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All Medicare fees are par, office, national unless otherwise noted.

Compliance

Look at strength of your case before accepting Medicare's appeals time-saving suggestions

Some alternatives in the Medicare appeals process may save you time and money once you get to the third level — but if you're not bringing a strong enough case, those savings may vanish.

In January, CMS changed the way Medicare appeals are administered and conducted by the Office of Medicare Hearings and Appeals (OMHA) (*PBN blog 1/13/17*). Most of the changes, such as limiting the number of entities that can take part in appeals hearings to one and letting adjudicators issue fully

*(see **Appeals**, p. 4)*

Regulatory update

Obamacare subsidies cut as insurance markets face added volatility

Some of your patients may face significant rises in insurance premiums, and perhaps a loss of coverage, after HHS cut off subsidies that help low-income individuals.

On Oct. 12, following consultation with the U.S. Attorney General, HHS and CMS stated in a joint announcement that they would stop funding cost-sharing reduction (CSR) payments, which a portion of individuals who obtain insurance through federal or state health insurance exchanges use to help afford coverage, immediately.

*(see **Subsidies**, p. 7)*

Physician payments

2 tips for busy practices to keep up with Medicare's reimbursement rules

You don't need TIA — total information awareness — to avoid money-draining changes to Medicare's reimbursement rules. However, a couple of recently submitted subscriber questions demonstrate that you need QIA — quarterly information awareness — and to know how to read Medicare's files to take advantage of new revenue opportunities and succeed during audits.

Check the latest RVU file updates for changes

Question: *We recently submitted a claim for* ***36473*** *(Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated) with modifier* ***50*** *(Bilateral procedure) and received a denial from Medicare. The 2017 CMS physician fee schedule relative value unit (RVU) file lists the code with a bilateral indicator of "0" (150% payment adjustment does not apply). However, an online coding tool we use states the modifier is allowed with this procedure. Can you explain the discrepancy?*

Answer: It appears that the coding tool contains the current RVU data. CMS changed the bilateral modifier indicator for 36473 from "0" to "1" (150% payment adjustment does apply) in the fourth quarter update to the RVU file. CMS announced the update in Change Request 10222 issued Aug 25.

The change request contains two dates you should note. The implementation date is Oct. 2. That was your Medicare administrative contractor's (MAC's) deadline for updating its system with the new information. More importantly, the effective date is Jan. 1. Claims for the endovenous ablation therapy submitted with modifier 50 after Jan. 1 should be reimbursed. However, you will need to resubmit the claim to get paid.

"Medicare contractors need not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors shall adjust claims brought to their attention," CMS states in the change request.

Watch fifth column activity in CCI edits file

Question: *During an audit, the auditor questioned the use of* ***77003*** *(Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures [epidural or subarachnoid] [List separately in addition to code for primary procedure]) with* ***64510*** *(Injection, anesthetic agent; stellate ganglion [cervical sympathetic]).*

According to the auditor, an edit bundles the imaging service into the injection. I found a bundling edit for the pair in the Correct Coding Initiative (CCI) file. However,

Subscriber information

Have questions on a story? Call toll-free **1-855-CALL-DH1**

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I use an online coding tool that states there is no edit. Which source is correct?

Answer: Take a second look at the edit pair 64510/77003 in the CCI file. You'll see that the fourth column contains the number 20100401, which represents the edit's April 1, 2010, effective date. Next, look at the fifth column for the row. The number 20161231 represents the edit's deletion date: Dec. 31, 2016.

It is important to check the fifth column because the CCI file retains deleted edit pairs. A date in the fifth column indicates that edit has been deactivated.

CCI PTP edit files are released once a quarter and the files are typically available about a month before the new edits go into effect. You probably don't want to scan the entire edit file: The complete set of PTP edits contain about 200,000 entries stretched over four Excel files. However, you should check CMS' summary of CCI edits. The files contain the new, deleted and changed edit pairs for the quarter. Save these files and the files for updates to medically unlikely edits to your computer so you'll have it in the event of an audit. — *Julia Kyles, CPC (jkyles@decisionhealth.com)*

Resources:

- CMS 100-04, Change Request 10222: *www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3838CP.pdf*
- Physician fee schedule relative value files: *www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html*
- National correct coding initiative files: *www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html*

Quality Payment Program

Proposal to include Part B drug charges under MIPS scoring elicits concerns

Providers who routinely administer expensive prescription drugs that are billable to Medicare should keep a close eye on the pending Quality Payment Program (QPP) final rule — your future revenue may shrink or rise more dramatically than previously anticipated.

Buried in the extensive QPP proposed rule, a brief section about Part B payments that would be subject to a reimbursement adjustment under the merit-based incentive payment system (MIPS) in 2018 suggests adding Part B-covered drugs to the overall tally.

"For Part B items and services furnished by a MIPS-eligible clinician, such as purchasing and administering Part B drugs that are billed by the MIPS-eligible clinician, such items and services may be subject to MIPS adjustment based on the MIPS-eligible clinician's performance during the applicable performance period," states the proposed rule (*PBN 6/26/17*).

With the proposal, CMS is "seeking to change the calculation of the MIPS payment," says Richard Kane, senior director of health care consultancy Avalere in Washington, D.C. With no indication of including the cost of Part B drugs in MIPS-adjusted revenue in the 2017 proposed or final rules, CMS "caught some stakeholders by surprise" with the 2018 proposal, adds Kane.

Some practices may bill thousands, or even millions, of dollars in drugs that are payable under Part B, which would place them at risk of significant cash fluctuations, says Robin Zon, M.D., a medical oncologist with Michiana Hematology Oncology in Mishawaka, Ind., and chair of the American Society of Clinical Oncology's (ASCO) government relations committee.

Zon says that "practices never expected" that Part B drug charges would be included in the MIPS adjustment and that the proposed policy may "really [put] at risk small, rural practices" that operate with little profit margin.

In 2020, when the positive or negative payment adjustments linked to the 2018 performance year come to fruition, practices participating in MIPS are expected to see up to a 5% adjustment, depending on their performance. For example, under current MIPS rules, if a rheumatology practice receives $1 million in Medicare charges it could lose up to $50,000 if taxed with the full 5% cut. In 2018, if the proposal stands and the same rheumatology practice receives $1 million in Medicare charges and also bills Medicare for $1 million in Part B drugs, it could lose up to $100,000.

For practices that score poorly on MIPS or don't report at all, the negative adjustment of up to 5% on all Medicare charges could turn into a big drain on resources, and some projections show that 5% may be only the tip of the iceberg.

Penalties may rise more than intended

Complicating matters further, some estimates propose that the cost drainage facing some practices would be far worse than a 5% hit. In a comment letter submitted to CMS, ASCO projects that actual payment losses may total as high as 23% of a practice's revenue, resulting in a situation that would "seriously distort the magnitude of the MIPS penalty and bonuses," states the letter.

The reason behind the higher number comes down to how most practices operate, says Zorn. In most cases, a practice "pays up front for drugs and later bills the insurance company," she says. The different dollar amounts at play might be large, but the practice generally isn't seeing much in return on, say, a $200,000 drug, notes Jim Tate, president and founder of MIPS Consulting and EMR Advocate in Asheville, N.C.

"There's a lot of money involved in [Part B drugs]," says Tate. "I'm not saying there's a lot of revenue."

Tate's view jibes with ASCO's stated analysis and underscores the slippery slope of levying penalties on money that is not tied to physician revenue, according to experts. "Applying this adjustment to the large dollar amounts associated with the cost of drugs — the huge majority of which is just a 'pass through' for practices — results in penalties and bonuses far beyond anything ever intended with the creation of this program," states the ASCO letter.

A separate review that Kane undertook at Avalere found that the drug proposal could result in negative payment adjustments as high as 29% by performance year 2020. In that review, ophthalmologists, hematologists/oncologists and rheumatologists would be on the hook for an outsize portion of payment adjustments, while groups that do not provide many, if any, Part B-covered drugs, such as internal medicine providers, would not face as much risk.

Weighing the ramifications

Numerous specialty groups report millions of dollars per year for a range of high-dollar drugs, such as infusion drugs, chemotherapy agents and spinal injections (*see benchmark, p. 5*). Some practices, such as rheumatology groups, might not find it fiscally feasible to provide drug therapy to their patients under the proposed policy, warns Tate. "If they start losing money on those medications, then they'll stop doing drug infusions," he says.

Several professional groups, including ASCO and the Oncology Nursing Society (ONS), have called for CMS to do away with the Part B drug inclusion. While practices that perform well under MIPS could see a significant upward adjustment — of the same level as the potential cut — industry groups fear that the drug policy would do more harm than good. "The impact of a negative MIPS adjustment could permanently close the doors of small and rural oncology practices," states the letter that ONS submitted to CMS.

The QPP final rule, which is currently under review at the Office of Management and Budget, is expected to come out no later than early November. Should the proposal get finalized as written, specialty groups will have little recourse to the MIPS penalty-and-incentive structure because the other option — advanced alternative payment models (APMs) — offers few alternatives to specialty providers, says Kane. — *Richard Scott (rscott@decisionhealth.com)*

Resources:

- QPP proposed rule: *www.federalregister.gov/documents/2017/06/30/2017-13010/medicare-program-cy-2018-updates-to-the-quality-payment-program*
- Avalere study: *http://avalere.com/expertise/life-sciences/insights/cms-proposal-for-new-medicare-payment-system-could-lead-to-large-payment-va*

Appeals

(continued from p. 1)

favorable decisions without a hearing or even prior notice to the appellants, are "tweaks" to speed up proceedings and help cut through OMHA's enormous backlog of cases, says Andrew Selesnick of the Buchalter law firm in Los Angeles.

Alternative to ALJs

But a major change in the rule is the admission of attorney adjudicators (AAs) to deal with some cases normally handled by administrative law judges (ALJs) at the third level of appeal, after the provider loses at the first (redetermination) and second (reconsideration) levels. AAs are licensed attorneys who can review a case, assess facts and make decisions. But they can't conduct hearings or perform certain other ALJ functions, such as calling in an OMHA expert.

CMS says the change "could redirect approximately 24,500 appeals per year to attorney adjudicators, who would be able to process these appeals at a lower

(continued on p. 6)

Benchmark of the week

Specialists who claimed millions in drug payments could face fluctuating rates

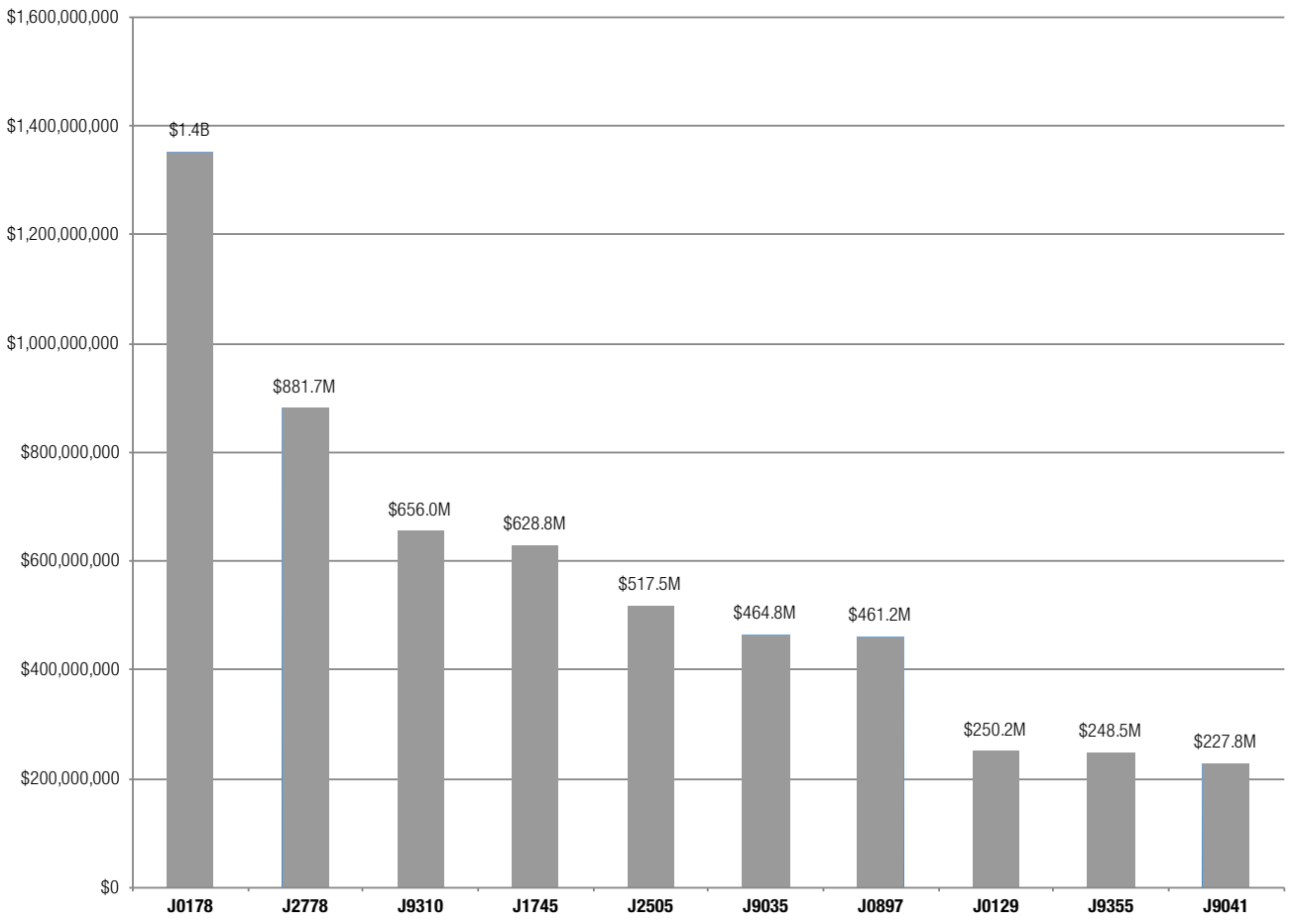
Do a quick calculation on your drug-code billing; some groups that bill a lot of Part B-covered drugs could see wild swings in their Medicare payment rates under the merit-based incentive payment system (MIPS) in future years (*see story, p. 3*).

The top 10 drug codes that practices reported most often in 2015 accounted for approximately $5.7 billion in payments from Medicare, according to claims data. Because a MIPS proposal would wrap up Part B drug payments into a provider's total amount of revenue that's subject to a penalty or incentive payment, the large drug payments could lead to substantial losses or gains — starting at 5% and increasing from there — on a practice's bottom-line numbers.

In addition to the chart below detailing the 10 most-reported drug codes in 2015, a second chart (*see online*) breaks out the five codes with the largest payment amounts in 2015 and shows the physician specialty tied to the largest portion of those dollar figures. Ophthalmologists, who reported a significant number of **J0178** (Injection, aflibercept, 1 mg) and **J2278** (Injection, ziconotide, 1 microgram) claims, have a lot at stake under the proposed MIPS rule, as do hematologists/oncologists, who received millions in payment for **J9310** (Injection, rituximab, 100 mg) and **J2505** (Injection, pegfilgrastim, 6 mg).

Specialists in medical oncology also reported a substantial number of J9310 and J2505 claims. Rheumatology providers returned the most in payments for code **J1745** (Injection, infliximab, excludes biosimilar, 10 mg), with about $450 million in reimbursement in 2015, and they are also linked to more than $100 million in payments for J9310. The MIPS final rule, which at press time is under review at the Office of Management and Budget, is expected to clarify the question of whether Part B drugs will count toward a provider's potential MIPS-adjusted dollars. — *Richard Scott (rscott@decisionhealth.com)*

10 highest grossing drug codes billed under Medicare in 2015



Source: Part B News *analysis of Medicare claims data*

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cost than would be required if only ALJs were used to address the same workload." Note: OMHA had more than 650,000 pending appeals as of October 2016.

"If all the issues can be decided by reviewing the record, without need for live testimony, cross examination or oral argument, the attorney adjudicator process would be a way to expedite a determination," says William H. Maruca, a partner with the Fox Rothschild law firm in Pittsburgh. But "if you plan to introduce testimony or raise new issues that were not raised in the prior appeal," it won't save any time, as attorney adjudicators are supposed to refer cases that need hearings to an ALJ.

New changes address big loads

The final rule also made some changes to the appellant's ability to challenge findings from OMHA's "Statistical Sampling Initiative," including a requirement that appellants give a reason for each sample claim they challenge. The sampling initiative, which began in 2014, allows providers headed to the ALJ to have several of their reconsideration decisions reviewed at once. Sampling allows a panel of OMHA reviewers to boil down large caseloads — up to 10,000 claims — much as a Medicare auditor would, based on a random sample of claims, whereupon one or more ALJs will rule on the "universe" of cases as if they were one large case.

It would seem to be a time-saving alternative for cases involving hundreds of claims — and also for caseloads in which individual claims may not rise to the "amount in controversy" (AIC) of $160 required to hold the appeal.

Many providers will have large numbers of cases going through the system at once, says Wayne J. Miller, health care law attorney and partner at Compliance Law Group in Los Angeles. "RAC [recovery auditor] and ZPIC [zone program integrity contractor] audits often look at many years of billings so that their audits can result in very large overpayments involving hundreds of claims," says Miller. "Often too their audits are cursory and can have a lot of errors. A provider may have significant cost in pursuing these cases — but at the same [time] may have such a large potential liability that providers are essentially forced to appeal."

However, says Miller, "if the case involves medical necessity or appropriate code use issues — which is often the case — the sampling option may help or hurt the appellate provider depending on how representative the chosen samples are." Also, if the case doesn't go the provider's way, "the provider may have to spend more time and money evaluating and, if necessary, challenging the sampling process in addition to dealing with the substantive issues on appeal — so the overall cost and time in pursuing these cases may increase" rather than decrease, says Miller.

Choosing appropriately matched cases for sampling with a strong rationale for appeal may increase your chances of a favorable outcome, says Selesnick.

"When we litigate in court, we are always seeking a common issue — no judge is interested in wading through a claim-by-claim process," says Selesnick. "For example, we

get denials on Part C (Medicare Advantage) cases because there was no pre-authorization. If they all came through the emergency room, you might be able to group those together and make the argument that since they were all emergencies, unstable for transfer, the pre-authorization shouldn't be required. Those you might do, especially if there's a decent volume and money at stake."

Be careful of bad precedent

Some of the allegedly time-saving features in the final rule you won't have much to say about — for example, "precedential" decisions. The HHS Departmental Appeals Board (DAB) is authorized to designate some decisions from the fourth level of appeal, Medicare Appeals Council, to be used as guidance for similar cases, "providing clear direction on repetitive legal and policy questions and, in limited circumstances, factual questions" in cases involving "recurring legal issues."

"It could be helpful, but the problem is hard cases make bad law," says Selesnick. "People aren't well-versed in what precedent means or how it applies… When you go before a court of appeals, you may disagree with the decision, but when they make it you can see they know what they're doing. They recognize what to do when things have to serve as guidance. I'm not satisfied that that sort of system has been set up in Medicare."

Selesnick's recommendation to CMS: "Do a study of how many cases were affirmed at level 1, and if it's a hugely high percentage, if they see it's a rubber stamp, they should just cut out that whole level of bureaucracy and get everyone closer to where they want to be."
— *Roy Edroso (redroso@decisionhealth.com)*

Resource:

- Medicare Program: Changes to the Medicare Claims and Entitlement, Medicare Advantage Organization Determination, and Medicare Prescription Drug Coverage Determination Appeals Procedures: *www.federalregister.gov/documents/2017/01/17/2016-32058/medicare-program-changes-to-the-medicare-claims-and-entitlement-medicare-advantage-organization*

Subsidies

(continued from p. 1)

About 9 million people receive subsidies under the Affordable Care Act (ACA), says Mike Ferguson, attorney with BakerHostetler in Washington, D.C., and leader of the firm's federal policy team. Halting the subsidy payments "could certainly lead to fewer people with health insurance," predicts Ferguson.

A number of health care organizations criticized the subsidies cessation. In a joint letter addressed to President Donald Trump and members of Congress, several groups — including the AMA, the American Academy of Family Physicians, the American Hospital Association and America's Health Insurance Plans — called on lawmakers to restore funding.

"Without CSRs, health care coverage will be out of reach for [people who previously received subsidy assistance]. Plans will likely drop out of the market. Premiums will go up for everyone. Costs will go up for taxpayers. And doctors and hospitals, foundational to their communities, will see even greater strains on their ability to care for people," states the letter.

Some areas already are bracing for higher insurance costs. On Oct. 15, the Pennsylvania Insurance Department announced that insurance premiums for individuals who will no longer receive subsidies are expected to rise by 30.6% in 2018.

The decision by the Trump administration to cut off subsidies is the latest attempt to undermine the ACA — which has withstood a years-long call for repeal among Republican lawmakers, even as those attempts at outright repeal have fizzled in Congress (*PBN 10/2/17*).

The decision appears to be "a political shot across the bow" to spur bipartisan discussion on reforming the way individuals obtain health insurance, says Ferguson. "The political message was, 'We believe the ACA is a flawed model [and] it's on a path to destruction,'" he says. Ending subsidies may "hasten its demise," Ferguson adds.

Already, one bipartisan bill put forth by Sens. Lamar Alexander, R-Tenn., and Patty Murray, D-Wash., that would have restored subsidy payments appears to have stalled before going up for a vote. Hours after the senators announced details of the bill, Trump indicated support only to reverse course the following morning. The future of the bill remains uncertain.

As one approach to insurance coverage took a blow to the midsection, another was given a breath of wind. In an executive order issued Oct. 13, Trump instructed the Secretary of Labor to propose regulations or revise current guidance "to expand access to health coverage by allowing more employers to form AHPs [association health plans]."

The executive order seeks to broaden the ability of employer groups, such as small business owners, to pool their numbers and self-insure or form large coalitions and purchase group health insurance.

"This is not a new concept," says Mike Strazzella, co-head of the Washington, D.C., office of law firm Buchanan, Ingersoll & Rooney and practice group leader for federal government relations. While some groups currently use AHPs for coverage, the scope is fairly limited. The new edict from the White House urges policymakers "to re-evaluate existing regulations to see if [they] interpret the law differently."

The executive order also seeks "to facilitate the purchase of insurance across state lines"; however, specific details as to how that may work — or what insurance products would look like — are still unclear. Ultimately, any changes borne out of the executive order "still have to go through the rule-making process," says Strazzella. "This is not going to happen overnight." — *Richard Scott (rscott@decisionhealth.com)*

Resources:

- HHS CSR memo: *www.hhs.gov/sites/default/files/csr-payment-memo.pdf*
- Health groups' joint letter: *www.ahip.org/letters-to-the-president-congress-regarding-csrs/*
- Executive order: *www.whitehouse.gov/the-press-office/2017/10/12/presidential-executive-order-promoting-healthcare-choice-and-competition*

From the *Part B News* blog

Take note of the news that happens between *Part B News* issues by checking out the free *Part B News* blog at *https://pbn.decisionhealth.com/Blogs/default.aspx*. Here's a sampling from this week.

Poll: Did your clinicians skip QPP participation this year, test the waters or dive right in?

The first year of Medicare's new Quality Payment Program (QPP) is winding down. The final rule for QPP 2018 is at the Office of Management and Budget as of press time. In other words, it's the perfect time to take our confidential QPP survey (*https://www.surveymonkey.com/r/QPP2017*) as you prepare for year two of the program.

We've put together a quick survey to gauge where people are in the QPP process — and what they think of the program — starting with the all-important question: Is at least one clinician at your practice participating in QPP this year?

Not all practices are taking part in the program, and we want to hear from the abstainers just as much as we want to hear from practices that participated for the full year. Read more: *https://pbn.decisionhealth.com/Blogs/Detail.aspx?id=200639*.

Coding and billing guidelines — read 'em or weep

This $2 million settlement announcement illustrates the importance of keeping up with — and following — coding and billing gudiance from AMA and your Medicare contractor.

It was mentioned in the Department of Justice's (DOJ) announcement that Syracuse N.Y.-based New York Spine & Wellness Center agreed to pay a hair less than $2 million dollars — $1,941,850.29 to be exact — to resolve False Claims Act allegations.

What happened? According to the announcement released Oct. 3, the practice regularly reported moderate sedation services that failed to meet the intraservice time requirement of at least 16 minutes. (Until this year, moderate sedation services involved 30 minutes of intraservice time or at least 16 minutes under the CPT manual's half-time rules for time-based codes.) Read more: *https://pbn.decisionhealth.com/Blogs/Detail.aspx?id=200638*.

Providers in jurisdiction J: Say hello to a new MAC in 2018

Medical practices in Alabama, Georgia and Tennessee will be saying goodbye to one Medicare administrative contractor (MAC) and welcoming a new one after the calendar flips to 2018.

Effective Feb. 26, 2018, providers billing Medicare Part B in the three southern states officially will shift their claims processing and all other MAC-directed operations to Palmetto GBA, the MAC currently covering North Carolina, South Carolina, Virginia and West Virginia.

At that time, Cahaba GBA will forfeit its hold over the three states in jurisdiction J, aka JJ. Palmetto GBA will assume coverage of Part A services in those states as well, leaving the future of Cahaba, which has been around since Medicare's inception and will lose its only active jurisdiction under Parts A and B, in question. Read more: *https://pbn.decisionhealth.com/Blogs/Detail.aspx?id=200636*.

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