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# The Business of Medicine

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COMPLIANCE

## Medicare therapy coverage doesn't hinge on patient 'improvement'

We at DoctorsManagement have been aware of Medicare payers improperly applying the government's "improvement standard" far too broadly, using it to deny physical and occupational therapy services in particular.

This is wrong, and we have the regulatory support to back up this fact. As for those Medicare payers who are using a lack of patient improvement to deny reimbursement, we can only attribute their actions to a lack of training and education within the ranks of their auditors.

While the improvement standard *is* based in Medicare rulemaking and does apply sometimes, it is being incorrectly applied across multiple care settings. Those individuals at Medicare payers with the power to make such determinations have ardently followed the improvement standard, depriving tens of thousands of beneficiaries from receiving medically necessary care.

### What is the 'improvement standard'?

Let's take a look at the federal regulations that do exist around the concept of patient improvement in response to treatment. Medicare rules do hold that some services are only repeatedly billable when they are shown to improve a patient's condition. If they do not, then they are not medically necessary.

However, CMS also says: "The restoration potential of a patient is not the deciding factor in determining whether skilled services are needed. Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities."

The CMS manual also instructs payers to "support coverage if the individual's condition will improve" *or* if "the skills of a therapist [are]

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necessary to perform a safe and effective maintenance program." In fact, the Medicare rules that do refer to a need for improvement only do so with regard to services for a "malformed body member." So unless the care being provided is specifically aimed at treating a "malformed body member," improvement is *not* necessary for Medicare coverage. A light bulb should be going off in your head right now if you are an attorney or if you are a consultant providing litigation or audit appeal support.

## A strong legal precedent

The strongest support for our position on this is the outcome of a 2011 lawsuit, *Jimmo v. Sebelius*, a nationwide class action suit in which Medicare beneficiaries with chronic conditions – with help from various advocacy organizations – challenged CMS contractors' use of the improvement standard to deny payment (and thus treatment). The case took more than two years to resolve and ended in a settlement agreement.

The settlement agreement states that Medicare coverage hinges on a beneficiary's need for skilled care (nursing or therapy) and not on his or her potential for restoration or improvement.

The settlement applies to Medicare coverage for home health care, skilled nursing facility services, outpatient therapies, and to some extent, care provided by inpatient rehabilitation facilities. A federal judge granted final approval of the settlement on Jan. 24, 2013, after which CMS officially began a campaign to revise its policy and educate its contractors.

Unfortunately, we are still seeing providers being denied payment and coverage due to improper use of the improvement standard. Even with the settlement requiring CMS to randomly audit its own contractors to ensure they have stopped illegally applying the improvement standard, providers are still losing money over it.

## Concluding thoughts

In this article, we focused on the illegal application of the improvement standard in a skilled nursing context, but it is important to understand that this standard applies across a much wider spectrum of services. When your practice is hit with adverse audit findings and federal overpayment demands because they claim that the services billed will not result in the improvement of patients' conditions, you should consider building your defense strategy.

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**CONGRESSIONAL ACTION**

## With repeal stalled, Trump moves to weaken ACA

With Republican efforts to repeal the Affordable Care Act (ACA) completely stalled, President Donald J. Trump has begun taking matters into his own hands, using executive power to strip away key provisions of the law in an attempt to force Congressional action. His latest moves have created still more uncertainty for the already wavering insurance companies that remain in the ACA's exchanges.

The most recent and significant move came Oct. 12, when Trump signed an executive order that will eliminate the ACA's federal subsidy payments, used to help low-income people afford their premiums. While the order will take at least a year to percolate through HHS and various other federal agencies, it could significantly impact insurance premiums in 2019.

This comes on top of agency-level moves engineered by Trump's cabinet members. In September, HHS slashed the advertising budget for the ACA's exchange plans from $100 million under the Obama administration in 2016 to just $10 million. The ACA's open enrollment period begins in November and the money will be used to try and increase participation in the various insurance exchanges. HHS officials have said that the cuts are appropriate because most Americans already know about the ACA and that further spending would be an inefficient use of money due to "diminishing returns," as reported in *The New York Times*.

The marketing budget cuts come on top of a move by HHS to reduce the ACA exchanges' open enrollment by half, from 90 days to 45 days.

Supporters of the ACA, including those who work at the non-profit "navigator" groups which receive federal funding to promote the exchanges, say that the HHS statement is untrue and that many Americans are confused about whether the ACA will continue to function, and that information and outreach is more important now than in previous years.

### Congress could restore Trump's subsidy cuts

Members of Congress in both parties expressed concern at the short-term effects of Trump's latest executive order, which is likely to accelerate the ongoing exodus of private insurers from the ACA's exchanges. In what seems to be a rapid response, a bipartisan agreement surfaced Oct. 17 between Sens. Lamar Alexander (R-Tenn.) and Patty Murray (D.-Wash.) that would require the government to continue funding the ACA's cost-sharing subsidies for the next two years.

Such a short-term guarantee would offer insurers and patients stability for the near-term and avoid "chaos" in the words of Sen. Alexander. "In my view, this agreement avoids chaos," he told reporters on Oct. 17. "I don't know a Democrat or a Republican who benefits from chaos."

The provisions of the agreement would also restore the advertising dollars cut by HHS under the Trump administration, just as the ACA's open enrollment period is set to begin Nov. 1. President Trump quickly voiced support for the move by Congress to offset the impacts of his executive order, calling it a "short-term solution so that we don't have this very dangerous little period."

Even with two years of guaranteed subsidy payments, premium costs are still likely to go up. The cost of the average benchmark premium for an exchange plan could

## CMS chief could take over at HHS after Price resignation

The sudden resignation of Tom Price, the former Georgia Congressman, from his post as HHS Secretary creates more uncertainty over how the agency will approach crucial initiatives, such as enforcing the politically divisive Affordable Care Act (ACA) and overseeing the rollout of the Merit-based Incentive Payment System (MIPS) as it accelerates toward 2019, the first year that physician payments will see adjustment.

Don Wright, the acting assistant secretary for health at HHS, was swiftly tapped by the White House to become acting HHS Secretary. Wright was replaced as acting secretary earlier this month when the Senate confirmed Eric Hargan as deputy secretary at HHS.

Several individuals are currently considered the front-runners to permanently succeed Price: Scott Gottlieb, now the commissioner of the Food and Drug Administration (FDA), Bobby Jindal, the former Republican governor of Louisiana, Seema Verma, now the administrator of CMS, and Alex Azar, a former executive with Eli Lilly.

- Gottlieb finished a residency in internal medicine and practiced as a hospitalist in New York before embarking on a long career as a pharmaceutical industry consultant. The connection with the pharmaceutical industry could complicate his confirmation to be HHS Secretary.
- Jindal has a strong resume, with expertise in healthcare policy and a stint as assistant secretary at HHS under President George W. Bush. However, he was highly critical of President Trump during the 2016 election, and could be considered too politically toxic to serve in Trump's cabinet.
- Verma would have perhaps the smoothest course to be HHS chief; like Gottlieb, she has been confirmed already by the Senate, but unlike either Gottlieb or Jindal, she has no particular special interest ties and also enjoys the confidence of Vice President Mike Pence, whom she helped with the conservative reform of Indiana's Medicaid program during his time as governor.
- Azar is a former general counsel and deputy secretary under the Bush (43) White House. Since leaving Washington, DC, Azar has spent his time in pharmaceuticals working his way up the corporate ladder at Eli Lilly in Indianapolis to head the company's US operations.

President Trump has not always acted quickly to fill high-level positions; he took two months to nominate a permanent Secretary of Homeland Security after asking the previous Secretary, retired general John F. Kelly, to become the White House Chief of Staff. That left only an acting Secretary in place until Oct. 10, when Trump nominated Kirstjen Nielsen for the post.

jump 15% in 2018, according to a September report by the non-partisan Congressional Budget Office (CBO).

It's not clear how the agreement would become law, but early signs point to supporters in Congress insisting on its inclusion in the forthcoming federal spending bill that must be passed in December, when the current budget expires. The fate of the agreement could rest with more conservative Republicans, particularly those in the House of Representatives, some of whom have already objected to the amount of spending it would require.

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REVENUE CYCLE MANAGEMENT

## Why the Hierarchical Condition Category (HHC) model matters

For many providers and administrators, Hierarchical Condition Categories (HCCs) are still something of a mystery, a concept that seems to do most of its work in the background. But now, as the healthcare industry accelerates towards alternative payment models, HCCs are set to take center stage.

**In a nutshell:** The HCC model is a payment methodology that attempts to quantify the risk posed by an illness or injury, use that risk to predict healthcare costs, and issue payments accordingly. Medicare Advantage (MA) plans have long relied on HCCs to help set specific per-patient dollar amounts for their capitated payments. If MA plans make up a significant portion of your payer mix, being familiar with HCCs is all the more important.

Also, many insurance plans operating in the Affordable Care Act (ACA) exchanges rely on the HCC model because they potentially receive additional federal dollars based on the risk of their patient populations. Going forward, more payers are likely to embrace HCCs, while CMS has a provision in its Quality Payment Program (QPP) proposed rule that would issue a "complex patients" bonus payment to Medicare Part B providers who see particularly sick patients.

### HCCs' intimate connection to ICD-10

In the HCC model, each ICD-10 diagnosis code correlates to one of 79 HCC categories (79 categories are active in 2017 out of 189 total HCC categories in existence). Each HCC category has an associated risk factor value that is combined with demographic information on patients, such as age and gender, to generate a risk score for that diagnosis.

The scores are then used to prospectively set capitated payment amounts (i.e. current year scores determine next year payment). The payment is thus **risk-adjusted** based on the type and severity of diagnoses for each patient.

**The HCC model explicitly ties ICD-10 codes to payments.** Three years after CMS made the ICD-10 diagnosis code set mandatory, most payers have chosen not to be aggressive in requiring the highest levels of ICD-10 specificity, paying claims that use the unspecified codes. Now, HCCs offer providers a reason to spend more time selecting more specific ICD-10 codes and entering additional secondary ICD-10 codes, because this will better capture the clinical severity of their patients – potentially increasing their capitated payments from MA plans.

MA plans that currently run on the HCC model use all the reported ICD-10 diagnoses from providers, crosswalk them to HCC categories, and then combine them with demographic information on patients (such as gender, age, socioeconomic factors, and disability status) to generate numerical risk scores for patients. The greater the risk, the higher the projected cost of treating those patients, and thus the HCC model is used prospectively to set the capitated payment amounts for the following year.

### What should you do about HCCs?

The extent to which HCCs affect your payments will depend on how many payers exist in your practice's mix that use HCCs to shape payments. Typically these will be MA plans or ACA exchange plans, though in 2019 CMS could potentially give you a bonus payment for complex patients if it finalizes its proposed QPP rule.

To take advantage of the HCC model, your providers should be selecting the most specific ICD-10 diagnosis codes possible, with an emphasis on reporting clinically

relevant comorbid conditions that complicate care as secondary diagnoses. For orthopaedic surgeons, such secondary diagnoses would include conditions such as type 2 diabetes with neuropathic complications, hypertension, and heart disease.

In the future, most payers are likely to rely on HCCs to some extent, and if your providers simply report the bare minimum ICD-10 codes, such as a single unspecified principal diagnosis code, they will be short-changing themselves by portraying their patients to be clinically less complex than they are, and thus in need of fewer resources.

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CODING

## Improve your E/M coding by focusing on medical decision making

Now that CMS is committed to revising its E/M documentation requirements to reduce the burden and complexity they pose to providers, it's a great time to review the trickiest E/M component: medical decision making (MDM).

**Remember:** CMS is considering several tweaks to its venerable E/M rules, and is prioritizing the history and exam components to change first in its 2018 Medicare Physician Fee Schedule (PFS) proposed rule. No decision has been made yet, but one proposal in the rule would cause E/M code level to be decided solely by the level of

## ONC relaxes EHR certification rules in a potentially risky move

In a surprise move, the HHS Office of the National Coordinator for Health Information Technology (ONC) is relaxing certification standards for electronic health records (EHR) systems. The announcement came in a Sept. 21 blog post that cited the ONC's desire to make its certification program more efficient and to "reduce burden industry-wide."

This would make it easier for EHR vendors to meet CMS certification requirements, but it could also make it easier for "approved" products to be found lacking advertised features once implemented, a problem that was spectacularly showcased earlier this year when eClinicalWorks signed a $150 million settlement with the government for claiming its EHR software had capabilities that it didn't.

### Two big changes

The changes to the certification requirements appear to be in effect already, and they represent a significant reduction in difficulty for vendors. **First, for 30 of the 55 certification criteria evaluated by the ONC**, vendors will be able to "self-declare" their products' compliance rather than having to actually demonstrate it via testing. The testing has usually consisted of a visual demonstration of the functionality required for a given criterion, or a submitted report describing the functionality.

Now, neither is required – only the vendor's good word. In defense of the move, the ONC writes that "self-declaration is not a new approach, and is used among other industry testing programs. In evaluating the certification program's potential burdens, ONC determined that this industry approach would best meet our efficiency goals while maintaining overall integrity."

**The second major change is the ONC suspending audits** of its six Authorized Certification Bodies (ACBs), which are responsible for the actual certification of EHR products. The ONC has the authority to conduct randomized surveillance of its ACBs to ensure those entities are complying with its certification guidelines. "This exercise of enforcement discretion will permit ONC-ACBs to prioritize complaint-driven, or reactive, surveillance and allow them to devote their resources to certifying health IT to the 2015 edition," the ONC writes in its blog post.

While EHR vendors have every incentive to avoid the fate of eClinicalWorks, these moves by the ONC could make it easy, if not tempting, to spend less time and effort on strict adherence to the ONC's certification requirements, particularly for the 30 items that can now be met with a simple self-declaration.

MDM (or in the case of counseling-dominated visits, the amount of face time spent with the patient).

## What is MDM and is it different from medical necessity?

The history and exam components are easy to understand in principle; history is about collecting information from the patient and/or records, while the exam is just that – a physical (or more limited) exam of the patient's body.

MDM is a more complex concept: It represents CMS' best effort to quantify the amount of *cognitive labor* required to evaluate and treat the patient's problems. It is often seen by payers as the most important key component, more so than the history or exam, particularly in an era where EHR templates can allow providers to easily document the highest level of history and exam with just a few clicks.

However, MDM is not the same concept as "medical necessity" – the latter is seen as the one overarching criterion for supporting any level of service. Medical necessity is often confused with MDM or used interchangeably, but it is actually a distinct concept, and the difference is significant:

- MDM is more relevant to CPT than to insurance payers because it is referenced in all CPT code descriptors for E/M services as a way to describe providers' cognitive labor.
- Medical necessity is the requirement that a service is "reasonable and necessary."
- Medical necessity is not quantified via any grid or tool, but is either met or not met; it is met when a service (any service, not just E/M) "is furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition," according to the Medicare Program Integrity Manual (chapter 13, section 5.1).
- Thus medical necessity is more relevant to payers than CPT because it answers the crucial question of whether the cost of the service was a justifiable use of resources given the patient's condition.

While medical necessity has no numerical metric like a point system, the closest proxy for medical necessity would be one of the three subcomponents of MDM: the "number and nature of presenting problems." Managing multiple problems whose nature is severe would support a higher code level based on medical necessity, as long as all the other E/M components are also met.

## Number and nature of problems

This first element of MDM may be the simplest to understand, at least in principle. It asks how many problems does the patient have that will be evaluated and managed during this specific visit, and what is the nature of these problems? This element is scored on a point system, from 1 to 4 points maximum.

- **Self-limited/minor.** These are minor problems or those that will resolve on their own without the need for intervention. Worth 1 point, capped at 2 points total.
- **Established problem, stable/improved.** These problems are established (already known/previously evaluated) to the *provider*, not the patient. Worth 1 point and without any cap.

- **Established problem, worsening.** Established problems that have worsened, or are failing to respond as expected to treatment. Worth 2 points, no cap.

- **New problem, no additional workup.** These problems are new to the *provider* (have not been previously evaluated), but no additional workup is planned to address them. Worth 3 points, capped at 3 points total.

- **New problem, additional workup planned.** New problems that have additional workup documented in the note. Worth 4 points, no cap. Additional workup would be any work (tests, labs, studies, specialist referrals) that are expected to occur outside the current visit. Procedures do not count as additional workup unless diagnostic in nature.

## Amount and complexity of data review

This element accounts for any diagnostic data that the provider reviews during the visit, including ordering diagnostic tests, discussing results with other providers, or digging up old records. It is also scored on a 1-4 point system, with a maximum of 4 points.

- **Review/order clinical labs.** Clinical labs include analysis of specimens such as blood, urine, feces, synovial fluid, semen, etc. For easy reference, clinical labs will refer to the ***CPT code range 80047-89398.*** Worth 1 point for review or order.

- **Review/order radiology tests.** Radiology tests include imaging studies such as X-rays, CT scans, MRIs, etc. For easy reference, radiology tests will refer to the ***CPT code range 70010-79999.*** Worth 1 point for review or order.

- **Review/order medicine tests.** Medicine tests include EKGs, EEGs, ECGs, audiometry tests, speech or swallow studies, allergy testing, etc. For easy reference, medicine tests will refer to the ***CPT code range 90700-99199.*** Worth 1 point for review or order.

- **Discuss test with performing physician.** Requires that the provider discuss the patient's case with the physician who performed and/or interpreted the test. The note must state the discussion occurred and summarize the findings; worth 1 point.

- **Independent review of image, tracing, or specimen.** Requires the provider to personally review a diagnostic test result, whether an image, tracing, or specimen, and document his/her takeaways (i.e. summarize the results). This may be done regardless of whether there is already an interpretation or report by another physician, but it must be based on a personal review of the test result itself rather than an existing interpretation or report. Worth 2 points.

- **Decision to obtain old records.** Deciding to obtain a patient's prior records, and documenting that this decision was made, is worth 1 point. Also credited for obtain history from someone other than the patient.

- **Review and summarization of old records.** This requires reviewing a patient's past records (whether progress notes or lab results) *and* summarizing them. The summary can be a concise 1-2 sentence description but it should be specific and unique to that patient (generic statements such as "old records were reviewed" cannot be credited). Typically a total 3 points is credited if the note states a decision to obtain old

**New DoctorsManagement clients**

| Client | Services provided |
|---|---|
| Urology practice, AZ | Monthly management |
| Dermatology practice, AZ | Monthly management |
| Orthopedic practice, PA | Practice startup |
| Dermatology group, TN | Practice assessment |
| Wellness center, FL | Practice assessment |
| Podiatry group, TN | MIPS/quality reporting management |
| Primary care practice, FL | Practice startup |
| Hospital, GA | Physical therapy audit |
| Association for Value-based Cancer Care | Speaking engagement |
| Allergy/asthma group, TN | Annual post-bill audit |

records was made, and then those records are reviewed and summarized. Also credited for review and summary of history from someone other than the patient.

## Overall risk to the patient

This last element of MDM is often the murkiest, because the official guidance consists only of the CMS "Table of Risk," a document that is not intended to be all-encompassing. For most specialties, the most difficult cases will often be a one-level difference in E/M code, such as whether to report 99213 or 99214 for a patient, based on MDM.

**Example:** An established patient comes in with worsening pain in the right ear. He has a history of Eustachian tube dysfunction and tinnitus. He was previously seen a week prior with minor right ear pain, diagnosed as acute otitis media. Today the problem is identical, just with worsening pain that has evidently not responded to the previous treatment of applying a warm washcloth over the ear and taking over-the-counter pain relievers. The physician prescribes Augmentin in response. Should this be reported as 99213 or 99214, assuming the history and exam supports either code?

**Analysis:** Following E/M guidelines, we see one established problem that is worsening (2 points for number and nature of problems) and an overall risk that would be moderate (established problem with mild exacerbation, prescription medication management). This is only sufficient to support 99213 because 2 points for number and nature of problems is consistent with low complexity MDM. However, 99214 could be supported based on medical necessity, given the patient's past history of ear issues. The overall clinical picture suggests a case of otitis media that is more complex than typical, and thus warrants greater care than what would otherwise be an acute but uncomplicated problem.

A more conservative practice might choose to report 99213 anyway, because according to the E/M guidelines (often captured using a grid tool such as the Marshfield Clinic Scoring Tool), 99213 is the only code that can be supported without any data reviewed during the visit. This is an example where the practice must consider its risk tolerance and whether it would be comfortable making the argument outlined above to support 99214.

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