From: **Courtney Flookes** courtney@anco.org
Subject:
Date: February 13, 2020 at 12:13 PM
To:

CF

Like

E-Reimbursement Newsletter

Join Our List

It's easy to join our mailing list! Just send your email address by text message: Text CODEMISTRESS to 22828 to get started. Message and data rates may apply. Or, just click Join Our Mailing List! below!!

Issue: #2 Volume 30 February 2020

Dear Jose Luis,

Happy February, Everybody! **True to our word, this is the second monthly edition of this newsletter. We were so pleased to get such very positive feedback on our January newsletter. We also had a number of really good coding and billing questions. And, we only have one thing to say about that: KEEP THEM COMING!!! We based one of our articles on questions we had regarding "incident to"...sooo, if you have urgent questions, please e-mail me.**

Our first article this month is about Part C (Medicare Advantage) and Part D (Prescription Drug Coverage). Early in the year, CMS announces their Proposed Rule. **Not a lot is happening, but still, more benefits are being offered under Medicare Advantage as opposed to regular Medicare**.

As mentioned, we have a very cool "Incident to" article. It aims to answer all of your most pressing questions about 'incident to'. These include what to do about Nurse Practitioners and Physician Assistants in the 'incident to' scenario versus billing under their own billing number. Bear in mind that 'incident to' rules are for office-based Medicare patients only.

Are you billing for Principal Care Management yet? Do you think you should be? Well, we have an article about it, in case you are interested. This code is tailor-made for specialists and we believe that lots of cancer patients will qualify. **The one thing you should find out for yourself is whether commercial payers in your area will also reimburse for these codes.**

Finally, we have follow up on our article regarding TPE audits. One thing we know for sure is that hundreds of thousands of dollars are being held in drug claims by Novitas. Why? Many of these audits are pre-payment and the ENTIRE claim is being held not just E/M.

Also, check out our Sound Bytes---you'll be glad you did.

Da' Mistress

Part C and Part D Proposed Rules for 2021

On February 5, 2020, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule and the second part of the Advanced

Notice, which would make policy and technical changes to the Medicare Part C and D programs, including the Medicare Advantage (MA) Program, the Medicare Prescription Drug Benefit Program, the Medicaid Program, the Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly. Unlike in prior years, the agency did not release a separate call letter. But, it will separately issue bidding instructions for plans. In this rule, CMS proposes the following-- increase the portion of a health plan's risk score that is based on encounter data, enable plans to meet some network adequacy requirements through telehealth, and provide plans with greater flexibility to tailor benefit packages for the chronically ill, among other Parts C and D changes. **CMS projects that these changes will result in an increase in MA plan revenue of 0.93%**.

Some of the Major Provisions include the following:

- Risk Adjustment and Encounter Data--CMS proposes to continue its planned departure from relying on diagnosis information (HCCs) submitted by health plans to diagnoses collected through encounter data for purposes of calculating risk scores that impact plan payment. CMS began this transition in 2015, calculating risk scores based in part on plan-submitted information through the Risk Adjustment Processing System (RAPS) (90%) and encounter data (10%). For plan year 2020, CMS balanced the risk score based on these types of data (50% RAPS/50% encounter data). For 2021, CMS proposes to increase the proportion based on encounter data to 75%.
- Medicare Advantage Coding Pattern Adjustment--Each year, as required by law, CMS makes an adjustment to plan payments to reflect differences in diagnosis coding between MA organizations and FFS providers. For CY 2021, CMS proposes to apply a coding pattern adjustment of 5.90 percent, which is also the minimum adjustment for coding intensity required by the statute
- Network Adequacy and Telehealth--CMS proposes several changes to 'network adequacy' rules for MA plans to address medical access challenges in rural areas. CMS proposes to allow health plans to use telehealth to meet certain access requirements for some specialties, including psychiatry, neurology and cardiology, meaning not Oncology. CMS expects this change also could increase plan choices for beneficiaries in rural areas and facilitate provider adoption of new health care technologies. Too bad they never want to expand telehealth in Part B.
- Kidney Organ Acquisition Costs--Federal law now permits all individuals with end stage renal disease (ESRD) to enroll in Medicare Advantage ("MA") plans, effective January 1, 2021. The law also stipulates that MA plans no longer will be responsible for organ acquisition costs for kidney transplants. Said costs will be excluded from MA benchmarks and carved out separately under the Medicare fee-for-service program. This provision is required by law, so this is not really a proposal. It's the real thing.
- Supplemental Benefits for the Chronically Ill-- Federal law already permits MA plans to offer certain supplemental benefits to subsets of beneficiaries who meet certain criteria as chronically ill. These supplemental benefits do not have to be primarily health-related but do have to provide a reasonable expectation of improving or maintaining the health status or overall function of the enrollee. CMS proposes changes to this policy to provide plans with more flexibility in identifying who may qualify for this broader range of supplemental benefits that are not offered to all plan participants.
- Star Ratings-- The agency proposes several changes to the "Star" (Quality) Ratings program for MA and Part D plans, including increasing the effect that patient experience and access measures have on a plan's Star Rating. Notably, the agency solicits feedback on a measure concept related to prior authorization (which ought to be salty!!!), plus, CMS said it is seeking comments on whether to develop generic and biosimilar utilization metrics that would be used to calculate a Part D plans' star rating.
- Part D Program Out-of Pocket Costs--If finalized, the rule would require Part D plans to offer real-time benefit tools beginning

January 1, 2022, providing consumers with out-of-pocket cost data and allowing them to use that data to shop for lower-cost alternative therapies. Additionally, **CMS in the advanced notice said it is looking to encourage plans to guide beneficiaries toward using more generic and biosimilar drugs**, which usually cost less than their branded reference products.

- Part D Tiers--The proposed rule also would establish a second, **"preferred" specialty tier with a lower cost-sharing amount, providing Part D plans with more leverage when negotiating with drug companies.**
- Substance Abuse--Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act expands drug management and medication therapy management programs and requires Part D plans to provide education on opioid risks, alternative pain treatments and safe disposal.

To review the Proposed Rule, click here. For those of you who would like to avoid dying of boredom, CMS also issued a Fact Sheet for this guidance.

"Incident To" Blues

We have published many, many articles on this topic. However, with the advent of so many Advanced Practitioners in the world of office-based Oncology and an influx of Oncology Newbies, we thought we would review some of the Frequently-Asked Questions we get from folks out there in the Cancer Space.

- Question: Who does 'incident to' apply to? Answer: *It applies to Physician Offices billing Part B Medicare. "Incident to" is a Part B Coverage Rule and does not apply to hospitals. Hospitals have their own set of arcane supervision rules.*
- Question: What does "incident to" really mean? Answer: *In brief, "Incident to" is a set of billing instructions that outline how physicians and Non-Physician Practitioners (Advanced Practitioners hereafter called "NPPs") may bill for staff services and items/drugs under their National Provider ID. These rules say, among other things, that the physician must initiate, supervise, and be present in the office suite throughout the 'incident to' service or drug.*
- Question: What 'incident to' services can an NPP bill under their own number? Answer: *Any service that they certified to perform under your State's Scope of Services. In order for a service to qualify as incident-to billing by an NPP, the patient must be an established patient with an established diagnosis or condition.*
- Question: So, does that mean an NPP cannot bill for a New Patient? Answer: *They cannot bill a new patient or problem as an 'incident to' servic*e. Theoretically, *an NPP can bill a New Patient visit under their own NPI. However, in the long term, the physician must initiate treatment for the patient to EVER be billed under their number. And they should for very good reasons. First, if the NPP initiates treatment, the NPP will have to bill it under their own number and that means they will get 85% reimbursement for all services (not drugs or labs) that they bill as the 'incident to' provider. Secondly, all services from the first visit onward will have to be billed under their number at a reduced rate. Therefore, most practices always have the physicians see new patients.*
- Question: So, if a patient develops a new problem, should we make the doctor see the patient or can it be billed 'incident to' by an NPP? Answer: *Experts disagree on this, but it may depend on the problem. If it is a problem that has been anticipated in the Care Plan, like a chemo side effect, it likely can be billed 'incident to'. If it is a brand spanking new problem that needs an initiation of care, then it is the same situation as with a New Patient.*
- Question: When a NPP sees a patient in the hospital and the doctor is in the building, can we bill 'incident to'? Answer: *Nope. If a physician assistant (PA) sees a patient in the hospital and the*

physician does not have a face-to-face encounter and/or a substantive portion of the E/M service by the doctor is not documented in the medical record, then the service may only be billed under the NPP's NPI.

- Question: What happens when a service, for example, chemotherapy is started when the physician and NPP is in the office, but then the physician leaves mid treatment? Which NPI should we use? Answer: *Since the physician left the office mid-treatment, the supervision requirements were not met for direct supervision. So, the service would be submitted under the NPP's NPI since he/she was there during the entire treatment.*
- Question: What are the Medicare signature requirements for 'incident to' services? Answer: *Remember that signature requirements are also subject to State Law. But, there is a handy, dandy chart on Palmetto's web site* that you can use for Medicare guidelines.
- Question: The 'incident to' Rules state that the physician must actively participate in the patient's ongoing care. Exactly what does that mean? Answer: *The exact requirement is usually defined by the state licensure rules for physician supervision of NPPs. Tip: We know that many of you see non-Oncology patients needing infusions. These are also billed 'incident to' a physician or NPP. This means they must be seen periodically as well.*
- Question: Can an NPP bill incident to another NPP's service? Answer: Nope. NPPs can only supervise other staff.
- Question: What about counseling? Can an NPP bill that 'incident to'? Answer: *Physicians cannot use incident-to billing when more than 50 percent of the service is counseling or coordination of care billed on the basis of time spent with the patient. For that, only "face time"with the physician qualifies. NPPs can bill for counseling or coordination of care in their own names at 85 percent of the Medicare fee schedule amount.*

For more information, see Internet only Manuals

- Incident To: Pub. 100-02, Chapter 15, § 60.1. B, 60.2
- Split/Shared E/M Services: Pub. 100-04, Chapter 12, § 30.6.1 B and 30.6.13H

Principal Care Management: Are You Billing It?

Starting with dates of service from January 1 onward, CMS will allow billing for Principal Care Management for Medicare patients. Check with private payers in your area to see if they are paying for this. This service will provide additional care to patients with a single, serious, chronic condition. The concept of Principal Care Management ("PCM") services was created to fill a gap left by the Chronic Care Management ("CCM") CPT codes that were established by the Center for Medicare & Medicaid Services (CMS) in 2015. The CCM codes require that a patient have a diagnosis of at least two chronic conditions in order for care management services to be reimbursable by Medicare.

Again, this is a G-code, so please see if this will be reimbursed by commercial and/or secondary payers.

Under the new PCM codes, specialists may now be reimbursed for providing their patients with care management services that are more targeted within their own particular area of specialty. More generalized care management services may continue to be provided by a patient's primary care physician as appropriate.

To qualify for PCM, a patient must have a diagnosis expected to last between three months and a year, or until the death of the patient, may have led to a recent hospitalization, and/or place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

PCM closely mimics Chronic Care Management (CCM) requirements, and may not be billed concurrently with CCM, behavioral health integration

may not be billed concurrently with CCM, behavioral health integration services, monthly capitated ESRD payments and during a surgical global period. **Like CCM, a verbal consent is required and must be documented in the patient's chart.**

A difference is that PCM has a time requirement of 30 minutes a month, as opposed to CCM's 20-minute requirement. **The great benefit to PCM is to provide management for patients with one chronic illness to help navigate and stabilize the condition and the possible prevention of an exacerbation or secondary diagnosis to arise**.

CMS has approved two new G codes to support PCM for CY 2020.

- **HCPCS G2064 ($92.03 Office/ $78.68 Hospital on average across the US)** Comprehensive care management services for a single high-risk disease, e.g. Principal Care Management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements
    - One complex chronic condition lasting at least 3 months, which is the focus of the care plan;
    - The condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization;
    - The condition requires development or revision of disease-specific care plan;
    - The condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities

- **HCPCS G2065 ($39.70 for All on average across the US)**: Comprehensive care management for a single high-risk disease services [sic], e.g. Principal Care Management, at least 30 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month with the following elements
    - One complex chronic condition lasting at least 3 months, which is the focus of the care plan;
    - The condition is of sufficient severity to place a patient at risk of hospitalization or have been cause [sic] of a recent hospitalization;
    - The condition requires development or revision of a disease-specific care plan;
    - The condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities

Caveats to billing of these codes include the following:

- Billing Practitioner: **The billing practitioner for both codes must be a physician or other qualified health care practitioner ("NPP").** Though it is not a stated requirement, the Centers for Medicare and Medicaid Services ("CMS") states in the Final Rule that they expect most PCM services will be provided and billed by **specialists focused on managing patients with a particular complex chronic condition that requires substantial care management**. According to the Final Rule, the expected outcome of the provision of PCM services is for the patient's condition to be stabilized by the treating specialist clinician so that overall care can be returned to the patient's primary care practitioner at some point. If the patient has only one complex condition that is overseen by the primary care provider, then that PCP provider will also be able to bill for PCM.

- Qualifying Condition: The Final Rule does not enumerate specific qualifying conditions or contain ICD-10 codes for purposes of PCM, **but states that PCM services will typically be triggered by exacerbation of a qualifying condition such that disease-specific care is warranted**. This is the 'trigger' for PCM. If your

patient is documented as 'getting along fine'--that may restrict the use of this code.

- Number of Physician/NPP Claims/Month: The Final Rule implies that it is possible for a **patient to receive PCM services from multiple specialists for multiple different conditions simultaneously** (e.g. a cancer doc for the cancer, cardiologist for arrhythmia and an endocrinologist for diabetes); however PCM services should not be furnished or billed at the same time as:
    - Other care management services by the same practitioner for the same beneficiary; nor
    - Interprofessional consultations for the same condition by the same practitioner for the same patient.

- Management of Care/Care Transitions: Ongoing communication and care coordination between all practitioners/facilities furnishing care to the beneficiary must be documented by the billing practitioner in the patient's medical record. This should be counted toward the 30 minutes per month.

- Supervision: HCPCS code G2065 allows for PCM services to be provided by clinical staff under supervision of the billing physician or NPP. These services can be provided **under General Supervision, meaning the billing practitioner need not be co-located in the same office as the clinical staff member providing the services, but must be available to the clinical staff member when necessary**.

- Initiating Visit: For new patients and patients not seen within a year prior to initiation of PCM, **the billing practitioner must conduct an initiating visit with the patient** in order to educate the patient on PCM and obtain the patient's informed consent. This visit is can be an annual wellness visit (AWV) or other separately billable visit.

- Types of Consent: The billing practitioner must obtain the patient's consent and clearly document that consent in the patient's medical record. Consent can be obtained verbally, but the patient should be educated as to:
    - That only one practitioner can bill per month for an indicated, specific chronic condition;
    - The fact that the patient has the right to stop the services at the end of any service period; and
    - Any cost-sharing may apply.

- Care Plan Required: Under Chronic Care Management (CCM), practitioners are required to develop a comprehensive care plan in order to bill relevant CCM codes. **For PCM, CMS set forth in the Final Rule that billing practitioners should instead develop a disease-specific care plan for patients receiving PCM services**, focusing only on the disease or condition at issue.

- Reporting Monthly Elements of PCM: The Final Rule also states that all elements **do not necessarily have to apply every month**in order for the codes to be billed as long as the record evidences that care coordination for a single condition is reasonable and medically necessary for the patient's condition.

For more information, see this article.

Update on TPE Audits

Remember last month when we told you all about TPE audits? Just to briefly review: these are educational (not Fraud) audits and are called "Targeted Probe and Educate"(TPE) audits, are (among other topics) aimed at looking at visits billed (with Modifier -25) with chemotherapy or other drug administration. COA and I asked for e-mails from folk who are subject to the to the audit and many people responded, Here is what we have learned:

- 25 practices responded;
- This audit is only being done by Novitas right now;
- Most audits are PRE-PAYMENT, meaning that all monies on the claim (not just the E/M are being held);
- Novitas just wants the E/M notes;
- Most practices have $6 figures of drug money being held;
- 35-40 records requested;
- 45 days to get records in;
- Novitas has 30 days to respond; and,
- No results have been reported yet.

Novitas has published a "Tips for Modifier 25" that may give some clues as to how they think about visits with chemo, although this publication is mostly aimed at surgery. If you have been tapped for this audit, please email me if you would like to join our group.

Sound Bytes

Are you charging your patients for copies of their records?? You should be. Well, the 2016 HIPAA guidance on limits to charging patients has been lifted when it comes to patient information charged to THIRD PARTIES. **Fees remain the same when the patient wants their own information. HIPAA-covered entities and business associates were directed to charge fees based on calculating the labor cost it takes to fulfill a record request or by charging a flat fee capped at $6.50 per request. This flat fee has been changed when your patient requests that their information is sent elsewhere. For more information, see the Modern Healthcare article...New surprise billing legislation from the House Ways & Means Committee is expected to leave out a benchmark payment mechanism** that has proved a nonstarter for hospitals and specialty physician groups, according to sources familiar with the draft legislation.**Ways & Means Chair Richard Neal (D-Mass.) said Wednesday that he expects his committee's bill to be released by last Friday, ahead of a February 12 target markup date.** Patients would be protected from balance billing under the draft legislation, and if a provider and insurer cannot agree on the remaining payment for certain medical bills, they will enter a negotiation period, said sources familiar with the draft legislation. If they remain at an impasse, the parties could then go to a third-party, baseball-style arbitration process where the loser pays the administrative cost**. This legislation is aimed at large groups and hospitals, according to Modern Healthcare...Remember when Medicaids could no longer fund patients at the end of the year? Expect that this might happen again. The Trump administration unveiled a plan a week or two ago that would dramatically revamp Medicaid by allowing states to opt out of part of the current federal funding program and instead seek a fixed payment each year in exchange for gaining unprecedented flexibility over the program.** Medicaid, a federal-state health program that covers 1 in 5 Americans, has been an open-ended entitlement since its beginning in 1965. That means the amount of money provided by the federal government grows with a rise in enrollment and health costs. **The administration said the new program would allow states to offer patients more benefits while controlling government spending. States would not be required to switch to the new model. It will be optional, and states interested in it would have to seek authority from the federal government. Trump administration's new Medicaid block grant plan would let states exclude coverage of some prescription drugs while still receiving the program's guaranteed drug rebates.** That is not sitting well with drugmakers who have argued that the large discounts they provide to Medicaid is part of a trade-off in which states must cover essentially all FDA-approved medicines. Under traditional Medicaid, brand-name drugmakers must provide states a 23 percent rebate or the best price available on the U.S market, whichever is lower...**Oncology practices participating in the Centers for Medicare & Medicaid Innovation's Oncology Care Model (OCM) are willing to take on two-sided risk, according to the results of a survey conducted by**

the Community Oncology Alliance (COA). The results suggest that **oncology practices are confident they can succeed in delivering high-quality and cost-effective cancer care as the health care system undergoes a paradigm shift from fee-for-service to value-based care**.COA surveyed OCM participants following the Center for Medicare & Medicaid Innovation (CMMI) December 3, 2019 deadline, by which practices had to decide whether to continue in the OCM program, as well as to commit to two-sided risk going forward. A total of 68 OCM practices responded to the 15-question survey which was available online between December 4-20, 2019. The survey results found:

- 47.1% (32 practices) opted to remain in the OCM with one-sided risk
- 36.8% (25 practices) chose to remain and enter into two-sided risk
- 32.4% (22 of the 25 practices) selected two-sided risk and had not received a single performance-based payment
- 16% (11 practices) said they were dropping out of the OCM
- Ten of the 11 practices leaving the OCM had not received a performance-based payment over the preceding four performance periods

Anthem more than doubled its fourth-quarter 2019 net income in large part due to the launch of its pharmacy benefit manager IngenioRx, which now serves more than 15 million people. But the insurer also grew its membership organically: it recorded **Medicare Advantage enrollment growth of 21% year over year**, while Medicaid membership grew 8.2%. Anthem's fourth-quarter medical loss ratio, which represents the amount of premiums spent on medical care, came in higher than investors' expectations, but Anthem blamed the high MLR on the one-year waiver of the health insurance fee. We say: "Sure, Anthem"...**Healthcare administrative and bureaucracy costs in the U.S. reached $812 billion in 2017--a whopping four times higher than Canada, according to a new study by Harvard researchers in the *Annals of Internal Medicine*.** And Medicare for all could be the way to achieve huge savings.In fact, bringing down U.S. paperwork costs to Canada's levels would save more than $600 billion. In 2017, **the cost of healthcare bureaucracy was 3.42% of total expenditures for doctor visits, hospitals, long-term care and health insurance**...Recently, the US Department of Justice announced that it has reached an agreement with Patient Services, Inc., ("PSI"), a not-for-profit foundation in Midlothian, Virginia, **to resolve alleged False Claims Act ("FCA") violations acted as a conduit and provided kickbacks to Medicare patients by paying patients' copayments. PSI agreed to pay $3 million to resolve the suit, and to enter into a three-year Integrity Agreement.** The DOJ alleged that PSI paid kickbacks to Medicare patients taking drugs manufactured by several companies. The DOJ further alleged that PSI worked with the companies to "design and operate certain funds that funneled money from the companies to patients," and further that the "schemes minimized the possibility that the companies' contributions to the funds would go to patients taking competing drugs ... and undermined the nature of these contributions as bona fide donations.

Remember this newsletter is a summary of regulations for Medical Oncology. It is a preliminary reading of complex coding and billing material. There may be typos and misinterpretations. Providers are responsible for the information on every claim. Payers have differing rules and interpretations thereof. Reading this newsletter does not substitute for understanding regulations and verifying the validity of every claim. This information is time-sensitive and is subject to constant change. onPoint Oncology Incorporated and/or its partners/founders accepts no liability for any statements or articles herein. Statistics given herein are valid for the date of report only.

CPT codes are owned and trademarked by the American Medical Association. All Rights Reserved.

Sincerely,

Da' Mistress of All She Surveys

Sincerely,

Roberta Buell
onPoint Oncology LLC

onPoint Oncology Inc, 3006 Pine Trails Circle, Hudson, OH 44236

SafeUnsubscribe™ director@anco.org
bbuell@onpointoncology.com | Update Profile | About our service provider
Sent by bobbibuell1@yahoo.com in collaboration with

Constant Contact
Try email marketing for free today!

ANCO
Educating and Empowering the Northern California Cancer Community

José Luis González, *Executive Director*
Courtney G. Flookes, *Executive Director*
Post Office Box 2954
Alameda, California 94501
415-472-3960 | www.anco.org