reduction Act approval process to confirm a start date for a new Review Choice Demonstration for Home Health Services program and intends to implement a 5-year Review Choice Demonstration for the Home Health and Medicare Administrative Contractor (MAC) Jurisdiction M (Palmetto) providers operating in Illinois, Ohio, North Carolina, Florida, and Texas.

- The demonstration will begin in Illinois and be phased into the other states with at least 60 days' notice before implementation.
- The goal of the demonstration is to test improved methods for identifying, investigating, and prosecuting Medicare fraud occurring in the home health program while maintaining or improving the quality of care provided to Medicare beneficiaries.
Other Medicare News

- CMS has implemented several initiatives to address improper payments, resulting in this being the first year in improper payment reporting history that the Medicare Fee-For-Service (FFS), Medicare Part C, Medicare Part D, Medicaid and Children’s Health Insurance Program achieved reductions in all five programs’ improper payment rates. The Medicare FFS improper payment rate is at its lowest since 2010.
- The 2018 Medicare FFS improper payment rate is 8.12% - the lowest Medicare FFS improper payment rate since 2010 and the second consecutive year that the Medicare FFS improper payment rate is below the 10% threshold for compliance established in the Improper Payments Elimination and Recovery Act of 2010.
Other Medicare News

• Due to the successes of CMS’ actions to address improper payments in home health and skilled nursing facility claims, CMS has achieved a decrease in the Medicare FFS improper payment rate from 9.51 % in 2017 to 8.12 % in FY 2018.

• This represents a $4.59 billion decrease in estimated improper payments from 2017 to 2018. The 2018 Medicare FFS estimated improper payment rate represents claims processed between July 1, 2016 and June 30, 2017.
• Home health corrective actions resulted in a significant $6.92 billion decrease in estimated improper payments from 2015 to 2018.
• The home health improper payment rate decreased from 58.95% in 2015 to 17.61% in 2018.
Other Medicare News

CMS has put emphasis on prevention-oriented activities including policy clarifications and simplifications; prior authorization initiatives that ensure applicable coverage, payment, and coding rules are met before services are rendered; a targeted probe and educate medical review strategy that focuses on outlier providers, limits the number of medical records requested, and puts emphasis on education and assistance in correcting claims errors; and provider education on Medicare policy.
CMS Medicare Beneficiary Identifier Card

The Medicare Access and CHIP Reauthorization Act of 2015 requires CMS to remove Social Security Numbers from Medicare cards and, as a result, CMS is replacing the existing health insurance claim number with a Medicare Beneficiary Identifier (MBI). We will conduct a series of reviews to assess controls in place to distribute and implement usage of the MBI. We will (1) determine the number and nature of Medicare cards returned as undeletable and the extent to which CMS tracks and follows up on Medicare cards returned as undeletable, (2) assess CMS’s safeguards in place to protect the MBI, and (3) conduct a review of payments to providers to determine whether Medicare cards deemed high risk and cards mailed and retained as undeletable are being used for inappropriate items and services.

<table>
<thead>
<tr>
<th>Announced or Revised</th>
<th>Agency</th>
<th>Title</th>
<th>Component</th>
<th>Report Number(s)</th>
<th>Expected Issue Date (FY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2016</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>CMS Medicare Beneficiary Identifier Card</td>
<td>Office of Audit Services</td>
<td>W-00-18-35817</td>
<td>2019</td>
</tr>
</tbody>
</table>

Review of States' Oversight of Opioids

Opioid abuse and overdose deaths are at crisis levels in the United States, with more than 42,000 Americans dying from opioid use in 2016. We will analyze data from 2013 to 2016 on opioid overdose trends from the Centers for Disease Control and Prevention in order to select multiple States for review. We will review the oversight of opioid prescribing and monitoring of opioid use in the selected States. Specifically, we will review policies and procedures, data analytics, programs, outreach, and other efforts. To support HHS's ongoing efforts to identify and disseminate effective practices to address the opioid epidemic in the United States, we will highlight these statewide efforts.

<table>
<thead>
<tr>
<th>Announced or Revised</th>
<th>Agency</th>
<th>Title</th>
<th>Component</th>
<th>Report Number(s)</th>
<th>Expected Issue Date (FY)</th>
</tr>
</thead>
</table>
Physicians Billing for Critical Care Evaluation and Management Services

Critical care is defined as the direct delivery of medical care by a physician(s) for a critically ill or critically injured patient. Critical care is usually given in a critical care area such as a coronary, respiratory, or intensive care unit, or the emergency department. Payment may be made for critical care services provided in any location as long as the care provided meets the definition of critical care. Critical care is exclusively a time-based code. Medicare pays physicians based on the number of minutes they spend with critical care patients. The physician must spend this time evaluating, providing care and managing the patient’s care and must be immediately available to the patient. This review will determine whether Medicare payments for critical care are appropriate and paid in accordance with Medicare requirements.

<table>
<thead>
<tr>
<th>Announced or Revised</th>
<th>Agency</th>
<th>Title</th>
<th>Component</th>
<th>Report Number(s)</th>
<th>Expected Issue Date (FY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2018</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>Physicians Billing for Critical Care Evaluation and Management Services</td>
<td>Office of Audit Services</td>
<td>W-03-16-5616; various reviews</td>
<td>2019</td>
</tr>
</tbody>
</table>

Review of Post-Operative Services Provided in the Global Surgery Period

Section 523 of Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to collect data on post-operative services included in global surgeries and requires CMS to audit and verify a sample of the data collected. We will review a sample of global surgeries to determine the number of post-operative services documented in the medical records and compare it to the number of post-operative services reported in the data collected by CMS. We will verify the accuracy of the number of post-operative visits reported to CMS by physicians and determine whether global surgery fees reflected the actual number of post-operative services that physicians provided to beneficiaries during the global surgery period.

<table>
<thead>
<tr>
<th>Announced or Revised</th>
<th>Agency</th>
<th>Title</th>
<th>Component</th>
<th>Report Number(s)</th>
<th>Expected Issue Date (FY)</th>
</tr>
</thead>
</table>
Medicare Part B Payments for End-Stage Renal Disease Dialysis Services

Medicare Part B covers outpatient dialysis services for beneficiaries diagnosed with end-stage renal disease (ESRD). Prior OIG work identified inappropriate Medicare payments for ESRD services. Specifically, OIG identified unallowable Medicare payments for treatments not furnished or documented, services for which there was insufficient documentation to support medical necessity, and services that were not ordered by a physician or ordered by a physician that was not treating the patient. (Social Security Act §§ 1862(a)(4) and 1852(a), 42 CFR §§ 410.32(a) and (b), 42 CFR §§ 410.12(a)(3), 42 CFR §§ 410.12(a)(3), and 424.10). Additionally, prior OIG reviews identified claims that did not comply with Medicare consolidated billing requirements (31 U.S.C. § 1381(a)(14), Medicare Claims Processing Manual, Pub. No. 100.04, Ch. I and Medicare Benefit Policy Manual, Pub. No. 100.02, Ch. 11). We will review claims for Medicare Part B dialysis services provided to beneficiaries with ESRD to determine whether such services complied with Medicare requirements.

<table>
<thead>
<tr>
<th>Announced or Revised</th>
<th>Agency</th>
<th>Title</th>
<th>Component</th>
<th>Report Number(s)</th>
<th>Expected Issue Date (FY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2018</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>Medicare Part B Payments for End-Stage Renal Disease Dialysis Services</td>
<td>Office of Audit Services</td>
<td>W-00-18-33811</td>
<td>2019</td>
</tr>
</tbody>
</table>

Medicare Part B Outpatient Cardiac and Pulmonary Rehabilitation Services

Medicare Part B covers outpatient cardiac and pulmonary rehabilitation services. For these services to be covered, however, they must be medically necessary and comply with certain documentation requirements. Previous OIG work identified outpatient cardiac and pulmonary rehabilitation service claims that did not comply with Federal requirements. We will assess whether Medicare payments for outpatient cardiac and pulmonary rehabilitation services were allowable in accordance with Medicare requirements. We will also determine whether potential risks in outpatient cardiac and pulmonary rehabilitation programs continue to exist.

<table>
<thead>
<tr>
<th>Announced or Revised</th>
<th>Agency</th>
<th>Title</th>
<th>Component</th>
<th>Report Number(s)</th>
<th>Expected Issue Date (FY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 2018</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>Medicare Part B Outpatient Cardiac and Pulmonary Rehabilitation Services</td>
<td>Office of Audit Services</td>
<td>W-00-18-33806</td>
<td>2019</td>
</tr>
</tbody>
</table>
Toolkit: Using Data Analysis To Calculate Opioid Levels and Identify Patients At Risk of Misuse or Overdose

- This toolkit provides detailed steps for using prescription drug claims data to analyze patients' opioid levels and identify certain patients who are at risk of opioid misuse or overdose.
- It is based on the methodology that OIG has developed in our extensive work on opioids.

This new OIG product provides highly technical information to support our public and private sector partners, such as Medicare Part D plan sponsors, private health plans, and State Medicaid Fraud Control Units. It is intended to assist our partners with analyzing their own prescription drug claims data to help combat the opioid crisis.
Why did the OIG Create the Toolkit?

• Opioid abuse and overdose deaths are at epidemic levels in the United States. As one of the lead Federal agencies fighting health care fraud, OIG is committed to supporting our public and private partners in their efforts to curb the opioid epidemic.

• They can use this toolkit to analyze claims data for prescription drugs and identify patients who may be misusing or abusing prescription opioids and may be in need of additional case management or other followup.

What does the Toolkit Include

• This toolkit provides steps to calculate patients' average daily morphine equivalent dose (MED), which converts various prescription opioids and strengths into one standard value.

• This measure is also called morphine milligram equivalent (MME). The toolkit includes a detailed description of the analysis and programming code that can be applied to the user's own data.
HIPAA News

• On October 25, 2018, the Office of Civil Rights (OCR) launched a public education campaign about civil Rights protections in response to the national Opioid Crisis. OCR is issuing materials to help educate the public about civil rights protections regarding evidence-based opioid use disorder treatment and recovery services.

• The campaign complements OCR’s 2017 guidance – How HIPAA Allows Doctors to Respond to the Opioid Crisis - informing doctors on how they can share information to help patients suffering from an opioid crisis.
Online Resources

- Get your questions answered on hhs.gov’s online resource - HIPAA FAQs for Professionals at https://www.hhs.gov/hipaa/for-professionals/faq/index.html.

- Free CME Training to Educate Providers about the HIPAA Right of Access at https://www.hhs.gov/hipaa/for-professionals/training/index.html.
HIPAA Enforcement Results as of July 31, 2018

- Since the compliance date of the Privacy Rule in April 2003, OCR has received over 186,453 HIPAA complaints and has initiated over 905 compliance reviews. We have resolved ninety-six percent of these cases (178,834).
- OCR has investigated and resolved over 26,152 cases by requiring changes in privacy practices and corrective actions by, or providing technical assistance to, HIPAA covered entities and their business associates.
- In another 11,518 cases, our investigations found no violation had occurred.

- Additionally, in 29,042 cases, OCR has intervened early and provided technical assistance to HIPAA covered entities, their business associates, and individuals exercising their rights under the Privacy Rule, without the need for an investigation.
- In the rest of our completed cases, (112,122) OCR determined that the complaint did not present an eligible case for enforcement.
• The most common types of covered entities that have been required to take corrective action to achieve voluntary compliance are, in order of frequency:
  – General Hospitals;
  – Private Practices and Physicians;
  – Outpatient Facilities;
  – Pharmacies; and
  – Health Plans (group health plans and health insurance issuers).

Healthcare Data Breaches
• Mega-breaches and hacking persist as top cybersecurity concerns, and healthcare continues to be a major target.
  – October 2018 - North Carolina-based Catawba Valley Medical Center is notifying 20,000 patients that their personal data was breached after three successful phishing attacks. Two breaches went on for weeks to months.
  – August 2018 - Gold Coast Health Pan Health Plan discovered that hackers compromised the email account of one employee from June 18 to Aug. 1 through a phishing attack. They notified 37,000 patients that their data was hacked.
  – The Minnesota Department of Human Services - phishing attacks on two separate employee email accounts went undetected for more than a month, breaching 21,000 patient records.
Reported Data Breaches

Fines/Penalties Examples (2018)

- Fresenius Medical Care North America agreed to pay $3.5 million to the HHS Office for Civil Rights (OCR)
- Filefax, located in Northbrook, Illinois, advertised that it provided for the storage, maintenance, and delivery of medical records for covered entities. Although Filefax shut its doors during the course of OCR’s investigation into alleged HIPAA violations, it could not escape its obligations under the law.
- On June 18, 2018, an HHS ALJ granted summary judgment against the University of Texas MD Anderson Cancer Center requiring the provider to pay $4.3 million in civil monetary penalties for HIPAA violations.
Fines/Penalties Examples (2018)

- Anthem, Inc. has agreed to pay $16 million to the U.S. Department of Health and Human Services, Office for Civil Rights (OCR) and take substantial corrective action to settle potential violations of the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules after a series of cyberattacks led to the largest U.S. health data breach in history and exposed the electronic protected health information of almost 79 million people.

Cybersecurity

- Protection of patients' confidential information and electronically stored information in particular continues to be a high priority for HHS enforcement, just as cybersecurity and data privacy issues explode in complexity and public attention.
- OCR issues monthly Cybersecurity Newsletters in order to provide guidance on what specific security measures providers can take to decrease exposure to various security threats and vulnerabilities that exist in the health care sector, and how to reduce breaches of electronic-protected health information.
1. The Overdose Prevention and Patient Safety Act

- The Overdose Prevention and Patient Safety Act (OPPS) Act passed the House of Representatives with overwhelming support and will be further considered by the U.S. Senate at the end of the year. The act promises to improve the quality of care delivered to those dealing with drug addiction while reducing errors in treatment. The bill is widely supported by both parties.
- The OPPS will align 42 Code of Federal Regulations Part 2 with HIPAA regulations and enable the disclosure of protected health information for certain patients. This law increases the availability of patient records. Providers and practice leaders must implement processes to adhere to this rule without disclosing unnecessary protected health information. Practices should update rule-based electronic health records and train staff on this new rule.

2. The Every Prescription Conveyed Securely Act

- The Every Prescription Conveyed Securely Act (EPCS) would force states to move from paper prescriptions to electronic ones. This bill was introduced in the House of Representatives in July 2017, and is still being considered in that chamber.
- If enacted nationally, the law would affect providers that prescribe medications in addition to pharmacies. It is estimated that less than 28% providers would currently be prepared to comply. Under the law, fax would not be adequate. Providers should prepare by adopting new technology, i.e., HIPAA-compliant email, and ensuring that all prescribing physicians understand how to use it securely.
3. Impact from the Individual Mandate Repeal

- One (1) million less patients will be covered by Medicaid and three (3) million less are expected to have health insurance by the end of this year.
- With the cuts to health insurance subsidies for insurers, the healthcare system itself will be severely affected.
- Expect increases in premiums and decreases in reimbursements and subsidies.
- Careful documentation around changes in insurance premiums, coverages, co-pays, and reimbursements will be critical for compliance.
Medicare Beneficiary Updates

• Medicare Part D prescription drug benefits require enrollees with high prescription costs to pay more for their medicines after they reach a certain level of spending in one year creating a coverage gap.
• Beneficiaries of original Medicare won’t have to pay the full cost of outpatient physical, speech or occupational therapy because Congress permanently repealed the therapy cap that had limited coverage of those services.

• Medicare is updating the handbook it sends to beneficiaries each year to include checklists and flowcharts to make it easier to decide on coverage.
• The 21st Century Cures Act allows for Medicare beneficiaries to try an Advantage plan for up to three months and, if they aren’t satisfied, to switch to another Medicare Advantage plan or choose to enroll in original Medicare.
• Medicare has broadening the availability of telehealth programs that let patients confer with a doctor or nurse via telephone or the internet.
• In 2019 Medicare Advantage plans have the option to cover meals delivered to the home, transportation to the doctor’s office and even safety features in the home such as bathroom grab bars and wheelchair ramps. To be covered, a medical provider will have to recommend these benefits.

• Medicare Advantage plans will now include the option to pay for assistance from home health aides. These benefits represent a revised and broader definition of the traditional requirement that Medicare services must be primarily health related.

Medicare Part B
Premiums/Deductibles for 2019

• Medicare Part B covers physician services, outpatient hospital services, certain home health services, durable medical equipment, and certain other medical and health services not covered by Medicare Part A.

• The standard monthly premium for Medicare Part B enrollees will be $135.50 for 2019, an increase of $1.50 from $134 in 2018.

• An estimated 2 million Medicare beneficiaries (about 3.5%) will pay less than the full Part B standard monthly premium amount in 2019 due to the statutory hold harmless provision, which limits certain beneficiaries’ increase in their Part B premium to be no greater than the increase in their Social Security benefits.
Medicare Part B
Premiums/Deductibles for 2019

- The annual deductible for all Medicare Part B beneficiaries is $185 in 2019, an increase of $2 from the annual deductible $183 in 2018.
- Premiums and deductibles for Medicare Advantage and Medicare Prescription Drug plans are already finalized and are unaffected by this announcement.
- Since 2007, a beneficiary’s Part B monthly premium is based on his or her income. These income-related monthly adjustment amounts (IRMAA) affect roughly 5 percent of people with Medicare Part B.

The total premiums for high income beneficiaries for 2019

<table>
<thead>
<tr>
<th>Beneficiaries who file individual tax returns with income:</th>
<th>Beneficiaries who file joint tax returns with income:</th>
<th>Income-related monthly adjustment amount</th>
<th>Total monthly premium amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than or equal to $85,000</td>
<td>Less than or equal to $170,000</td>
<td>$0.00</td>
<td>$135.50</td>
</tr>
<tr>
<td>Greater than $85,000 and less than or equal to $107,000</td>
<td>Greater than $170,000 and less than or equal to $214,000</td>
<td>$54.10</td>
<td>$189.60</td>
</tr>
<tr>
<td>Greater than $107,000 and less than or equal to $133,500</td>
<td>Greater than $214,000 and less than or equal to $267,000</td>
<td>$135.40</td>
<td>$270.90</td>
</tr>
</tbody>
</table>

©2018 Practice Management Institute®
Premiums for high-income beneficiaries who are married and lived with their spouse at any time during the taxable year, but file a separate return, are as follows:

<table>
<thead>
<tr>
<th>Income-related monthly adjustment amount</th>
<th>Total monthly premium amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than or equal to $85,000</td>
<td>$0.00</td>
</tr>
<tr>
<td>Greater than $85,000 and less than $415,000</td>
<td>$297.90</td>
</tr>
<tr>
<td>Greater than or equal to $415,000</td>
<td>$325.00</td>
</tr>
</tbody>
</table>
Medicare Part A
Premiums/Deductibles for 2019

• Medicare Part A covers inpatient hospital, skilled nursing facility, and some home health care services.
• The Medicare Part A inpatient hospital deductible that beneficiaries will pay when admitted to the hospital will be $1,364 in 2019, an increase of $24 from $1,340 in 2018.

Part A Deductible and Coinsurance Amounts for Calendar Years 2018 and 2019 by Type of Cost Sharing

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital deductible</td>
<td>$1,340</td>
<td>$1,364</td>
</tr>
<tr>
<td>Daily coinsurance for 61st–90th Day</td>
<td>335</td>
<td>341</td>
</tr>
<tr>
<td>Daily coinsurance for lifetime reserve days</td>
<td>670</td>
<td>682</td>
</tr>
<tr>
<td>Skilled Nursing Facility coinsurance</td>
<td>167.50</td>
<td>170.50</td>
</tr>
</tbody>
</table>
Medicare Part A
Premiums/Deductibles for 2019

• Enrollees age 65 and over who have fewer than 40 quarters of coverage and certain persons with disabilities pay a monthly premium in order to voluntarily enroll in Medicare Part A.

• Individuals who had at least 30 quarters of coverage or were married to someone with at least 30 quarters of coverage may buy into Part A at a reduced monthly premium rate, which will be $240 in 2019, an $8 increase from 2018.

• Certain uninsured aged individuals who have less than 30 quarters of coverage and certain individuals with disabilities who have exhausted other entitlement will pay the full premium, which will be $437 a month, a $15 increase from 2018.

Questions?

• Thank you for your attendance!

• Get your questions answered on PMI's Discussion Forum: http://www.pmimd.com/pmiForums/rules.asp

©2018 Practice Management Institute®