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The Business of Medicine

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Modifier 25 revisited: Bundling E/M visits and procedures

As more payers embrace hardline policies to discourage the bundling of E/M services with minor outpatient procedures (see related story, pg. 3), practices must be more disciplined in their use of modifier **25** (**significant, separately identifiable evaluation and management service** by the same physician or other qualified health care professional on the same day of the procedure or other service).

This means not only knowing when to append modifier 25 and how to ensure providers have supporting documentation, but also knowing when *not* to use modifier 25 because it isn't needed.

At DoctorsManagement, our auditors often see practices appending modifier 25 routinely to all sorts of minor procedures when they are not needed. **Remember:** Modifier 25 is only necessary when a bundling edit exists between an E/M code and a procedural CPT code. The National Correct Coding Initiative (NCCI) maintains a list of all edits in effect. The NCCI database is updated quarterly, like clockwork, with new edits, changed edits, and occasionally deletion of existing edits.

Don't use modifier 25 'preventively'

You might think that it's no big deal to slap on modifier 25 just as a precaution. After all, payers do not decline payment for an unneeded modifier – typically you'll simply see those claim lines processed without comment.

But behind the scenes, both private and government payers are collecting reams of utilization data for CPT codes, diagnosis codes, and modifiers. Independence Blue Cross Blue Shield of Pennsylvania repeatedly cited such data as justification for a punishing policy of reducing payments by 50% for E/M services with modifier 25 attached. Their internal claims data showed that modifier 25 was being appended 50% more frequently than "commercial benchmarks,"

(continued on pg. 3)

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IBX states on its website in an FAQ about its unpopular modifier 25 policy.

So while you may be getting paid for services with modifier 25 that weren't bundled to begin with, you do drive up utilization numbers for modifier 25, giving payers statistical ammunition for harsh policies like IBX's, which has since been copied by multiple other Blue Cross Blue Shield payers (and were already being used by other commercial plans).

Examples of common procedures billed with E/M codes that *do not ever require modifier 25* include:

- EKGs (**93000**)
- Prothrombin check (**85610**)
- Transthoracic ECGs (**93303-93308**)
- Chest X-rays (**71045-71048**)
- Most lab panels (**80XXX**)
- When it's needed: Proper modifier 25 usage

You *do* need modifier 25 when the E/M service is being billed alongside minor surgical procedures (zero to 10 global days). The NCCI edits work by preventing the E/M service from being paid when it is billed with minor surgical procedures because the typical pre- and post-service work associated with the procedure are considered covered by the payment for the procedure itself.

Examples of procedures commonly billed with E/M services that *do* need modifier 25 include any type of **vaccine administration**, **corticosteroid injections**, **minor in-office scope procedures** (endoscopies, laryngoscopies), medicine tests such as **pulmonary or cardiovascular stress tests**.

Here are two documentation tips to ensure your providers produce notes that clearly support the use of modifier 25 properly.

1. Document a new or significant problem. To satisfy modifier 25's requirements that the E/M service is addressing a new or significant problem, the documentation should reference an acute new problem or explain that the existing problem being managed by the minor procedure is somehow exacerbated. Language such as "the patient also presents with" or "the patient reports new onset of" are very helpful in making the case that *a separate problem is being addressed* by the E/M service. Language such as "patient's migraines were especially severe yesterday, we will try a higher strength NSAID in addition to today's Botox injection" makes the case that the problem being addressed by the minor procedure (migraine requiring Botox injection) is more severe than typical, i.e. *is a significant* problem.

2. Documentation for new vs. established patients. It's more difficult to satisfy modifier 25 requirements for established patients, particularly if the documentation suggests that the minor procedure was scheduled earlier. If a procedure is planned, that means the problem requiring the procedure has been previously evaluated and there is no case to support a separate E/M code for the visit. On the other hand, for a new patient, the E/M can be supported on the grounds that the provider had to first evaluate the patient's problem (which is new to the provider) before deciding that a minor same-day procedure is medically necessary. The documentation must make this clear, however.

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Facing provider resistance, Anthem softens modifier 25 policy

At least one Blue Cross Blue Shield (BCBS) payer has responded to provider pushback against the modifier 25 payment reduction policy by weakening it. Anthem BCBS has announced that it will change the payment reduction from 50% to 25% for all codes with modifier 25 appended. Anthem will also delay the implementation date of this policy from Jan. 1 to March 1, 2018 in 12 affected states. The change to a 25% reduction affects all Anthem states.

Remember: The modifier 25 policy was first adopted by Independence BCBS in Pennsylvania. It is a payment rule that affects all E/M codes with modifier 25 appended, reducing their reimbursement by 50%. Independence and other BCBS payers had defended the policy by saying it was necessary to rein in overutilization of modifier 25, citing

internal data that showed their utilization was higher than national average.

The 12 states benefitting from the implementation delay are California, Colorado, Connecticut, Indiana, Kentucky, Maine, Missouri, New Hampshire, Nevada, New York, Ohio, and Wisconsin. The move by Anthem comes after payer officials met with local medical societies from the affected states. National provider stakeholder groups such as the American Medical Association (AMA) and Medical Group Management Association (MGMA) also came out strongly against the modifier 25 payment reduction policy.

Anthem to allow splitting E/M and procedure

Shortly after Independence BCBS implemented the modifier 25 policy, it released an online FAQ stating that providers are not allowed to circumvent the new rule by performing the E/M on one day and the minor procedure associated with the E/M on another day.

"We do not expect that you will modify your approach to delivering services in a way that will impact patient care or satisfaction," Independence states in its FAQ. "We will review and audit providers who ask patients to return for second visits."

Anthem has decided to not to follow Independence on this point, says Danielle Fife, CEO at Advanced ENT and Allergy, a 14-physician practice in Louisville, KY. Fife, who attended a meeting between Anthem officials and provider groups. At that meeting, a top Anthem official stated that the payer will allow practices to bill for an E/M visit and then bill for a related procedure on a separate day.

So far, Anthem is the only BCBS payer that has reversed course, at least partially, on the modifier 25 rule. As this issue of *The Business of Medicine* goes to press, multiple other payers have implemented the 50% cut to modifier 25 services, including AmeriHealth New Jersey, Regence Blue Shield Idaho, and Tufts Health Plan of Massachusetts.

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The Business of Medicine switches to quarterly format

Starting in February 2018, *The Business of Medicine* will switch from being a monthly newsletter to a more comprehensive newsletter that will be distributed quarterly. Any breaking news or more timely articles will be sent via email between quarterly distributions.

Our format will also change to replace the current PDF with HTML emails.

Taken together, these changes will allow us to better capture and deliver breaking news and analysis to you, our readers. The overall amount of content in each weekly distribution will change depending on the news cycle, but you can always look forward to comprehensive newsletters at key points in the year – such as the release of major proposed and final rules by CMS, for example.

We will continue to maintain an archive for *The Business of Medicine* at the DoctorsManagement website at https://www.doctors-management.com/dm-newsletter.

MEDICARE RULES

MIPS 2018 survival guide: Maximizing your score and bonus

The 2018 performance year for Medicare's Merit-based Incentive Payment System (MIPS) is well underway and it's time to look at how you can maximize your providers' MIPS score for a shot at the exceptional performance bonus payment, which will be *added* to the positive payment adjustment you receive in 2020 for full MIPS participation.

Remember: We looked at how to achieve the minimum MIPS score (15 points) required to avoid a negative adjustment in 2020 in last month's issue of *The Business of Medicine*. In this article, we will describe the benefits of hitting the exceptional performance threshold (70 points) and how to do so.

2018 MIPS score breakdown

The changes made to MIPS as part of the Quality Payment Program (QPP) final rule for 2018 include new ways to

score bonus points (for complex patients, small practices). We will discuss those bonuses later in this article. What hasn't changed is the point goal: You need a MIPS composite score (sometimes simply called the MIPS "final score") of **at least 70 points** to qualify for the exceptional performance bonus.

The highest possible MIPS score is 100 points and those providers or groups managing to reach 100 points will be guaranteed not only the maximum positive payment adjustment of 5% in 2020, they will also receive the highest exceptional performance bonus. The exceptional performance bonus comes from a $500 million pool of money set aside from the rest of the MIPS budget, which is designed to be neutral (those providers failing to meet the minimum threshold each year will get negative updates that help pay for the positive updates of the successful MIPS reporters).

Reaching the 70-point minimum for the exceptional performance threshold ensures at least a 0.5% positive payment boost on top of the maximum 5% positive update. The point threshold to receive the maximum 5% positive update will depend on how many providers choose to participate in MIPS for 2018 and on how well they do, but it is expected to be short of the 70-point mark for the exceptional performance bonus.

2018 MIPS performance categories

There are four MIPS categories: Quality, Advancing Care Information (ACI), Improvement Activities, and Cost. In 2018, the Quality performance category goes from accounting for 60% of your MIPS score to 50%, with the 10% difference going toward the Cost performance category (which was not scored in the 2017 performance year).

Tip: Don't be confused by the CMS usage of percentages for each category above. Because the highest possible MIPS score is 100, the denominator is effectively 100 which means each category's percentage weight represents the maximum number of points it can contribute to the score. For example, the Quality category is weighted at 50% which means even submitting half of the required Quality measures will yield 25 points and meet the minimum threshold (15 points).

Your best chance to hit or exceed a MIPS final score of 70 points requires performing well on Quality and ACI, the two biggest pieces of the MIPS pie in 2018. A full score for both categories would yield 75 points even with no points from the other categories.

Quality performance category

For this category, providers must report six Quality measures (many adopted from the Physician Quality Reporting System or PQRS), including at least one outcome measure or high priority measure. There are a total of 271 Quality measures available, including new specialty measure sets that are designed to better reflect the specific clinical conditions addressed by various specialists.

Small practices (defined as 15 or fewer providers for the purposes of this category) have an advantage; they don't have to report an additional hospital readmission Quality measure. For any Quality measure to count, it must be based on at least 20 patient encounters. All you can control is which Quality measures to report; CMS will score your performance on those measures and award you up to 10 points toward the Quality category score. The more measures you report, the more chances you have of maxing out your Quality category score (which accounts for up to 50 points of your MIPS final score).

ACI performance category

For this category, you must report base measures and performance measures. Base measures reflect fundamental EHR functionality such as the ability to issue electronic prescriptions. Performance measures span various categories and are based on the EHR Meaningful Use (MU) program measures from earlier years.

There are five base measures and 10 performance measures; the ACI category score is calculated using both. However, the base measures are mandatory and account for up to 50 points within the ACI category. The performance measures are optional and allow you to reach the maximum ACI category score of 100 points if you report enough of them. Achieving the maximum ACI category score of 100 points will yield 25 points toward your MIPS final score (because ACI is weighted at 25% of the MIPS final score).

Collect all the bonuses you can

One final piece of the MIPS puzzle to remember is that under the 2018 QPP final rule, CMS is handing out free

bonus points for treating complex patients and for small practices. Here's how they work.

- **Bonus points for improving from 2017.** CMS will award up to 10 bonus points toward the 2018 MIPS final score for all providers who demonstrate any improvement to either their Quality or Cost performance category score from 2017. Remember, the Cost category wasn't scored in 2017, but CMS did calculate it.

- **Bonus points for using the latest EHRs.** You get up an extra 10% bonus to your ACI category score for reporting at least 90 days of ACI measures using an EHR system that has the 2015 Certified EHR Technology (CEHRT) certification. Many systems still use the older, 2014 CEHRT certification, which CMS is allowing for MIPS reporting, but the bonus will only apply if your system as the 2015 certification.

- **New: Up to 5 points for complex patients.** You get up to 5 points toward your composite score. CMS will calculate this bonus automatically by crosswalking your patients' ICD-10 diagnoses to Hierarchical Condition Categories (HCC) to produce an average HCC risk score, which is then added to the dual eligible (patients eligible for Medicare and Medicaid) ratio and multiplying the result by 5. To maximize your chances of getting points for complex patients, make sure your providers select ICD-10 codes to the maximum level of specificity, and report any applicable secondary diagnoses to capture the full complexity of every patient visit.

- **New: 5 bonus points for small practices.** Like the complex patients bonus, the small practice bonus is calculated automatically by CMS. It's even better than the complex patients bonus however, because any practice with 15 or fewer MIPS-eligible providers will get the full 5 points (either individually or as a group depending on how they report). With the complex patients bonus, you won't know how many of the 5 possible points you'll earn until after the 2018 performance year is over.

All scores will be relative

One of the most difficult aspects of MIPS is that your payment adjustments will be affected by how the healthcare industry as a whole responds to MIPS every year. If many eligible providers choose to ignore MIPS or only offer minimal participation, those who do more in 2018, but still fall short of the 70-point exceptional performance threshold, will see a higher positive adjustment up to the maximum of 5% for 2020.

If many eligible providers overachieve on MIPS in 2018, and the number of providers with a final score of 70 or more is high, then even a score of 70 could yield only a small positive adjustment. Remember, the $500 million exceptional performance money must be shared between all providers who reach or exceed the 70-point threshold, though CMS has committed to a minimum of a 0.5% additional positive adjustment just for hitting 70 points (the $500 million will be distributed as positive Medicare payment adjustments rather than flat dollar amounts).

Thus doing more will always give you the best chance of more payments, but MIPS may reach a point where even significant participation will yield only minor positive adjustments. The program is still so new that participation data is scant.

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MedPAC recommends eliminating MIPS

A top Congressional advisory body has voted to recommend that Congress repeal the Merit-based Incentive Payment System (MIPS) and replace it with a simpler version that would not be mandatory like MIPS is for most providers who participate with Medicare.

The Medicare Payment Advisory Committee (MedPAC), an independent federal board whose mission is to advise Congress on the management of the Medicare program, voted 14-2 to make the recommendation. MedPAC, which was created in 1997, has no actual legislative power, but issues regular annual reports with recommendations to Congress on improving Medicare, which Congress can choose to act on (or not). In the past MedPAC has repeatedly recommended eliminating the Sustainable Growth Rate (SGR) formula and implementing delivery system reforms that would shift the industry from fee-for-service to pay-for-performance.

The MedPAC vote was criticized by some provider stakeholder groups on the grounds that, with MIPS well underway, many providers had invested significant time

and resources into participation, and that MedPAC's alternative proposal would not be consistent with Congress' legislative intention when it passed the law that created MIPS.

Anders Gilberg, vice president of government affairs for the Medical Group Management Association (MGMA), issued a statement opposing the move by MedPAC. While the MGMA acknowledges that MIPS can be "unduly burdensome," Anders said in a statement, the group also believes that MedPAC's vote asking Congress to repeal the program "fails to adequately address the problem and does not reflect the current value-based landscape."

The American Medical Association (AMA) also objected to MedPAC's Jan. 11 vote, arguing instead for reforms and changes to be made to MIPS as part of CMS' ongoing Quality Payment Program (QPP) rulemaking process.

MIPS is a key cog of the Medicare Access and CHIP Reauthorization Act (MACRA) that was passed with bipartisan support in 2015. While providers have complained about its reporting requirements, the lop-sided impact of its administrative burdens on small groups, and the rapid implementation time-table, most of the industry has focused on MIPS preparation and gradual reform of the program via QPP rulemaking.

MedPAC offers a 'redesigned' version of MIPS

Prior to the vote on recommending MIPS repeal, MedPAC published a June 2017 report in which it offered an alternative version of MIPS. This alternative, which MedPAC refers to as "a potential redesign of MIPS," would work by withholding a portion of all Medicare fee-for-service payments annually to fund a quality pool.

Medicare providers could then choose from one of the following actions:

1. **Do nothing** and lose the withheld money.
2. **Join or form an Advanced Alternative Payment Model** (A-APM) entity, after which they would receive the withheld money.
3. **Join a group of clinicians for performance measurement** by CMS and receive the withheld money, with a potential additional quality payment based on performance.
4. **Join a CMS-defined group treating a CMS-defined local population** for measurement and receive the withheld money, with a potential additional quality payment based on performance.

For the purposes of option #3 and #4, CMS would be doing all of the performance measurement via analysis of claims data and patient surveys, so no reporting actions would be required of any participating practices or providers (beyond simply submitting their decision to join either group), MedPAC states.

"Under this framework, clinicians could not be worse off by choosing to be measured as a group or local area member than if they made no election at all, that is, they could not lose more than their withhold," MedPAC writes in the report. "The concept is to adopt a broader, claims- and survey-calculated uniform measure set that assesses the overall performance of a health care delivery system and its clinicians."

MedPAC believes that MIPS, as currently constituted, "will not identify or appropriately reward high- and low-value clinicians" while simultaneously requiring "a massive reporting effort." Measuring large groups of clinicians on population-based outcomes would produce a more accurate picture, and is the design goal of MedPAC's proposed alternative.

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April 8-11	**AAPC National Conference 2018,** Orlando, FL – Shannon DeConda
April 14-18	**AAOE 2018 Annual Conference,** Orlando, FL – Sean Weiss

MedPAC can only recommend; Congress doesn't have to listen

An actual repeal of MIPS would require another act of Congress and support from the Trump administration. Seema Verma, the new CMS administrator appointed by President Trump, has voiced support for MIPS and pledged to simplify the reporting process while reducing its impact on smaller practices. It's not clear whether the MedPAC proposal will gain any momentum in Congress or support from the Trump White House.

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CMS unveils new, voluntary bundled payments program

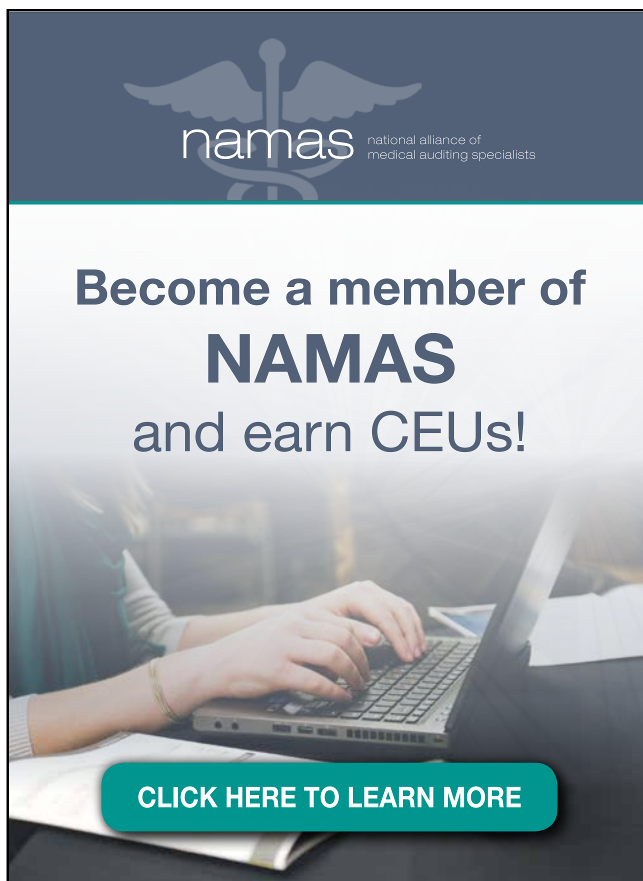
Shortly after announcing that it has eliminated several existing bundled payment initiatives, CMS has announced a new bundled payment model that focuses on voluntary participation. Dubbed "Bundled Payments for Care Improvement Advanced" (BPCI Advanced), the new program is based on the older BPCI program that it replaces.

CMS had previously cancelled its Episode Payment Models (EPM) program and scaled back procedure-specific programs such as the Comprehensive Care for Joint Replacement (CJR) model, but agency officials said the moves did not mean CMS was abandoning bundled payments. Instead, under the Trump administration, CMS wants such programs to be run on a more voluntary basis, as reported in the last issue of *The Business of Medicine*.

BPCI Advanced is just such a model: Participation is voluntary and the performance period begins on Oct. 1, 2018, running through Dec. 31, 2023. The deadline to apply for participation is March 12, 2018.

Below are a list of highlights for BPCI Advanced with an emphasis on its impact to practices:

- **Acute care hospitals and physician group practices may participate as Conveners or Non-conveners.** Much



like in the original BPCI program, conveners are the episode initiators, responsible assuming financial risk episode costs and for organizing downstream entities to coordinate resource use and reduce costs. Non-conveners are all the other entities that participate but assume financial risk for themselves only.

- **Qualifies as an Advanced Alternative Payment Model (A-APM).** CMS has already declared BPCI Advanced to meet its criteria for an A-APM, which means participating groups will be exempt from participating in the Merit-based Incentive Payment System (MIPS) while earning flat 5% positive Medicare payment adjustments. **Note:** This will begin with the 2019 MIPS performance year.

- **All participants bear downside financial risk.** Unlike the original BPCI program, BPCI requires immediate assumption of downside financial risk by all participating entities at the start of the performance period. The payment model is otherwise similar to BPCI, with fee-for-service payments made normally before being reconciled retrospectively against a pre-determined target cost for each type of clinical episode.

- **Inpatient episodes for multiple specialties.** Inpatient episodes for BPCI Advanced span multiple specialties and include double joint replacement procedures for the lower extremity, acute myocardial infarction, cardiac arrhythmia, cellulitis, bronchitis and asthma, coronary artery bypass graft, femur, hip, and pelvic fractures, gastrointestinal obstruction, major bowel procedures, renal failure, sepsis, stroke, and urinary tract infections.

- **Outpatient clinical episodes for multiple specialties.** These include percutaneous coronary intervention, cardiac defibrillators, and back & neck procedures except spinal fusion.

Applying for BPCI Advanced

CMS has already launched its online application portal for BPCI Advanced which you can visit at https://app1.innovation.cms.gov/bpciadvancedapp. You have until March 12 to apply and CMS is expected to announce selected applicants beginning May 2018.