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Maxine Collins, MBA, CPA, CMC, CMIS, CMOM

On the topic:
Hot Topics for Medical Office Managers
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HOT TOPICS for Medical Office Managers

Presented by
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AGENDA

• Upcoming Trends/Changes in Healthcare in the U.S.
• 2019 CMS Final Rule for the Medicare Physician Fee Schedule
  – E/M Documentation Changes in 2019
  – Future proposed changes in E/M beyond 2019
  – MACRA/MIPS 2019 and beyond
• First Quarter 2019 Insurance Updates
• Compliance Updates:
  – HIPAA
  – OSHA
  – Fraud and Abuse
  – Fraud, Waste and Abuse
  – Other
• Personnel Management Tips
"Let our New Year's resolution be this we will be there for one another as fellow members of humanity, in the finest sense of the word."

Goran Persson

2019 and BEYOND
PREDICTED TRENDS IN THE HEALTHCARE INDUSTRY
HEALTHCARE PREDICTIONS
FOR 2019

• According to Reenita Davis in the online article “Top 8 Healthcare Predictions for 2019” posted on Forbes.com (November 13, 2018), they accurately predicted almost 98% of trends for 2018.

• Forbes’ predictions for 2019:
  − “Prediction #1: 15% of global healthcare spending will be tied to Value-based Models”
    ▪ Value-based Healthcare with focus on Outcomes of care
    ▪ Risk-sharing
    ▪ Affordable and accessible healthcare will be focus of political agendas
    ▪ Costs spent on healthcare will impact all countries spending more than 10% of GNP on these services
    ▪ Continuing changes in reimbursement methodologies


FORBES PREDICTIONS for 2019

• Forbes’ predictions for 2019:
  − “Prediction #2: Artificial Intelligence (AI) for healthcare IT Application will cross $1.7 billion by 2019.”
    ▪ “AI platforms” across healthcare could result in 10-15% increase in productivity over next few years
    ▪ Pricing will be a concern for technology
    ▪ Human and machine interaction will evolve
    ▪ Changes will specifically occur in certain areas such as imaging diagnostic, drug discovery, and risk analytics applications

FORBES PREDICTIONS for 2019

• Forbes’ predictions for 2019:
  − “Prediction #3: Digital health tech catering to out of hospital will grow by 30% and cross $25 billion.”
    ▪ Individuals being able to manage their own health
    ▪ Increasing costs of healthcare will drive the movement to telehealth and other digital forms of care delivery
    ▪ Reimbursement models will change to accommodate technology in healthcare
    ▪ “Digital health applications will continue to expand care delivery models beyond physical medicine to include behavioral health, digital wellness therapies, dentistry, nutrition, and prescription management” states Forbes.


FORBES PREDICTIONS for 2019

• Forbes’ predictions for 2019:
  − “Prediction #4: Asia becomes the New Local Innovation Hub for Global Drug and Device OEMs.”
    ▪ Innovations in health care “has flowed historically from West to East”
    ▪ Drug & Device Original Equipment Manufacturer (OEMs) are targeting emerging markets in Asia to boost growth following the trends of growth in the Pharmaceutical industry ( growing 10-20% due to such markets).
    ▪ OEM describes a manufacturer who puts together computers made of other company's parts and then sells the product under its own brand name.
    ▪ Some examples of an OEM are Dell, Hewlett Packard, and Sony.
    ▪ Forbes predicts that by 2019, up to 10% of healthcare R&D will be invested to localize innovation for emerging markets in Asia
    ▪ Genomics revolution in Asia-Pacific? Could DNA and the language of life personalize and revolutionize medicine?

FORBES PREDICTIONS for 2019

• Forbes’ predictions for 2019:
  
  ¬ “Prediction #5: Analytics shifts from Big Data to Meaningful Small Data by Hospital Specialty.”
  
  ▪ Growth of specialty-specific analytic solutions;
  
  ▪ Impact on drug usage, treatment options, self-care programs for chronic conditions;
  
  ▪ Forbes predicts that “by end of 2019, 50% of all healthcare companies will have resources dedicated to accessing, sharing, and analyzing real-world evidence for use across their organizations”.
  
  ▪ Population health management
  
  ▪ Lower cost, better outcomes


FORBES PREDICTIONS for 2019

• Forbes’ predictions for 2019:

• “Prediction #6: Healthcare will be a dominant vertical in voice applications.”

  ¬ Voice technologies for healthcare
  
  ¬ Forbes predicts: “Moving forward, bringing voice technology to vetted clinical use cases such as elderly care, chronic condition management, physician’s assistant will provide growth opportunities”.

FORBES PREDICTIONS for 2019

• Forbes’ predictions for 2019:
  − “Prediction #7: Blockchain move from Hype to Real Initial Commercial Implementations generating ROI.”
    ▪ Sep 13, 2018 – “Blockchain technology is like the internet in that it has a built-in robustness. By storing blocks of information that are identical across its network, …”
      (Source: https://blockgeeks.com/guides/what-is-blockchain-technology/)
    ▪ A growing list of records linked by cryptography (codes that convert words into un-readable text)
    ▪ Technologies will move from “pilot” stage to “partial/limited commercial use”
    ▪ How and where can it be utilized in healthcare will be explored
    ▪ Look for company names in this segment such as Change Healthcare, Hashed Health, and Guardtime, etc.


FORBES PREDICTIONS for 2019

• Forbes’ predictions for 2019:
    ▪ Healthcare Insurance Industry expected to see less than a 1.5% growth in 2018 due to inadequate coverage policies and failure to meet the needs of the beneficiaries.
    ▪ As a result, Forbes predicts that “5-10% of health insurance plans will be linked to lifestyle and health data-driven interactive policies in some form by end of 2019”.

SUMMARY OF FINAL RULE

- **Background:** Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary to establish a fee schedule of payment amounts for physicians’ services for the subsequent year.

- The Centers for Medicare & Medicaid Services (CMS) final rule (Regulation number CMS-1693-F) that updates payment policies and Medicare payment rates for services furnished by Physicians and Nonphysician Practitioners (NPPs) that are paid under the MPFS in CY 2019 was published on November 1, 2018.

- This final rule also addresses public comments on Medicare payment policies proposed earlier in this year.

PATIENTS OVER PAPERWORK INITIATIVE

Patients Over Paperwork

- The Patients Over Paperwork initiative is focused on reducing administrative burden while improving care coordination, health outcomes and patients’ ability to make decisions about their own care.
- Physicians tell us they continue to struggle with excessive regulatory requirements and unnecessary paperwork that steal time from patient care.
- This Administration has listened and is taking action.
- The proposed changes to the Physician Fee Schedule address those problems head-on, by proposing to streamline documentation requirements to focus on patient care and proposing to modernize payment policies so seniors and others covered by Medicare can take advantage of the latest technologies to get the quality care they need.

Medical Record Documentation Supports Patient Care

- Clear and concise medical record documentation is critical to providing patients with quality care and is required for physicians and others to receive accurate and timely payment for furnished services.
- Medical records chronologically report the care a patient received and record pertinent facts, findings, and observations about the patient’s health history.
- Medical record documentation helps physicians and other health care professionals evaluate and plan the patient’s immediate treatment and monitor the patient’s health care over time.
- Many complain that notes written to comply with coding requirements do not support patient care and keep doctors away from patients.
STREAMLINING EVALUATION AND MANAGEMENT (E/M) AND REDUCING CLINICIAN BURDEN

• The 2019 Medicare Physician Fee Schedule Conversion Factor is:
  – $ 36.0391 – up from $ 35.996. Wow - up $.0431!
• The 2019 Anesthesia Conversion Factor is:
• For CYs 2019 and 2020:
  – CMS will continue the current coding and payment structure for E/M office/outpatient visits; and
  – Practitioners should continue to use either the 1995 or 1997 E/M documentation guidelines to document E/M office/outpatient visits bill to Medicare.
STREAMLINING EVALUATION AND MANAGEMENT (E/M) AND REDUCING CLINICIAN BURDEN

• For CY 2019 and beyond, CMS is finalizing the following policies:
  − Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit
  − For established patient office/outpatient visits:
    • When relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed.
    • They need not re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed.
    • Practitioners should still review prior data, update as necessary, and indicate in the medical record that they have done so.

• CMS is clarifying that for E/M office/outpatient visits and new/established patient visits:
  − Practitioners need not re-enter in the medical record on the patient’s chief complaint and history that has already been entered by ancillary staff or the beneficiary.
  − The Practitioner may simply indicate in the medical record that he or she reviewed and verified this information.
• CMS is clarifying that for E/M visits furnished by teaching physicians they are removing potentially duplicative requirements for notations in medical records that may have previously been included in the medical records by residents or other members of the medical team.

• Beginning in 2021:
  - CMS will further reduce burden with the implementation of payment, coding, and other documentation changes.
  - Payment for E/M office/outpatient visits will be simplified and payment would vary primarily based on attributes that do not require separate, complex documentation.
Specifically for 2021, CMS is finalizing the following summary of policies:

- Reduction in payment variation for E/M office/outpatient visit levels by:
  - Paying a single rate for E/M visit levels 2 thru 4 for established and new patients;
  - While maintaining visit level 5 in order to better account for the care and needs of complex patients.

- Permitting practitioners to choose to document E/M office/outpatient levels 2 thru 5 using Medical Decision Making (MDM) or Time instead of applying the current 1995 or 1997 E/M documentation guidelines (or, continue using the current documentation guidelines framework).

The following tables indicate estimated payments when current documentation requirements are utilized (not documenting using time):

<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  
** Estimated Payment based on CY2019 finalized RVUs and CY2018 payment rate

MEDICARE BEGINNING IN 2021 FOR E/M OFFICE OUTPATIENT VISITS

- For E/M office/outpatient levels 2 thru 5, CMS will allow flexibility in how visit levels are documented. Choice from:
  - The current framework;  
  - Medical Decision Making (MDM); or  
  - Time

- For E/M outpatient levels 2 thru 4 visits, when using MDM or the current framework to document the visit:
  - CMS will also apply a minimum supporting documentation standard associated with level 2 visits.  
  - For these cases, Medicare would require information to support a level 2 E/M office/outpatient visit code for:
    - History;  
    - Exam; and/or  
    - MDM
BEGINNING IN 2021
FOR DOCUMENTING USING TIME

When time is used to document, practitioners will document the medical necessity of the visit and that the billing practitioner spent the required amount of time face-to-face with the patient (typical CPT time for code reported, plus any extended/prolonged time).

### 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 BY TIME**

- **When time is used to document:**
  - Practitioners will document the **medical necessity** of the visit; and
  - That the billing practitioner **personally spent the required amount of time face-to-face with the beneficiary.**
### 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</td>
<td>34-69</td>
<td>$157</td>
</tr>
<tr>
<td>(99212 + GPRO1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99213 extended</td>
<td>34-69</td>
<td>$157</td>
</tr>
<tr>
<td>(99213 + GPRO1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99214 extended</td>
<td>34-69</td>
<td>$157</td>
</tr>
<tr>
<td>(99214 + GPRO1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99215 prolonged</td>
<td>70+</td>
<td>$281+</td>
</tr>
<tr>
<td>(99215 + 99354-5)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### E&M Payment Amounts

<table>
<thead>
<tr>
<th>Complexity</th>
<th>Visit Code</th>
<th>Visit Code with Either Primary or Specialized Care Add-on Code***</th>
<th>Visit Code with New Extended Services Code (Minutes Required = 40)</th>
<th>Visit with Both Add-on and Extended Services Codes Added***</th>
<th>Current Prolonged Code Added (Minutes Required = 80)**</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Patient</td>
<td>Level 2</td>
<td>$76</td>
<td>$140 (at 59 minutes)</td>
<td>$187 (at 30 minutes)</td>
<td>$219</td>
</tr>
<tr>
<td></td>
<td>Level 3</td>
<td>$110</td>
<td>$140 (at 59 minutes)</td>
<td>$187 (at 30 minutes)</td>
<td>$219</td>
</tr>
<tr>
<td></td>
<td>Level 4</td>
<td>$167</td>
<td>$231</td>
<td>$310</td>
<td>$310</td>
</tr>
<tr>
<td></td>
<td>Level 5</td>
<td>$211</td>
<td>$231</td>
<td>$310</td>
<td>$310</td>
</tr>
<tr>
<td>Established Patient</td>
<td>Level 2</td>
<td>$45</td>
<td>$90</td>
<td>$167 (at 44 minutes)</td>
<td>$170</td>
</tr>
<tr>
<td></td>
<td>Level 3</td>
<td>$74</td>
<td>$163</td>
<td>$167 (at 44 minutes)</td>
<td>$170</td>
</tr>
<tr>
<td></td>
<td>Level 4</td>
<td>$103</td>
<td>$163</td>
<td>$167 (at 44 minutes)</td>
<td>$170</td>
</tr>
<tr>
<td></td>
<td>Level 5</td>
<td>$148</td>
<td>$148</td>
<td>$148</td>
<td>$148</td>
</tr>
</tbody>
</table>

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*This is not a new code. The current prolonged service code, describing 60 minutes of additional time but billable after 31 minutes of additional time, is only billed approximately once per one thousand visit codes reported. It is paid at approximately $110.

**For cases where one could bill both the primary and specialized care add-on, there would be an additional $16.

***The dollar amounts included in this projection are based on 2020 payment rates; actual amounts in 2021 when the policy takes effect will differ.
ADD-ON CODES THAT DESCRIBE ADDITIONAL RESOURCES INHERENT FOR SOME SPECIALTIES

• Implementation of *add-on codes* for:
  − *Primary care*; and
  − *Particular kinds of non-procedural specialized medical care* though they would not be restricted by physician specialty.

• These *codes would only be reportable with E/M office/outpatient levels 2 thru 4 visits*; and

• Their *use generally would not impose new per-visit documentation requirements*.

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Resource Use During a Visit

• We recognize that primary care services frequently involve substantial non-face-to-face work, and note that there is currently coding available to account for many of those resources, such as chronic care management (CCM), behavioral health integration (BHI), and prolonged non-face-to-face services.

• The currently available coding still does not adequately reflect the full range of primary care services, nor does it allow payment to fully capture the resource costs involved in furnishing a face-to-face primary care E/M visit.

• We are proposing to create a HCPCS G-code for primary care services, GPC1X (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 an established patient evaluation and management visit]).
NEW “EXTENDED VISIT” ADD-ON CODES

• Adoption of new “extended visit” add-on code for:
  – Use only with E/M office/outpatient levels 2 thru 4 visits to account for:
    • Additional resources required when practitioners need to spend extended time with the patient.
  
  • “CMS believes that implementation of all of 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.”

  • “CMS intends to engage in further discussions with the public to further refine the policies for CY 2021.”
CMS IS NOT FINALIZING THE FOLLOWING PROPOSALS IN THE 2019 MPFS

- After consideration of concerns raised by those who commented 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; and
  3. Standardized the allocation of practice expense for Relative Value Unit (RVUs) for the codes that describe these services.
MODERNIZING MEDICARE
PHYSICIAN PAYMENT

- CMS is finalizing its proposals to pay separately for two newly defined physicians’ services furnished using communication technology:
  1. Brief communication technology-based service
     Example – virtual check-in (HCPCS code G2012)
  2. Remote evaluation of recorded video and/or images submitted by an established patient (HCPCS code G2010).
- CMS is also finalizing policies to pay separately for new coding describing chronic care remote physiologic monitoring:
  - CPT codes 99453, 99454, and 99457; and
- Interprofessional internet consultation
  - CPT codes 99451, 99452, 99446, 99447, 99448, and 99499.

NEW MEDICARE HCPCS CODES FOR 2019

- G2010 - Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment
  - RVU – Non-Facility - $ 0.35; Medicare Allowable - $ 12.61 (National)
- G2012 - Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
  - RVU – Non-Facility - $ 0.401; Medicare Allowable - $ 14.78 (National)
NEW MEDICARE HCPCS CODES FOR 2019

• **G2011** - Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., audit, dast), and brief intervention, 5-14 minutes
  - RVU - $0.47; Medicare Allowable - $16.94 (National)

EXPANDING USE OF TELEHEALTH SERVICES FOR TREATMENT OF OPIOID USE DISORDER

• Through an interim final rule with comment period, CMS is implementing a provision from the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act:
  - 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
PROVIDING PRACTICE FLEXIBILITY FOR RADIOLOGIST ASSISTANTS

• CMS is revising the physician supervision requirements so that:
  − Diagnostic tests performed by a **Radiologist Assistant (RA) that meets certain requirements**, that would otherwise require a personal level of physician supervision as specified in its regulations;
  − **May now be furnished under a direct level of physician supervision to the extent permitted by state law and state scope of practice requirements.**

CHANGES TO OUTPATIENT THERAPY

• **CMS will discontinue the functional status reporting requirements** for services furnished after January 1, 2019.

• The Bipartisan Budget Act of 2018 *requires payment for services furnished in whole or in part by a therapy assistant at 85% of the applicable Part B payment amount for service effective January 1, 2022.*

• In order to implement this payment reduction, the law requires CMS to establish a new modifier by January 1, 2019. Two New modifiers have been finalized when services are furnished in whole or in part by Physical Therapy Assistants (PTA); or Occupational Therapy Assistants (OTA)
  − CMS is finalizing the new modifiers as “payment” rather than as “therapy” modifiers, based on comments by stakeholders.
  − These will be used alongside of the current PT and OT modifiers to report all PT, OT, and Speech Language Pathology (SLP) services that have been used since 1998 to track outpatient therapy services that were subject to therapy caps.
  − CMS is also finalizing a de minimis standard under which a service is furnished by the PTA or OTA, instead of the proposed definition that applied when a PTA or OTA furnished any minute of a therapeutic service.
  − **The new therapy modifiers for services furnished by PTAs and OTAs are not required on claims until January 1, 2020.**
2019 MIPS ELIGIBLE CLINICIAN TYPES ADDED

• 2019 the following eligible clinician types were added:
  − Physical therapist
  − Occupational therapist
  − Qualified speech-language pathologist
  − Qualified audiologist
  − Clinical psychologist
  − Registered dietitian or nutrition professionals

• Already included in previous years programs were:
  − Physician
  − Physician assistant
  − Nurse practitioner
  − Clinical nurse specialist
  − Certified registered nurse anesthetist

KEY CHANGES 2019 MIPS APMs FINAL RULE

MIPS = Merit-based Incentive Payment System
APMs = Alternative Payment Models

• When reporting for Promoting Interoperability and participation in an Advance APM, individual eligible clinicians and groups will have to use 2015-certified EHR technology.

• The Cost category will count toward 15% of the MIPS final score – which is an increase from 10% in 2018. This information is taken from Claims data filed by providers.

• Group practices can now report quality data measures using multiple data submission avenues, such as EHR and registry reporting.

• If a clinician or group falls below the low-volume threshold, they may choose to voluntarily opt-in to the MIPS program. If they do so, they will be subject to the same rules and payment adjustments as other participants.

• CMS has not announced any new Advanced APMs. Approximately 165,000 to 220,000 eligible clinicians are expected to become qualifying APM in 2019. This means that they “will be exempt from MIPS and eligible for a 5% Bonus.” It is estimated that APM bonuses will total from “$600-$800 million for the 2021 payment year”.

FINAL 2019 MIPS POLICY

- Eligible Clinicians (EPs) and group practices will continue to be scored from 0-100 points.
  - 4 Performance Categories:
    - Quality 45 points
    - Promoting Interoperability 25 points
    - Cost 15 points
    - Improvement Activities 15 points
  - The bonus will still be available for ECs and groups who treat complex patients. It can add up to 5 points to the final MIPS score.

MIPS 2019

- ECs and group practices must earn at least 30 points in 2019 to avoid a Medicare payment penalty of up to 7% in 2021. (An increase of 15 points from 2018).

- As it was in 2018, $ 500 million will be available for ECs and groups whose final score meets or exceeds the proposed exceptional threshold of 75 points in 2019. (An increase from 70 points in 2018.)

- ECs and groups must report a minimum of 90 consecutive days of data for the Promoting Interoperability and Improvement Activity categories; and 12 months of Quality measure data in 2019.

(Source: MGMA, “Final 2019 Medicare Physician Payment and Quality Reporting Changes”, MGMA Member-Exclusive Analysis. https://www.mgma.com/)
**TELEHEALTH SERVICES FOR 2019 MPFS**

- **New interpretation of Medicare’s telehealth services:**
  - Formerly restricted to beneficiaries located in a rural geographic setting at a clinical facility (“originating site”).
  - Re-defined by stating that “Medicare telehealth services applies to a discrete set of services that are ordinarily defined, coded, and paid as if they were furnished in an in-person encounter”.
  - CMS – “communication technology-based services are inherently remote and rely on technology communication and are therefore outside the scope of the definition of Section 1834(m) of the Social Security Act”.
  - The Act defined “Medicare telehealth services as including professional consultations, office visits and office psychiatric visits that are furnished using two-way, real-time interactive communication between an eligible beneficiary and practitioner. To be eligible, the beneficiary had to be located in a rural site”.
  - The change now provides new opportunities to recognize practitioners for the work they perform outside of the traditional office setting and leads to updated payment policies.

(Source: MGMA, “Final 2019 Medicare Physician Payment and Quality Reporting Changes”; MGMA Member-Exclusive Analysis. https://www.mgma.com/)

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**INTER-PROFESSIONAL CONSULTATIONS**

- **Two new codes and separate payment for**
  - Inter-professional internet/telephone consultations between a treating physician and a consulting physician:

    - **CPT code 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. RVU – Facility and Non-Facility - $ 1.01.

    - **CPT code 99452** - Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes. RVU – Facility and Non-Facility - $ 1.01.
REMOTE PATIENT MONITORING

• Three new Chronic Care remote physiologic monitoring codes effective 01/01/2019:
  − CPT 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.
    • RVU Facility or Non-Facility - $ 0.51. AMA Guidelines: (Do not report 99453 more than once per episode of care)
    • (Do not report 99453 for monitoring of less than 16 days)
  − CPT 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.
    • RVU – Facility or Non-Facility - $ 1.67. AMA Guidelines:
      • (For physiologic monitoring treatment management services, use 99457)
    • (Do not report 99454 for monitoring of less than 16 days)
    • (Do not report 99453, 99454 in conjunction with codes for more specific physiologic parameters [eg, 93296, 94760])
  − CPT 99457 - Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month.
    • RVU – Facility - $ 0.88; Non-Facility - $ 1.37. AMA Guidelines: (Report 99457 once each 30 days, regardless of the number of parameters monitored)
    • (Do not report 99457 in conjunction with 99091)

TWO NEW TELEHEALTH CPT CODES FOR PROLONGED PREVENTIVE SERVICES

• These qualify as “Medicare telehealth services” and must use the telehealth place of service (POS) code “02”.
  − 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).
    • RVU – Facility - $ 1.68; Non-Facility - $ 1.78.
  − 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).
    • RVU – Facility - $ 1.68; Non-Facility - $ 1.78.

- “Featuring expanded plan options with low or $0 monthly plan premiums in many areas, enhanced benefits and a more personalized member experience.”

- “We are proud to be a leader in $0 premium plan offerings, with approximately **72 percent of our 2018 Individual Medicare Advantage members enrolled in $0 premium plans,**” said Christopher Ciano, who was appointed head of Aetna Medicare earlier this year.

- “Our 2019 plan options will offer even more value to Medicare beneficiaries through a variety of expanded benefits, while still emphasizing affordability.”
• Expanded claims edits were added in 2017 & 2018. Now there will be more edits!
  − “We are adding more edits effective March 1, 2019. To view these edits, check our provider website for information. There, you’ll have access to a new prospective claims editing disclosure tool.
  − After you log in, go to Plan Central > Aetna Claims Policy Information > Policy Information > Expanded Claims to find out if our new claims edits will apply to your claim.”

• Clinical Policy and Coding Changes:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Effective date</th>
<th>What’s changed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application of prefabricated splints*</td>
<td>March 1, 2019</td>
<td>We will deny CPT codes 29105 – 29131 and 29505 – 29515, application of casts or splints, when billed for the same date of service as HCPCS codes for prefabricated collars, orthosis and splints.</td>
</tr>
<tr>
<td>National Correct Coding Initiative (NCCI)</td>
<td>March 1, 2019</td>
<td>Our existing Incidental Claim Edits policy includes recommendations provided by the Centers for Medicare &amp; Medicaid Services (CMS) OCE and the American Medical Association Current Procedural Terminology codes manual. For dates of service on or after March 1, 2019, we will apply this policy to claims for: Skilled nursing facilities (SNFs); Comprehensive outpatient rehabilitation facilities (CORFs); Outpatient physical therapy and speech-language pathology providers; Certain home health agencies (HHAs). This language is consistent with CMS’s NCCI.</td>
</tr>
<tr>
<td>Definitive drug testing*</td>
<td>March 1, 2019</td>
<td>We are updating our policy on definitive drug testing to allow testing of up to eight definitive drug classes per date of service.</td>
</tr>
</tbody>
</table>
  • We’ll continue to allow eight definitive drug test encounters per rolling 12-month period across all providers. |
  • Drug testing procedure codes received for an allowable encounter of more than eight definitive drug classes per day will be considered at the rate for G0481 and reimbursed accordingly. |

• Daily limits for lab codes* March 1, 2019 We currently allow a daily limit of one unit for many lab codes for professional claims. Starting March 1, 2019, we’re expanding these edits to include facility claims.

• Duplex scans* March 1, 2019 We will no longer allow payment for physiologic studies of upper or lower extremities (CPT codes 93922, 93923 and 93924) when performed on the same day as a duplex scan (CPT codes 93925, 93926, 93880 and 93882). We consider physiologic studies services and duplex scans to be mutually exclusive.

• Billable-times limitation on nursing care in the home* March 1, 2019 We will limit any combination of the following HCPCS codes to 24 units per date of service:
  • S9123 — Nursing care in the home; by registered nurse, per hour
  • S9124 — Nursing care in the home; by licensed practical nurse, per hour
  • Both of these codes, by definition, represent one hour of service.

• Prepayment coding reviews for Coventry Medicare claims March 1, 2019 For admission dates on or after March 1, 2019, we’ll expand our prepayment coding reviews for specific diagnosis-related group (DRG) claims. This will affect all Coventry Medicare claims.
  • As always, we want to ensure that the claims correctly show the services you give to our members. We will review DRG facility claims based on case history.
  To make sure we review your claims quickly and accurately, please make sure all necessary clinical information is provided up front. If we need more information, we may ask you for medical records.
  This program does not impact providers in the following states: Connecticut, Massachusetts, Maine, New Hampshire, Rhode Island, Texas and Vermont.
*Washington state providers: This item is subject to regulatory review and separate notification.
BCBSTX 2019

• Policy updates effective 04/01/2019 BCBS of Texas only:
  - Description: This policy is to provide a guideline on the coding and documentation requirements for the reimbursement of drug testing.
  - Reimbursement Information:
    ▪ **Billing guidelines for urine drug testing**, with a few exceptions, are intended to be **consistent with those established by CMS** for the safety, accuracy, and quality of diagnostic testing.
    ▪ **Reimbursement for presumptive testing will be considered for claim submissions containing CPT codes 80305, 80306 and 80307.**
    ▪ **Reimbursement for definitive testing will be considered for claims submissions containing HCPCS codes G0480, G0481, G0482, G0483 or G0659 based on CMS guidelines published in 2018 for drug testing.**
  - This policy will be modified as needed, in accordance with CMS coding changes. Refer to the Medical Policy MED207.154 on our website.

BCBSTX

UPDATES TO MEDICAL POLICIES

• The following Medical Policies have been revised.
  **January 2019**
  - MED201.048 Actigraphy
  - MED201.049 Polysomnography for Non-Respiratory Sleep Disorders
  - MED202.054 Biventricular Pacing
  - MED203.011 Detection of Circulating Tumor Cells in the Management of Patients with Cancer
  - MED204.005 Diagnosis and Medical Management of Obstructive Sleep Apnea Syndrome
  - MED205.034 Autonomic Nervous System (ANS) Testing
  - OB402.023 Reproductive Technologies or Techniques and Related Services
  - RX501.099 Ibalizumab-uiyk (Trogarzo)
  - RX502.058 Burosumab-twza (Crysvita)
BCBSTX
Medical Record Documentation

• Guidelines Policy Number: CPCPG001 Version 3.0 Clinical Payment and Coding Policy Committee Approval Date: 11/28/2018. Effective Date: April 1, 2019 (Blue Cross and Blue Shield of Texas Only)

• Description To help ensure submission of medical record documentation is pertinent, accurate, complete and legible for all services performed.

• Documentation Guidelines Illegible, Missing or Incomplete Signatures:
  • Medical records submitted to substantiate services rendered or ordered must be appropriately signed and credentialed.
  • Acceptable signatures include handwritten signatures or initials over a typed or printed name or authenticated electronic signatures.
  • An electronic signature usually contains a date and timestamp, and a printed statement such as “electronically signed by” or “verified/reviewed by,” followed by the practitioner’s name and professional designation.
  • Stamped signatures are not acceptable, nor are indications that a document has been, “signed but not read.”
  • The credentials of the provider rendering the service must also be listed somewhere on the medical record; either following the signature, in the typed or printed name or in the letterhead area of the record.

BCBSTX
Modifier Reference

• Guideline Policy Number: CPCP023 Version 4.0 Enterprise Clinical Payment and Coding Policy Committee Approval Date: 11/27/2018. Effective Date: 04/01/2019 (Blue Cross and Blue Shield of Texas Only)

• Providers are responsible for accurately, completely, and legibly documenting the services performed including any preoperative workup.

• The billing office is expected to submit claims for services rendered using valid codes from the Health Insurance Portability and Accountability Act (HIPAA) approved code sets.

• Claims should be coded appropriately according to industry standard coding guidelines including but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT Assistant, Healthcare Common Procedure Coding System (HCPCS), National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, Centers for Medicare and Medicaid Services (CMS) National Coding Initiative (CCI) table edits and other CMS guidelines.

• Claims are subject to the code auditing protocols for services/procedures billed.

• This policy serves as a general reference guidelines for appending modifiers to the appropriate procedure codes when submitting claims for reimbursement.
This policy serves as a general reference guideline for appending modifiers to the appropriate procedure codes when submitting claims for reimbursement.

This policy is not intended to impact care decisions or medical practice.

The American Medical Associate (AMA) Current Procedural Terminology (CPT) manual and Centers for Medicare and Medicaid Services (CMS) defines modifiers that may be appended to CPT/HCPCS codes to provide additional information about the services rendered.

For the purposes of this policy, a modifier should be appended to denote additional information about the services rendered.

Modifiers consist of two numeric or alphanumeric characters.

All valid CPT and HCPCS modifiers are accepted into the claims processing system used to review claims submitted.

Several modifiers have claims logic that may impact claim reimbursement and are outlined in this policy.


### MODIFIER REFERENCE

#### MODIFIER DESCRIPTION

**22** Increased Procedural Services

Should be appended to surgical procedure codes with supporting documentation to justify the unusual service:

- If documentation supports sufficient difficulty/complexity to warrant additional payment for a procedure submitted with Modifier 22. Otherwise, no additional payment is allowed.
- A provider is allowed one appeal if the initial request for recognition of Modifier 22 is denied.

**24** Unrelated Evaluation and Management (E/M) service by the same physician or other qualified health care professional during a postoperative period

The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by appending modifier 24 to the appropriate level of E/M service.

**25** Significant, separately identifiable E/M service by the same physician or other qualified health care professional on the same day of the procedure or other service

Records should reflect the significant, separately identifiable service.

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M service on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.
<table>
<thead>
<tr>
<th>MODIFIER</th>
<th>DESCRIPTION</th>
<th>WHEN TO APPEND A MODIFIER</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>Professional component</td>
<td>The total service for some procedures include both a professional component and a technical component. Codes within the Radiology, Lab/Pathology and Medicine sections of the CPT codebook have technical and professional components of the total service. Modifier 26 denotes the professional services for lab and radiological services.</td>
</tr>
<tr>
<td>TC</td>
<td>Technical Component</td>
<td>Modifier TC denotes technical component for lab and radiological services. Append the modifiers to the appropriate lab, radiological, or medicine procedures only. When a provider performs both the technical and professional service for a lab or radiological procedure, the total service is reported without a modifier. The professional and technical components should not be reported individually when both components are performed by the same provider.</td>
</tr>
<tr>
<td>33</td>
<td>Preventive services</td>
<td>When the primary purpose of the service is the delivery of an evidence-based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by appending 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.</td>
</tr>
<tr>
<td>50</td>
<td>Bilateral procedure</td>
<td>Append modifier to the appropriate 5-digit code for procedures that can be performed bilaterally at the same session.</td>
</tr>
<tr>
<td>52</td>
<td>Reduced services</td>
<td>Under specific circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.</td>
</tr>
<tr>
<td>57</td>
<td>Decision for surgery</td>
<td>This modifier is to be appended to the appropriate E/M code to denote that it resulted in the initial decision to perform a major surgical procedure. The modifier will be allowed only when appended to an E/M code reported for either one day prior OR same day as a major (90 day global) surgical procedure. Refer to CMS guidelines for global days.</td>
</tr>
<tr>
<td>58</td>
<td>Staged or related procedure or service by the same physician or other qualified health care professional during the postoperative period</td>
<td>Append modifier to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure.</td>
</tr>
</tbody>
</table>
### MODIFIER | DESCRIPTION | WHEN TO APPEND A MODIFIER
--- | --- | ---
59 | Distinct procedural service | Allowed only when modifier appended to procedure or service that are not routinely reported together. Documentation must support a different session, different procedure or surgery, different site or separate organ system, separate incision/excision, separate lesion, or separate injury not ordinarily encountered or performed on the same day by the same individual. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Refer to the current CPT guidelines for additional information.

I. **XE** | Separate encounter: Service that is distinct because it occurred during a separate encounter. Refer to CMS guidelines.
II. **XP** | Separate Practitioner: Service that is distinct because it was performed by a different practitioner. Refer to CMS guidelines.
III. **XS** | Separate structure: Service that is distinct because it was performed on a separate organ/structure. Refer to CMS guidelines.
IV. **XU** | Unusual non-overlapping service: Use of service that is distinct because it does not overlap usual components of the main service. Refer to CMS guidelines.

62 | Two surgeons | Two surgeons working together as primary surgeons. Both surgeons should submit this modifier on only those services where they are acting as primary surgeons. Each surgeon should report his/her operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s)) are performed during the same surgical session, Physicians acting as co-surgeons cannot bill as assistants. Separate code(s) may also be reported with modifier 62 added.

### MODIFIER | DESCRIPTION | WHEN TO APPEND A MODIFIER
--- | --- | ---
66 | Surgical team | More than two surgeons of different specialties working together under the “surgical team” concept. The surgeons should submit this modifier on only those services where they are acting as primary surgeon.

73 | Prior Discontinued Ambulatory Surgical Center (ASC) or Outpatient Hospital | Append modifier when a surgical procedure or diagnostic procedure is discontinued due to extenuating circumstances or threaten the well-being of the patient, prior to anesthesia in the outpatient hospital or ASC only.

76 | Repeat procedure or service by same physician or other qualified health care professional | Append modifier only when a procedure is repeated on the same date of service by the same physician or other qualified health care professional subsequent to the original procedure or service. This modifier should not be appended to an E/M service.

77 | Repeat procedure by another physician or other qualified health care professional | Append modifier only when a basic procedure or service is repeated by another physician or other qualified health care professional subsequent to the original procedure or service. Procedure must be the same procedure. The procedure code should be submitted on the claim form once and then listed again on a separate line with the appropriate modifier appended. This modifier should not be appended to an E/M service.
<table>
<thead>
<tr>
<th>MODIFIER</th>
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<th>WHEN TO APPEND A MODIFIER</th>
</tr>
</thead>
<tbody>
<tr>
<td>77</td>
<td>Repeat procedure by another physician or other qualified health care professional</td>
<td>Append modifier only when a basic procedure or service is repeated by another physician or other qualified health care professional subsequent to the original procedure or service. Procedure must be the same procedure. The procedure code should be submitted on the claim form once and then listed again on a separate line with the appropriate modifier appended. This modifier should not be appended to an E/M service.</td>
</tr>
<tr>
<td>78</td>
<td>Unplanned return to the operating/procedure room by the same physician or other qualified health care professional following initial procedure for a related procedure during the postoperative period</td>
<td>Append modifier if needing to indicate another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure.</td>
</tr>
<tr>
<td>79</td>
<td>Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period</td>
<td>Indicate performance of a procedure or service during the postoperative period as unrelated to the original procedure. Not a repeat procedure on the same day.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MODIFIER</th>
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<th>WHEN TO APPEND A MODIFIER</th>
</tr>
</thead>
<tbody>
<tr>
<td>80</td>
<td>Assistant surgeon (Physician)</td>
<td>Append modifier to those surgical procedures where an assistant surgeon is warranted. Physicians acting as assistants cannot bill as co-surgeons. Benefits will be derived based on the CMS designation for the assistant surgeon.</td>
</tr>
<tr>
<td>81</td>
<td>Minimum assistant surgeon (Physician)</td>
<td>Append modifier to those surgical procedures where minimum surgical assistant services are warranted. Physicians acting as assistants cannot bill as co-surgeons. Benefits will be derived based on CMS designation for the assistant surgeon.</td>
</tr>
<tr>
<td>82</td>
<td>Assistant surgeon (Physician) (When qualified resident surgeon not available)</td>
<td>Append modifiers to those surgical procedures where an assistant surgeon is warranted. The unavailability of a qualified resident surgeon is a prerequisite for use of the modifier to be appended. Physicians acting as assistants cannot bill as co-surgeons. Benefits will be derived based on CMS designation for the assistant surgeon.</td>
</tr>
<tr>
<td><strong>AS</strong></td>
<td>Physician assistant (PA), nurse practitioner (APN), licensed surgical assistant (LSA), or clinical nurse specialist services (CRNFA) for assistant at surgery</td>
<td>Append modifier when non-physician practitioners are assisting surgeons as a surgical assistant. The assistant surgeon provides more than ancillary services.</td>
</tr>
<tr>
<td></td>
<td>- Physician should use when billing on behalf of a PA, APN, CRNFA or LSA including that providers National Provider Identification (NPI) number for services provided when the aforementioned providers are acting ONLY as an assistant during surgery.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- PA’s, APN’s, CRNFA’s or LSA’s who are billing with their own NPI number should bill using modifier AS when assisting in a surgery.</td>
<td></td>
</tr>
</tbody>
</table>
**CIGNA POLICY UPDATES**

**Policy Name:**
- **Description of Service:**
  - Reimbursement Policy for Interventional and Administrative Services with Emergency Department Use
- **Update:**
  - Effective date: November 1, 2018

**Coverage Policy Updates**
- To view our existing policies, including an outline of monthly coverage policy changes and a full listing of medical coverage policies, visit the Cigna for Health Care Professionals website (www.cigna.com/HP). To review current policy changes, go to CignaHealthPlans.com and select **Coverage Changes**. If you do not have Internet access, and would like additional information, please call Cigna Customer Service at 1-800-804-2245.

*Please note that the plan's website is subject to change. For the most up-to-date information, please visit www.cigna.com/HP.*
NEW ENHANCEMENTS TO CIGNAFOREHCP.COM

If you recently logged in to the Cigna for Health Care Professionals website (CignaforHCP.com), you may have noticed some new features. They were created based on the feedback we received from providers who use the website, and are part of our commitment to improving your online experience.

The new features include:

- A precertification resource page that provides an easy and organized way to access information on how to start the precertification process.
- The ability to digitally upload supporting documents for pending claims.
- A deeper look into patient benefits and eligibility, including plan benefit history, current coverage details, and referral requirements. For certain patient benefits, you can view the number of visits used and the number remaining.
- Online electronic funds transfer enrollment.

More to come

We are listening to you, and look forward to bringing you more enhancements based on your feedback. Let us know what you think by using the feedback button on CignaforHCP.com.

Log in to CignaforHCP.com to explore the latest enhancements.

MARTKET MEDICAL EXECUTIVES
CONTACT INFORMATION

CLICK ON YOUR REGION TO VIEW YOUR MME CONTACT INFORMATION

Cigna Market Medical Executives (MME) are an important part of our relationship with providers. They provide personalized service within their local regions and help answer your healthcare related questions. MMEs cover specific geographic areas so they are able to understand the local community nuances in healthcare delivery. This allows them to provide you with a unique level of support and service.

| NATIONAL: Peter McCloud, Sr., MD, CPE | 1.131.646.5131 |
| Clinical Provider Engagement & Value-Based Relationships | |
| Jennifer Gutierrez, MD | 1.818.500.6469 |
| Clinical Strategy & Solutions | |

Reasons to call your MME:

1. Ask questions and obtain general information about our clinical policies and programs.
2. Ask questions about your specific practice and patient patterns.
3. Report or request assistance with a quality concern involving your patients with Cigna coverage.
4. Request or discuss recommendations for improvements or development of our health advocacy affordability, or cost transparency program.
5. Recommend specific physicians or facilities for inclusion in our networks, or identify clinical needs within networks.
6. Identify opportunities to enroll your patients in Cigna health advocacy programs.
UNITED HEALTHCARE

Join Our New Data Exchange and Medical Record Collection Programs

Direct EMR access: By downloading clinical information straight from your EMR system, we’ll be able to collect the medical records we need to process your claims and conduct medical necessity and other reviews — without needing assistance from you and your staff.

Clinical data exchange: Through an automated data exchange process, you can easily share Admit, Discharge, Transfers (ADTs), Discharge Summaries and prescribed medication lists, so we can help spot any medication errors to help lower the risk for adverse interactions.

Point of Care solutions: You’ll access valuable data during the point of care. Programs like PreCheck My Script will help you access real-time pharmacy benefit information like copays, drug costs and prior authorization requirements — so you can prescribe the most appropriate and lowest cost medication before your patients leave the office.
UHC ENTERPRISE MEDICAL RECORDS PROGRAM

To find out more about our programs, visit UHCprovider.com > Menu > Resource Library > UnitedHealthcare Enterprise Medical Records Program. To get started, visit Link on UHCprovider.com and choose the Remote EMR Access tool. You can also ask your Provider Advocate for additional assistance.

Guide for UnitedHealthcare Commercial and Medicare Advantage

Updated UnitedHealthcare Care Provider Administrative Guide Available Jan. 1, 2019*

We post this essential resource for physicians, hospitals, facilities and other health care providers on UHCprovider.com/guides annually on Jan. 1.

You can view the 2019 Guide as a PDF or webpage at UHCprovider.com/guides. Be sure to save the link to your favorites or download the PDF.

Quick Reference to UnitedHealthcare Care Provider Administrative Guides Now Available

The updated Quick Reference to Provider Administrative Guides is available at UHCprovider.com/guides. We developed this resource based on care provider feedback. It contains information that you are likely to need early and often in your relationship with UnitedHealthcare.

You’ll see the following changes to the 2019 UnitedHealthcare Care Provider Administrative Guide. This list is not all-inclusive; refer to the updated UnitedHealthcare Care Provider Administrative Guide for specific information.
Radiology Program Procedure Code Changes — Effective Jan. 1, 2019

Beginning Jan. 1, 2019, UnitedHealthcare is updating the procedure code list for the Radiology Notification and Prior Authorization Program based on code changes made by the American Medical Association (AMA). Claims with dates of service on or after Jan. 1, 2019 are subject to these changes.

The following CPT codes are being added to the Radiology Notification and Prior Authorization list:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Code description</th>
</tr>
</thead>
<tbody>
<tr>
<td>77046</td>
<td>Magnetic resonance imaging, breast, without contrast material, unilateral</td>
<td>New code replacing 77044. 77046 is a defined code as of Jan. 1, 2019.</td>
</tr>
<tr>
<td>77047</td>
<td>Magnetic resonance imaging, breast, without contrast material, bilateral</td>
<td>New code replacing 77045. 77047 is a defined code as of Jan. 1, 2019.</td>
</tr>
<tr>
<td>77048</td>
<td>Magnetic resonance imaging, brain, spine, and extremities, including computer assisted detection and/or quantitative analysis, performed, bilateral</td>
<td>New code replacing 77046. 77048 is a defined code as of Jan. 1, 2019.</td>
</tr>
<tr>
<td>77049</td>
<td>Magnetic resonance imaging, brain, spine, and extremities, including computer assisted detection and/or quantitative analysis, performed, unilateral</td>
<td>New code replacing 77047. 77049 is a defined code as of Jan. 1, 2019.</td>
</tr>
</tbody>
</table>

The following CPT codes are being removed from the Radiology Notification and Prior Authorization list:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>77050</td>
<td>Single photon emission computed tomography, performed, unilateral</td>
</tr>
<tr>
<td>77051</td>
<td>Single photon emission computed tomography, performed, bilateral</td>
</tr>
<tr>
<td>77052</td>
<td>Magnetic resonance imaging, breast, without contrast material, unilateral</td>
</tr>
<tr>
<td>77053</td>
<td>Magnetic resonance imaging, breast, without contrast material, bilateral</td>
</tr>
</tbody>
</table>

For more details and additional information, visit pmimd.com.

New and Updated Procedure Codes for CAR-T Cell Therapy — Effective Jan. 1, 2019

New procedure codes will become effective Jan. 1, 2019 due to updates from the Centers for Medicare & Medicaid Services (CMS). The following new codes for Chimeric Antigen Receptor T-Cell (CAR-T) Therapy are subject to prior authorization. Coverage reviews for CAR-T therapy are managed by Optum Transplant Resource Services through the same process as the transplant of tissue or organs.

- 02042 — Kyrinstein (isgualtucase) 
- 03317 — CAR-T therapy; harvesting of blood-derived T lymphocytes for development of genetically modified autologous CAR-T cells, per day 
- 03318 — CAR-T therapy; preparation of blood-derived T lymphocytes for transportation (eg, cryopreservation, storage) 
- 03319 — CAR-T therapy, workstation and preparation of CAR-T cells for administration 
- 03320 — CAR-T therapy, CAR-T cell administration, autologous
Changes in Advance Notification and Prior Authorization Requirements

Effective for dates of service on or after April 1, 2019, the following procedure codes will no longer require prior authorization for Undergraduate Community Plan of Texas (Interplan):

- Category: Dental/Prosthodontics
  - Codes: 19205, 19206, 19207, 19208
- Category: Orthodontics
  - Codes: 19250, 19251, 19252, 19253

Effective for dates of service on or after April 1, 2019, the following procedure codes will no longer require prior authorization for Undergraduate Community Plan - ALL plans including Undergraduate Connected 18 Medicare Provider, Undergraduate Connected 18 Medicare Advantage Plan, Undergraduate Connected 22 Medicare Provider, Undergraduate Connected 22 Medicare Advantage Plan, and Undergraduate Connected 99 Medicare Provider:

- Category: Dental/Prosthodontics
  - Codes: 19205, 19206, 19207, 19208
- Category: Orthodontics
  - Codes: 19250, 19251, 19252, 19253

Code Replacements to Prior Authorization

Effective for dates of service on or after April 1, 2019, the following codes have been replaced with procedure codes as noted below:

- Category: Dental/Prosthodontics
  - Code: 19205, 19206, 19207, 19208
- Code: 19250, 19251, 19252, 19253

Code Additions to Prior Authorization

Effective for dates of service on or after April 1, 2019, the following codes will require prior authorization:

- Category: Dental/Prosthodontics
  - Code: 19205, 19206, 19207, 19208
- Code: 19250, 19251, 19252, 19253

Note: This document is for informational purposes only and is not intended to be a substitute for professional medical advice. Always consult your healthcare provider about any questions you may have regarding a medical condition.
HEDIS® Season is Here

Beginning in January 2019, we may contact you to request memberspecific medical records. UnitedHealthcare is required by the Centers for Medicare & Medicaid Services (CMS) to collect Healthcare Effectiveness Data and Information Set (HEDIS®) information each year from our participating care providers. In addition to helping us meet CMS requirements, this medical record collection plays a critical role in supporting the care you provide to our members so together we can help them manage existing medical conditions and be more engaged with their preventive health.

Due to the volume of records we need to collect, UnitedHealthcare is working with several health information organizations, including Advertising, Change Healthcare, and Optum360 to coordinate collection. You may not be contacted, since our members are randomly selected for HEDIS® collection events. If you’re contacted by our health care organization, we’ll schedule a date for collection or explain the process for submitting records by mail, fax or electronically. We’ll send you a list of the requested medical records to help you prepare for the appointment or record submission. If you’re contacted, please respond within five business days to indicate your preference for medical record collection.

Discontinuation of Reimbursement for Codes S9083 and S9088

Beginning April 1, 2019, UnitedHealthcare commercial plans, UnitedHealthcare Oxford and UnitedHealthcare Community Plan in some states will revise their policies to no longer reimburse Healthcare Common Procedure Coding System (HCPCS) S9083 and S9088. The following charts show data impacted by these code changes:

<table>
<thead>
<tr>
<th>State</th>
<th>UnitedHealthcare Commercial &amp; Oxford (00883)</th>
<th>UnitedHealthcare Commercial &amp; Oxford (00883)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connecticut</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Maine</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Oregon</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Vermont</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
UnitedHealthcare Network Bulletin January 2019

UnitedHealthcare Commercial

UnitedHealthcare Medical Policy, Medical Benefit Drug Policy and Coverage Determination Guideline Updates


<table>
<thead>
<tr>
<th>Policy Title</th>
<th>Policy Type</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: XXXX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal CPT* and HCPCS Code Updates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UPDATED/REVISED</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abnormal Uterine Bleeding and Uterine Fibroids</td>
<td>Medical</td>
<td>Jan 1, 2019</td>
</tr>
<tr>
<td>Athletic Pubic Surgery</td>
<td>Medical</td>
<td>Dec 1, 2020</td>
</tr>
<tr>
<td>Atypical Pelvic Anomalies for Evaluation of Sleep Disorders</td>
<td>Medical</td>
<td>Jan 1, 2019</td>
</tr>
<tr>
<td>Balloon Sinus Dilation</td>
<td>Medical</td>
<td>Dec 1, 2020</td>
</tr>
<tr>
<td>Bilateral Tonsils A and B</td>
<td>Oral</td>
<td>Dec 1, 2010</td>
</tr>
<tr>
<td>Bronchietasis</td>
<td>Medical</td>
<td>Dec 1, 2019</td>
</tr>
<tr>
<td>Chemoprevention and Chemotherapy-Assisted Surgery</td>
<td>Medical</td>
<td>Dec 1, 2010</td>
</tr>
<tr>
<td>Clinical Trials</td>
<td>CDS</td>
<td>Dec 1, 2010</td>
</tr>
<tr>
<td>Computed Tomographic Imaging</td>
<td>Medical</td>
<td>Dec 1, 2010</td>
</tr>
<tr>
<td>Computed Tomographic Imaging and Angiography</td>
<td>Medical</td>
<td>Dec 1, 2010</td>
</tr>
<tr>
<td>Core Decompression for Aortic Accesses</td>
<td>Medical</td>
<td>Dec 1, 2010</td>
</tr>
<tr>
<td>Coreultrasound and Intravascular Ultrasound</td>
<td>Medical</td>
<td>Dec 1, 2010</td>
</tr>
<tr>
<td>Cytological Examination of Breastbiopsy for Cancer Screening</td>
<td>Medical</td>
<td>Dec 1, 2010</td>
</tr>
<tr>
<td>Electrophysiology and Cardiac Other Procedures</td>
<td>Medical</td>
<td>Dec 1, 2010</td>
</tr>
<tr>
<td>Durable Medical Equipment, Orthotics, Dietary Supplies, Medical Supplies and High Pressure Pumps</td>
<td>CDS</td>
<td>Jan 1, 2019</td>
</tr>
</tbody>
</table>

UnitedHealthcare Reimbursement Policies

Coordinated Commercial Reimbursement Policy Announcement

The following chart contains an overview of the policy changes and their effective dates for the following policy: Evaluation and Management (E/M) Policy.

<table>
<thead>
<tr>
<th>Policy</th>
<th>Effective Date</th>
<th>Summary of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation and</td>
<td>Quarter 2, 2012</td>
<td>• The Evaluation and Management (E/M) Policy provides guidance on the selection of E/M, ensuring information for scoring and interpretation of services defined by E/M procedure codes.</td>
</tr>
<tr>
<td>Management (E/M)</td>
<td></td>
<td>• The selection of the appropriate level of complexity and level of service must be reflected in the medical record documentation.</td>
</tr>
<tr>
<td>Policy</td>
<td></td>
<td>• Current providers submitting claims for E/M services may have their E/M code denied when the medical record documentation does not support the E/M code submitted.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Effective Quarter 2, 2019, providers may experience adjustments to the submitted level 4 or 5 E/M code to reflect an appropriate level E/M code or may receive a denial based on the medical record documentation.</td>
</tr>
</tbody>
</table>
UnitedHealthcare Commercial

UnitedHealthcare Medical Policy, Medical Benefit Drug Policy and Coverage Determination Guideline Updates

<table>
<thead>
<tr>
<th>Policy Title</th>
<th>Policy Type</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Updated/Revised</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prolotherapy for Musculoskeletal Indications</td>
<td>Medical</td>
<td>Dec 1, 2018</td>
</tr>
<tr>
<td>Self-Administered Medications</td>
<td>Drug</td>
<td>Dec 1, 2018</td>
</tr>
<tr>
<td>Sensory Integration Therapy and Auditory Integration Training</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty Medication Administration – Site of Care Review Guidelines</td>
<td>URG</td>
<td></td>
</tr>
<tr>
<td>Thermography</td>
<td>Medical</td>
<td>Dec 1, 2018</td>
</tr>
<tr>
<td>Virtual Upper Gastrointestinal Endoscopy</td>
<td>Medical</td>
<td>Dec 1, 2018</td>
</tr>
<tr>
<td>Visual Information Processing Evaluation and Orthoptic and Vision Therapy</td>
<td>Medical</td>
<td>Dec 1, 2018</td>
</tr>
<tr>
<td>Warming Therapy and Ultrasound Therapy for Wounds</td>
<td>Medical</td>
<td>Dec 1, 2018</td>
</tr>
<tr>
<td>Whole Body and Whole Spine Sequencing</td>
<td>Medical</td>
<td>Jan 1, 2018</td>
</tr>
</tbody>
</table>

Note: The inclusion of a health service is e.g., test, drug, device or procedural on this list does not imply that UnitedHealthcare provides coverage for the health service. In the event of an inconsistency or conflict between the information in this bulletin and the posted policy, the provisions of the posted policy prevail.
Blue Cross will start notifying providers on the CMS preclusion list in January 2019

- The Centers for Medicare & Medicaid Services adopted a rule in April 2018 that stipulates providers can’t be on a preclusion list and receive payment from a Medicare plan. CMS will make the preclusion list available to Part D sponsors and Medicare Advantage plans, beginning Jan. 1, 2019.

- The preclusion list is a list of providers and prescribers who are precluded from receiving payment for Medicare Advantage items and services or Part D drugs furnished or prescribed to Medicare beneficiaries. The list was created to replace the Medicare Advantage and prescriber enrollment requirements and to ensure patient protections and to protect the trust funds from prescribers and providers identified as bad actors.

- Once Blue Cross Blue Shield of Michigan receives the preclusion list on the first of each month, our Provider Enrollment and Data Management department will send a letter — within 30 days — to any contracted Medicare Plus Blue PPO provider who is on the list. The letter will include the effective date of the provider’s preclusion, which will be 90 days from the date of the published preclusion list. We’re required to remove any contracted provider who is included on the preclusion list from our networks. We’re also required to notify enrollees who have received care in the last 12 months from a contracted provider or a prescription from a provider who is on the preclusion list.

- In addition, effective April 1, 2019, Part D sponsors will be required to reject a pharmacy claim (or deny a beneficiary request for reimbursement) for a Part D drug that is prescribed by an individual on the preclusion list.

- Medicare Advantage plans will be required to deny payment for a health care item or service given by an individual or entity on the preclusion list. More information is available at the CMS website.
Colorado hospital failed to terminate former employee’s access to electronic protected health information

- Pagosa Springs Medical Center (PSMC) has agreed to pay $111,400 to the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services and to adopt a substantial corrective action plan to settle potential violations of the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules. PSMC is a critical access hospital, that at the time of OCR’s investigation, provided more than 17,000 hospital and clinic visits annually and employs more than 175 individuals.

- The settlement resolves a complaint alleging that a former PSMC employee continued to have remote access to PSMC’s web-based scheduling calendar, which contained patients’ electronic protected health information (ePHI), after separation of employment. OCR’s investigation revealed that PSMC impermissibly disclosed the ePHI of 557 individuals to its former employee and to the web-based scheduling calendar vendor without a HIPAA required business associate agreement in place.

- Under the two-year corrective action plan, PSMC has agreed to update its security management and business associate agreement, policies and procedures, and train its workforce members regarding the same.
BUSINESS ASSOCIATE AGREEMENTS

• Florida contractor physicians’ group shares protected health information with unknown vendor without a business associate agreement - December 4, 2018

• Advanced Care Hospitalists PL (ACH) has agreed to pay $500,000 to the Office for Civil Rights (OCR) of the U.S. Department of Health and Human Services (HHS) and to adopt a substantial corrective action plan to settle potential violations of the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules.

OCR Launches Public Education Campaign About Civil Rights Protections in Response to the National Opioid Crisis

• FOR IMMEDIATE RELEASE October 25, 2018
  − Today the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services (HHS) launched a public education campaign on civil rights protections in light of the president’s opioid bill signing yesterday and HHS’s ongoing efforts to combat the opioid epidemic.
  − The campaign aims to improve access to evidence-based opioid use disorder treatment and recovery services, such as Medication Assisted Treatment, by ensuring that covered entities are aware of their obligations under federal nondiscrimination laws, including laws prohibiting discrimination on the basis of disability or limited English proficiency.
  − In addition, the campaign seeks to educate the public about disability rights protections that may apply to persons in recovery from an opioid addiction.
  − To learn more about OCR’s commitment to fighting against opioid misuse and addiction and how federal civil rights laws protect qualified individuals with an opioid use disorder, please visit www.hhs.gov/ocr/opioids. The website also highlights OCR’s important work on ensuring that HIPAA supports accessing and sharing important health information about individuals who are in crisis due to opioid addiction.
ANTHEM PAYS OCR $16 MILLION

- Anthem pays OCR $16 Million in record HIPAA settlement following largest health data breach in history - October 15, 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 health data breach in history and exposed the electronic protected health information of almost 79 million people.

BOSTON MEDICAL CENTER

- Unauthorized Disclosure of Patients' Protected Health Information During ABC Television Filming Results in Multiple HIPAA Settlements Totaling $999,000 – September 20, 2018
- The Department of Health and Human Services, Office for Civil Rights (OCR) announced that it has reached separate settlements with Boston Medical Center (BMC), Brigham and Women’s Hospital (BWH), and Massachusetts General Hospital (MGH) for compromising the privacy of patients’ protected health information (PHI) by inviting film crews on premises to film an ABC television network documentary series, without first obtaining authorization from patients.
How HIPAA Allows Doctors to Respond to the Opioid Crisis

• **HIPAA regulations allow health professionals to share health information with a patient's loved ones in emergency or dangerous situations** – but misunderstandings to the contrary persist and create obstacles to family support that is crucial to the proper care and treatment of people experiencing a crisis situation, such as an opioid overdose.

• **This document explains how health care providers have broad ability to share health information with patients’ family members during certain crisis situations without violating HIPAA privacy regulations.**


HIPAA allows health care professionals to disclose some health information without a patient’s permission under certain circumstances, including:

- **Sharing health information with family and close friends who are involved in care of the patient if the provider determines that doing so is in the best interests of an incapacitated or unconscious patient and the information shared is directly related to the family or friend's involvement in the patient's health care or payment of care.**

  For example, a provider may use professional judgment to talk to the parents of someone incapacitated by an opioid overdose about the overdose and related medical information, but generally could not share medical information unrelated to the overdose without permission.

- **Informing persons in a position to prevent or lessen a serious and imminent threat to a patient's health or safety.**

  For example, a doctor whose patient has overdosed on opioids is presumed to have complied with HIPAA if the doctor informs family, friends, or caregivers of the opioid abuse after determining, based on the facts and circumstances, that the patient poses a serious and imminent threat to his or her health through continued opioid abuse upon discharge.
OSHA FOR MEDICAL and DENTAL OFFICES

• **Bloodborne Pathogens Standard** (29 CFR 1910.1030) basic requirements include:
  - A written exposure control plan, to be updated annually;
  - Use of universal precautions;
  - Consideration, implementation, and use of safer, engineered needles and sharps;
  - Use of engineering and work practice controls and appropriate personal protective equipment (gloves, face and eye protection, gowns);
  - Hepatitis B vaccine provided to exposed employees at no cost;
  - Medical follow-up in the event of an “exposure incident”;
  - Use of labels or color-coding for items such as sharps disposal boxes and containers for regulated waste, contaminated laundry, and certain specimens;
  - Employee training; and
  - Proper containment of all regulated waste.

OSHA FOR MEDICAL and DENTAL OFFICES

• **HAZARD COMMUNICATIONS** (29 CFR 1910.1200):
  - The hazard communication is sometimes called the “employee right-to-know” standard. It requires employee access to hazard information. The basic requirements include:
    • A written hazard communication program;
    • A list of hazardous chemicals (such as alcohol, disinfectants, anesthetic agents, sterilants, mercury) used or stored in the office;
    • A copy of the Material Safety Sheet (MSDS) for each chemical (obtained from the manufacturer) used or stored in the office; and
    • Employee training.
OSHA FOR MEDICAL and DENTAL OFFICES

- **Ionizing Radiation** (29 CFR 1910.1096) – This standard applies to facilities that have an x-ray machine and requires the following:
  - A survey of the types of radiation used in the facility, including x-rays;
  - Restricted areas to limit employee exposures;
  - Employees working in restricted areas must wear personal-radiation monitors such as film badges or pocket dosimeters; and
  - Rooms and equipment may need to be labeled and equipped with caution signs.

OSHA FOR MEDICAL and DENTAL OFFICES

- These standards include the requirements for providing safe and accessible building exits in case of fire or other emergency. It is important to become familiar with the full text of these standards because they provide details about signage and other issues. OSHA consultation services can help or your insurance company or local fire/police service may be able to assist you. The basic responsibilities include:
  - Exit routes sufficient for the number of employees in any occupied space; and
  - A diagram of evacuation routes posted in a visible location.
OSHA FOR MEDICAL and DENTAL OFFICES

- **ELECTRICAL** (Subpart S-Electrical 29 CFR 1010.301 to 29 CFR 1910.399) –
  - These standards address electrical safety requirements to safeguard employees.
  - OSHA electrical standards apply to electrical equipment and wiring in hazardous locations.
  - If you use flammable gases, you may need special wiring and equipment installation.
  - In addition to reading the full text of the OSHA standard, you should check with your insurance company or local fire department, or request an OSHA consultation for help.

OSHA FOR MEDICAL and DENTAL OFFICES

- **OSHA POSTER:**
  - Every workplace must display the OSHA poster (OSHA Publication 3165), or the state plan equivalent. The poster explains worker rights to a safe workplace and how to file a complaint.
  - The post must be placed where employees will see it.
  - You can download a copy or order one free copy from OSHA’s web site at [www.osha.gov](http://www.osha.gov) or by calling (800) 321-OSHA.
OIG WORK PLAN 2019

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.*

States' Compliance with FFS and MCO Provider Enrollment Requirements

- Provider enrollment is a key program integrity tool to protect Medicaid from fraudulent and abusive providers.
  - The 21st Century Cures Act (the Cures Act) requires States to enroll all Medicaid providers, both those in Medicaid fee-for-service (FFS) and managed care organizations (MCOs).
  - This study, mandated by the Cures Act, will survey State Medicaid agencies about their enrollment of FFS and managed care providers and implementation of required provider enrollment screening activities.
Assessing Inpatient Hospital Billing for Medicare Beneficiaries

• In 2016, hospitals billed Medicare $114 billion for inpatient hospital stays, accounting for 17 percent of all Medicare payments.

• The Centers for Medicare & Medicaid Services and the Office of Inspector General have identified problems with upcoding in hospital billing: the practice of mis- or over-coding to increase payment.

• OIG will conduct a two-part study to assess inpatient hospital billing.
  − The first part will analyze Medicare claims data to provide landscape information about hospital billing. OIG will determine how inpatient hospital billing has changed over time and describe how inpatient billing varied among hospitals.
  − We will then use the results of this analysis to target certain hospitals or codes for a medical review to determine the extent to which the hospitals billed incorrect codes.

Data Brief: Early Results from the Opioid State Targeted Response Grants

• The 21st Century Cures Act authorized $1 billion in Opioid State Targeted Response (Opioid STR) grants, to be awarded and overseen by the Substance Abuse and Mental Health Services Administration (SAMHSA).

• As described by SAMHSA, the purpose of these grants is to "address the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment and recovery activities for opioid use disorder."

• The majority of funds must be used for opioid treatment services using clinically appropriate evidence-based practices, particularly the use of medication assisted treatment.

• We will review early results of the Opioid STR grants. In particular, we will describe States’ use of Opioid STR grant funds in the first year of the program, including the populations reached and the extent to which Opioid STR grant-funded treatment included medication assisted treatment.
KEY LABOR AND EMPLOYMENT LAWS EFFECTIVE IN 2019

• Some taking effect in 2019; some beyond:
  - Federal – majority of bills are stalled in the 115th Congress
    • “Most significant in 2018 that had impact – Congress’s Omnibus Budget Bill, the Consolidate Appropriations Act (“the Act”) which amended the Fair Labor Standards Act – prohibiting an employer from keeping tips received by its employees for any purposes (this includes allowing managers or supervisors to keep any portion of employees’ tips), regardless of whether the employer takes a tip credit.”
  - Tax laws - The Tax Cuts and Jobs Act (12/22/17) has an affect on certain deductions and reporting for 2018 in 2019.
    • “Law eliminated through 2025, the exclusion for employer-paid relocation expenses, the deduction for employer-paid transportation fringe benefits, and the business deduction for entertainment expenses.....”


IMMIGRATION ISSUES

• Immigration Issues are a Trump Administration priority. No bill advanced in 2018. However, employers will probably see continued debate on this issue.

• Other changes in 2019:
  ▪ Federal Employment law has been primarily directed at the regulatory issues.
  ▪ Example: the National Labor Relations Board (NLRB) issued proposed rule in September that would reverse the NLRB’s 2015 Browning-Ferris industries decision and clarify the standard for joint employment. Comment period closed 12/13/2018 and a final rule is expected in 2019.
  ▪ The Department of Labor’s Wage and Hour Division may propose its own joint employer rule – a re-vamped “white collar” overtime proposed rule and a rule clarifying the “regular rate of pay calculation for purposes of overtime compensation. Some final rules will take effect immediately, while others might afford employers a compliance grace. Period.

• State and local news:
  ▪ See chart on next slide for activity that will take effect in 2019 on a variety of topics, including protected time off, sexual harassment training, and salary history inquiries.
  ▪ Information shown is not all inclusive and does not include all state changes.
## STATE UPDATES 2019

<table>
<thead>
<tr>
<th>STATE</th>
<th>UPDATE</th>
<th>DESCRIPTION</th>
<th>EFFECTIVE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>Minimum Wage</td>
<td>New minimum wage of $9.89 per hr.</td>
<td>01/01/2019</td>
</tr>
<tr>
<td>Arizona</td>
<td>Minimum Wage</td>
<td>New minimum wage of $11.00 per hr.</td>
<td>01/01/2019</td>
</tr>
<tr>
<td>Arkansas</td>
<td>Minimum Wage</td>
<td>Revised to include new minimum wages for 2019, 2020 and 2021</td>
<td>01/01/2019</td>
</tr>
<tr>
<td>California</td>
<td>Minimum Wage &amp; Discrimination</td>
<td>Updated Minimum Wage to add 2019 and 2020 minimum wage rates as well as allowances for room and board under the minimum wage tab. Discrimination notice revised with new harassment training requirements for employers.</td>
<td>01/01/2019</td>
</tr>
<tr>
<td>Colorado</td>
<td>Minimum Wage</td>
<td>Updating with new 2019 minimum wage rate.</td>
<td>01/01/2019</td>
</tr>
<tr>
<td>Delaware</td>
<td>Minimum Wage &amp; Discrimination</td>
<td>Revised to include new 2019 minimum wages and governor name. Discrimination Notice now includes new information about Sexual Harassment, rights for disabled individuals, and rights for pregnant women.</td>
<td>01/01/2019</td>
</tr>
<tr>
<td>Florida</td>
<td>Minimum Wage</td>
<td>Updated to reflect new minimum wage rate of $8.46 per hour effective January 1st, 2019 and new tipped rate of $5.44 per hour.</td>
<td>01/01/2019</td>
</tr>
</tbody>
</table>

## OFFICE PRACTICE MANAGERS

- **Qualities of super efficient/effective medical practice Office Managers:**
  - “What is the “secret sauce” to getting ahead as a practice manager?”
  1. “Superstar managers excel at the core responsibilities.”
     - Master all core functions of the practice.
     - Revenue cycle; financial stats, human resources, successful communication techniques, clinic operations, risk management, and compliance.
  2. “Superstar managers embrace change.”
     - Responding to a constantly evolving healthcare industry.
     - Embrace challenges and set the tone for leading staff to successful change.
  3. “Superstar managers retain a teachable spirit.”
     - Huge learning opportunity in the body of knowledge in healthcare.
     - Jason Cornelius, MHA, MBA, Chief Operating Officer at Ft. Worth Brain and Spine in Fort Worth, Texas is quoted in the above article as advising – “Always stay humble and never stop learning. Surround yourself with people who are smarter than you, who can mentor you and people who have “more gray hair than you.”

Source: "5 Qualities of Superstar Practice Managers: by Amy Bower, MBA, Apr. 11, 2018"
QUALITIES OF A SUPERSTAR MEDICAL PRACTICE MANAGER

4. “Superstar managers think like both a clinician and a businessperson.”
   - Understand the business side of medicine, but also engage in knowledge of the medical specialty and understanding what the clinicians do and what they have to respond to in providing their services.
   - Ask questions; see issues from their point of view; remember the primary goal of any healthcare service provider – quality, efficient patient care.

5. “Superstar managers nurture relationships.”
   - Develop the ability to understand and assess other people’s emotions and constantly strive to improve communication skills.
   - Successful office managers develop skills to act as a “buffer” and are able to calmly stabilize the needs of each department and encourage teamwork to achieve a fun, healthy work environment that is passionate about:
     • Supporting the clinicians providing patient care;
     • Bringing out the best in each staff member and effectively managing personnel;
     • Efficiently handling the challenges of maximization of revenue for the practice’s growth and survival;
     • While never losing site of achieving the main goals of patient care and safety.

QUALITIES OF A SUPERSTAR STAFF MEMBER

• The same except goal is to master your current job and be ready to cross-train to lend a helping hand when needed.
• Remember some day you may be managing an office.
   - Passion about your job.
   - Doing your best and correcting tasks when necessary.
   - Respect for others.
   - Communication skills
   - Enjoyment of life.
Let us celebrate the dates on which we change the world
——— Akin Nathan Logeswaran

HAVE A GREAT 2019!

• Questions?
• Comments?
• THANK YOU!!

• Contact – mcollins@pmimd.com