Margie Vaught.com

July 2018 Volume 7 Issue 7

Proposed 2019 Fee Schedule is out – hang on to your seats…

CMS released the 12th of July the proposed changed for the physician fee schedule for 2019 (https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-07-12.html). Here are some of the highlights

1) Changes to EM system – Probably the biggest and the one that caught everyone's eye was the "Streamlining E/M Payment and reducing clinician burden. Specifically, they state "Responding to stakeholder concerns, several provisions in the proposed CY 2019 Physician Fee Schedule would help to free EHRs to be powerful tools that would actually support efficient care while giving physicians more time to spend with their patients, especially those with complex needs, rather than on paperwork. Specifically, this proposal states:

   CMS is proposing several coding and payment changes to reduce administrative burden and improve payment accuracy for E/M visits. We propose:

   to allow practitioners to choose to document office/outpatient E/M visits ***using medical decision-making or time*** *instead of applying the current 1995 or 1997 E/M documentation guidelines, or alternatively practitioners could continue using the current framework;*

to expand current options by allowing practitioners **to use time as the governing factor** *in selecting visit level and documenting the E/M visit, regardless of whether counseling or care coordination dominate the visit;*

to expand current options regarding the documentation of history and exam, **to allow practitioners to focus their documentation on what has changed since the last visit or on pertinent items that have not changed, rather than re-documenting information**, *provided they review and update the previous information; and*

to allow practitioners to simply **review and verify certain information in the medical record that is entered by ancillary staff or the beneficiary, rather than re-entering it."**

The proposal also has some interesting aspects such as having a 'single blended payment rates for new and established patients for office/outpatient EM levels 2-5 visits with a series of 'add-on' codes to reflect resources involved in furnishing primary care and non-procedural specialty generally recognized services. They would also see about have the 'standard' documentation for levels 2-5 OR more of just medical decision-making to determine the levels 2-5 or using just time even without it being counseling. For time documentation they would still require the 'medical necessity' for the encounter, also the total amount of time spent face-to-face with the patient. They would still allow providers to add additional documentation for clinical, legal, operational or other purposes, however CMS would only require documentation to support the medical necessity of the visit, etc.

When it comes to EM services were minor procedures are also performed, CMS proposes "a multiple procedure payment adjustment that would apply." Which appears to infer similar reductions that are currently applied for multiple surgical procedures performed during the same encounter/date. They also want to develop a separate set of coding EM visits for podiatry services. They are also proposing a 'new prolonged face-to-face EM code, as well as a technical modification to the practice expense methodology.'

CMS is also seeking public comment on 'potentially eliminating a policy that prevents payment for same-day EM visits by multiple practitioners in the same specialty within a group practice.' For EM

visits furnished by teaching physicians they are proposing 'to eliminate 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.'

Finally, CMS states: "We are soliciting public comment on the implementation timeframe of these proposals, as well as how we might update E/M visit coding and documentation in other care settings in future years. CMS believes these proposals would 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."

2) Discontinue Functional Status Reporting Requirements for Outpatient Therapy

3) Outpatient PT and OT Services Furnished by Therapy Assistants – "The Bipartisan Budget Act of 2018 requires payment for services furnished in whole or in part by a therapy assistant at 85 percent of the applicable Part B payment amount for the service effective January 1, 2022. In order to implement this payment reduction, the law requires us to establish a new modifier by January 1, 2019 and we detail our plans to accomplish this in the proposed rule. We are proposing to establish **two new therapy modifiers** – one for PT Assistants (PTA) and another for OT Assistant (OTA) – when services are furnished in whole or in part by a PTA or OTA. These are to be used in conjunction with the three existing therapy modifiers that have been used since 1998 to track outpatient therapy services that were subject to the therapy caps. The new therapy modifiers for services furnished by PTAs and OTAs are not required on claims until January 1, 2020.

4) **Conversion Factor – Proposed $36.05 up from the 2018 value of $35.99**

5) Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging

6) Patient's over paperwork – CMS has also released a video https://www.cms.gov/About-CMS/story-page/patients-over-paperwork.html
Learn how we're putting patients over paperwork and they list things like Implementing MACRA to lessen your burden & cost; Cutting documentation requirements; Making the medial review process

clearer; Making it easier for people to get the treatment they need; Making meaningful measures; and lowering drug costs

7) Increasing Telecommunications
8) Removing MIPS process-based quality measures that clinicians have said are low-value or low-priority, in order to focus on meaningful measures that have a greater impact on health outcomes
9) Overhauling the MIPS "Promoting Interoperability" performance category to support greater EHR interoperability and patient access to their health information
10) Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration
11) Price transparency: Request for information

Public comments on the proposed rules are due by September 10, 2018.

Please take the time to read through the sections, especially the changes to EM reporting and make your comments BEFORE the Sept 10th deadline. As I continue to read through the 1473 pages if I found other exciting things relating to Orthopedic issues, I will let you know, but the second link below will get you your own copy of those pages that you can also browse through. For more information:

For a fact sheet on the CY 2019 Physician Fee Schedule proposed rule, please visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-07-12-2.html

To view the CY 2019 Physician Fee Schedule proposed rule, please visit: https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-14985.pdf

For a fact sheet on the CY 2019 Quality Payment Program proposed rule, please visit: https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2019-QPP-proposed-rule-fact-sheet.pdf

To view the CY 2019 Quality Payment Program proposed rule, please visit: https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-14985.pdf

For a fact sheet on the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration, please visit: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-07-12.html

OIG Work Plan added 99024 for auditing

The OIG is going to be reviewing the code 99024 to see about how many postoperative days are being documented for a given surgery. Exactly how they are going to audit these is still unclear. Since this code has not dollar amount assigned to it, it normally is not billed to CMS unless other billable services are performed. CMS is already tracking these postop encounters in several States, but it is unclear if that is the data that will be used. We will have to wait to see if CMS/OIG will be providing any additional information.

The OIG plan states W-00-18-35810 Expected Issue Date FY 2019: "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 OIG 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."
https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000309.asp

CPT updates their policy regarding nerve root decompressions and interbody fusions

AANS, NASS and AAOS have been working hard on getting CPT to change their previous October 2016 CPT Assistant regarding nerve root decompression 63047 and interbody fusion 22633 being inclusive. As of the May 2018 it appears that those specialty societies have accomplished CPT/AMA to change that policy. In the May 2018 issue they reversed their previous October 2016 Assistant stating:

> "On further analysis of this issue, it was demonstrated that this recommendation was inconsistent with previously published *CPT® Assistant* advice, which is that codes 22633 and 63047 may be reported for the same interspace when additional work is required to complete a decompression at a single spinal level. It is also appropriate to report codes 22633 and 63047, if the two procedures are performed at different interspaces. Modifier 59, *Distinct Procedural Service,* should then be appended to indicate that these are two distinct procedures.

This correction aligns the coding advice with historical precedent published prior to the incorrect revisions in advice given in the October 2016 FAQ."

However, this change does not appear to have affected Medicare's opinion via the NCCI guidelines Chapter Four which states that they continue to feel that 63047/63042 are inclusive in 22630/22633 unless performed at a different interspace. Meaning that if they did nerve root decompressions of L2, L3, L4 and L5 and also did a PLIF (22630) or double fusion (22633) and L4/5 – you will only be able to report 63047-59 (L2 nerve root); 63048-59 (L3 nerve root) as the nerve root decompressions of L4 and L5 will continue to be bundled into the 22630/22633.

What this change does to is allow you to use it in an appeal with your private payers if they deny your reporting of 63047 and 63048s with 22633 when performed at the same levels. But keep in mind, if your contracted payers state that they follow NCCI guidelines and edits, they may still be able to deny reimbursement.

NASS and the other societies are still trying to work with Medicare/NCCI to over-turn this bundling but as of the updated 2nd quarter edits it is still there.

Bone Marrow Aspiration CPT Coding

As of Jan 1st, 2018, CPT Code 38220 is no longer available to be reported for the bone marrow aspiration from the iliac crest that many of the surgeons are using for surgical procedures other than spinal procedures. CPT states both in the CPT Manual and in the May 2018 CPT Assistant that for spinal procedures where they are harvesting bone marrow aspiration from a separate site code 20939 was developed and for all other surgical procedure it would fall under 20999. If you are getting denials for the 20999 as being inclusive, you maybe able to use this May 2018 CPT Assistant article in your appeal process as it states:

> *"Effective January 1, 2018, code 38220 is no longer reported for bone marrow aspiration to be used as a therapeutic autograft in conjunction with a spine procedure. Instead, new add-on code 20939 is now reported for this procedure, and it should be reported only in conjunction with the appropriate spinal code(s) from the subsections of Fracture/Dislocation (22319); Lateral Extracavitary Approach Arthrodesis (22532, 22533, 22534); Anterior Approach Arthrodesis (22548, 22551, 22552, 22554, 22556, 22558), Posterior Approach Arthrodesis (22590, 22595, 22600, 22610, 22612); Posterior Arthrodesis (22630, 22633, 22634), and Spine Deformity (22800,*

*22802, 22804, 22808, 22810, 22812), as noted in the parenthetical note following code 20939. **Code 20999, Unlisted procedure, musculoskeletal system, in general, should be reported for aspiration of bone marrow for the purpose of bone grafting, other than spinal surgeries**. In addition, codes 38205 and 38206 are reported for bone marrow harvesting for transplantation, and code 0232T should be reported for bone marrow aspiration for platelet-rich stem cell injection."*

The newsletters will now start coming out quarterly and if there is 'breaking' updates that need to come out sooner, then special editions will be sent. So, the next newsletter will be around September.

If you have issues or concerns that you would like further input on, please feel free to send emails to info@margievaught.com. If you would like to schedule any audios or live presentations, please feel free to contact me.

Margie Scalley Vaught, CPC, COC, CPC-I, CCS-P, MCS-P, ACS-EM, ACS-OR
Auditing, Coding, Documentation and Compliance Consulting
Healthcare Consultant
scalley123@aol.com, info@margievaught.com
fax 413-674-7668
www.margievaught.com
for workshops and audio http://www.margievaught.com/calendar/index.cfm
Want to receive a monthly newsletter - signup on margievaught.com

Check out below for upcoming Audios and Live Presentations

Upcoming Audios and Workshops 2018

August 7th, 2018 – Audio –Documentation EM style for Orthopedic issues– sponsored by https://www.audioeducator.com/orthopedics/orthopedic-documentation-em-level-of-service.html

Sept 20th, 2018 – Audio –ICD-10 updates and reminders for 2019 for Orthopedic issues– sponsored by https://www.audioeducator.com/orthopedics/icd-10-for-orthopedics.html

October 10th, 2018 – Audio –Arthroscopic procedures – Shoulders, Wrist, Hips, Knees and Ankles– sponsored by

https://www.audioeducator.com/orthopedics/arthroscopy-coding-changes.html

October 15th – 17th, 2018- 18th Annual Advanced Orthopedic Symposium – Hilton Orlando, FL - sponsored by DecisionHealth - **http://www.codingbooks.com/specialty-coding**

November 5th – 7th, 2018- GAOE – Annual Conference – Omni Amelia Island Plantation in Amelia Island, Florida - https://www.gaoe.org/annual-meeting.html

Nov 29th, 2018 – Audio –2019 updates for Orthopedic Issues; Auditing Orthopedic specific EM services; Shoulder procedures - sponsored by www.audioeducator.com