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Prepared for: Maryland Department of Health
Office of Population Health Improvement

March 22, 2023

Local Health Department Billing Manual Training

Presented by:
Kem Tolliver, CMPE, CPC, CMOM

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No advice

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Your Speaker

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Kem Tolliver holds dual Bachelor of Science degrees in Healthcare Administration and Organizational Management; Summa Cum Laude and Magna Cum Laude respectively. Certifications include: Certified Medical Practice Executive (CMPE), Certified Professional Coder (CPC) and Certified Medical Office Manager (CMOM).

Kem is the co-author of, "Revenue Cycle Management: Don't Get Lost in the Financial Maze" published by MGMA ® ISBN: 978-1-56829-677-7. Medical practices managed by Kem have received MGMA® "Better Performing Practice" distinctions in the areas of Accounts Receivable and Collections. In a desire to lead, Kem served on the Board of Directors of MD MGMA as the Chair of the Practice Management Committee, Chair of the Government Affairs Committee. She received MD MGMA's 2016 Outstanding Service Award and was the 2018 State of Maryland ACMPE Certification Rep.

She has been instrumental in collaborating with MedChi The Maryland State Medical Society on member practice improvements and to provide testimony and guidance on healthcare legislation within the Maryland General Assembly. Kem served as a member of Maryland's 2018 General Assembly House of Delegates – Health & Government Operations Prior Authorization special session workgroup.

Kem provides state-wide risk management training programs for Medical Mutual Insurance policy holders. She serves as a SME for: Henry Health start-up behavioral-telehealth app, Ability Networks-An Inovalon Company and Zane Networks. She was an Adjunct Professor of Revenue Cycle at Catonsville Community College.

Ms. Tolliver is the President of PG County, MD chapter of AAPC, co-Founder of Prince George's County Practice Manager's Association and serves on the Novitas JL Carrier Advisory Committee.

From 2017-2018, Kem served on the Board of Directors for Laurel Regional Hospital. She was a Mentor for the Prince George's County Public School's 2018 PTECH Health Innovation Program. Kem served on the Totally Linking Care-Maryland Advisory Council and was a faculty member for Beyond the Exam Room.

The State of Maryland Governor's awarded Kem with Volunteer Service Certificate for 2015-2018. Nexus Health, Fort Washington Medical Center nominated her for the 2016 Community Health Award. Kem was awarded the Heart to Hand, Inc. 2019 Heart of Gold Award for 501 (c) (3) community based public health medical practice leadership.

Learning Objectives

1. Overview of Revised LHD Billing Manual
2. No Surprises Act Summary
3. 2023 CMS Final Rule
4. LHD Survey
5. Staying Connected with MRCS

Billing Manual Sections

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The LHD Billing Manual provides information in the following sections:

1. COVID-19 Billing and Coding Information
2. Maryland General Billing Information
3. Billing Foundation Resources
4. Revenue Cycle Management
5. Local Health Department Programs and Services
6. Billing Software Resources
7. Maryland Payers Billing Guidelines
8. Credentialing, Contracting, and Fee Schedules
9. Compliance
10. Coding and Medical Record Documentation
11. Telehealth Coding and Billing Resources
12. Archive

LHD Billing Manual Overview

https://health.maryland.gov/pophealth/Pages/LHD-Billing-Manual-Main-Page.aspx

Upcoming Events

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2 Training Programs for 2023

Preregistration is not required, but is recommended. The Maryland Department of Health will facilitate training programs for Local Health Departments (LHDs) that will be conducted by Medical Revenue Cycle Specialists (MRCS). This training is offered to support billing and related efforts of all LHDs via live webinars.

Monthly Q & A for 2023

Monthly Office Hour Q & A With Medical Revenue Cycle Specialists

The Maryland Health Department will facilitate Local Health Departments (LHDs) ability to ask questions and receive answers to billing and related information. The Monthly Office Hour is a time set on the 1st Wednesday of each month in which LHDs may communicate directly with the Medical Revenue Cycle Specialists (MRCS) team.

https://health.maryland.gov/pophealth/Pages/Upcoming-Events-Home-Page.aspx

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Frequently Asked Questions

Expect Responses within 24-48 Hours depending upon investigation required

https://health.maryland.gov/pophealth/Pages/LHD-Billing-Manual-FAQs.aspx

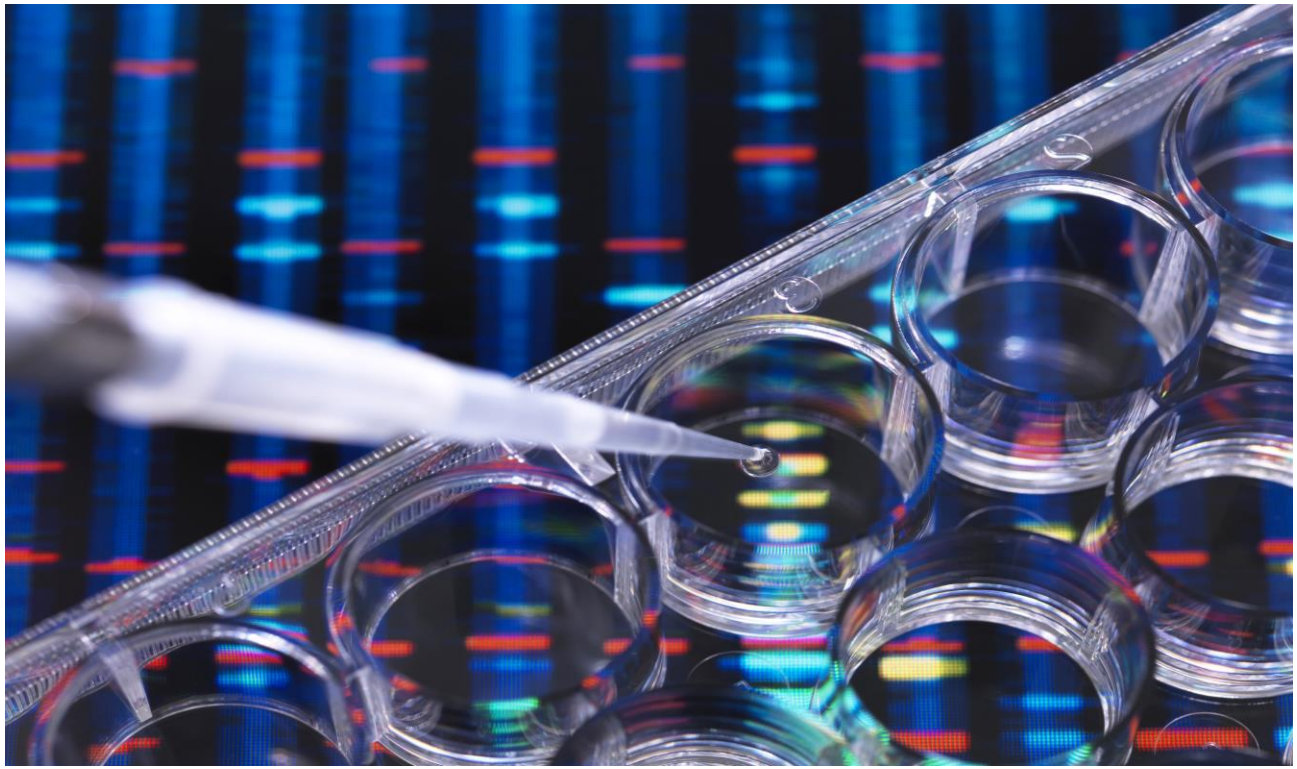
Find A Resource

Document Title	Date	Expiration	Description	Source

Can't find what you're looking for in the other sections? This general Information section contains general information about programs, services, and billing.

https://health.maryland.gov/pophealth/Pages/Find-a-Resource.aspx

Trending Hot Topics



https://health.maryland.gov/pophealth/Pages/Trending-Hot-Topics.aspx

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Audience Questions/Comments

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What is the No Surprises Act

This rule provides protections for patient which regulate the balance billing process and create new ways for patients to understand their financial responsibilities.

This act went into effect on January 1, 2022.

Surprise Billing Defined

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HHS defines surprise medical billing, or balance billing, as follows:

"When patients receive care from **out-of-network providers or facilities and the service costs are not fully covered** by the patient's insurance provider"

Compliance Components

Billing Compliance

This section regulates the definition of a surprise bill, which facilities/provider types it applies to, and any services that are not included under this mandate, as well as IDR Process

Price Transparency

This component defines the provider's responsibility to provide cost information to the patient in advance, including alternative options available

Patient Protection

Notably, if surprise medical bills (as defined by HHS) are issued to patients, the patient will be held harmless, and the facility may be at risk for violating this rule

No Surprises Act

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Requirements to Balance Bill

- Patients must be made aware that care being provided is out of network
- Notify patients if there are other in-network providers at the facility
- Inform patients of estimated cost of care

Balance Billing Disclosure Document

- There are specific requirements for timing to be given to patients
- Information included within the document

Excluded Non-Ancillary Out of Network Providers

- Emergency Medicine
- Anesthesiology
- Pathology, Radiology, Laboratory
- Neonatology Services
- Items & services provided by Assistance Surgeons, Hospitalists and Intensivists

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ERISA & No Surprises Act

- Self-Funded Plans are **NOT** generally regulated by the state, and this did not change with the No Surprises Act

- HHS recognized that under ERISA, the federal requirements related to balance billing would generally apply to all self-funded plans, however:
  - HHS created an exception in states where self-funded plans can opt-in and comply with state processes
  - In states with the above exceptions, self-funded plans can voluntarily opt-in to state laws that provide for a method of determining cost sharing

Provided by MGMA

Price Transparency

- This means giving patients all the information they need to make an informed decision on out-of-network care so that they can avoid large surprise bills
- The goals are to improve patient's understanding of:
  - The total cost of care
  - Provider networks
  - Insurance plan cost sharing

Good Faith Estimates (GFE)

Effective **1/1/22**, the GFE must be provided to these patients

Good faith estimates apply to:

- All uninsured patients
- Insured patients who do not plan to submit claims to insurance
- Self-pay patients

What is the GFE

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This is a document to be provided to patients which identifies

(1) The cash price for services
(2) Less any discounts and
(3) Reflects the total cost of care by the provider for that period of care.

In this definition, period of care means the day or multiple days in which the primary service is performed and other additional services that would likely be done alongside the primary item or service.

GFE: Who & When

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Who. The requirement to provide a GFE applies to **all** physicians or other healthcare providers who act within the scope of practice of that provider's license or certification.

- Per CMS: These requirements don't apply to people with coverage through programs like Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE. These programs have other protections against high medical bills.

When. The GFE must be provided to a patient prior to all scheduled services or when requested if the patient is shopping for care.

- If the service is scheduled more than 10 days in advance, the provider must provide the FTE within 3 business days.
- If the item/service is scheduled within 3 business days in advance, the GFE must be provided within 1 business day

GFE: What to Include

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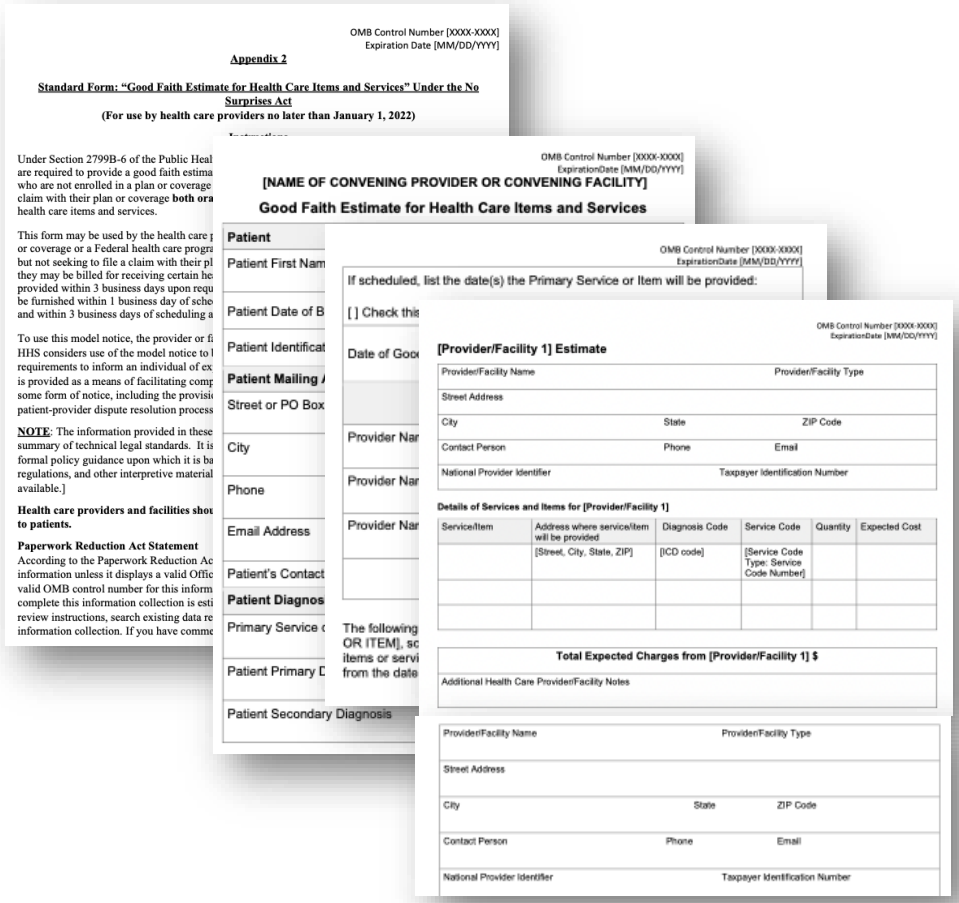
- Patient's name and Date of Birth
- Date of scheduled services
- Name, NPI, and TIN of provider, states and facility location of care
- Total Cost of Care for the period of care
- Itemized list and description of expected services with service codes
- Itemized list of related diagnosis codes and descriptions
- All associated and anticipated charges
- Disclaimer that there may be additional services which would be scheduled separately that are not reflected
- Disclaimer that this information is only an estimate
- Disclaimer that informs patient about their right to initiate a dispute resolution process
- Disclaimer that the GFE is not a contract
- It should not exceed a scope of 12 months

*__Note__: If a patient requests a GFE prior to scheduling, the GFE must be given to the patient again once scheduled

GFE Template

This ten-page document includes the information and form template required to begin the GFE process right away. There have templated out sections for three providers/facilities to start and providers can add on to that as needed.

Download this toolkit and educate staff right away to ensure compliance.



OMB Control Number [XXXX-XXXX]
Expiration Date [MM/DD/YYYY]

Appendix 2

Standard Form: "Good Faith Estimate for Health Care Items and Services" Under the No Surprises Act
(For use by health care providers no later than January 1, 2022)

Under Section 2799B-6 of the Public Heal
are required to provide a good faith estima
who are not enrolled in a plan or coverage
claim with their plan or coverage **both ora**
health care items and services.

This form may be used by the health care p
or coverage or a Federal health care progra
but not seeking to file a claim with their pl
they may be billed for receiving certain he
provided within 3 business days upon requ
be furnished within 1 business day of sche
and within 3 business days of scheduling a

To use this model notice, the provider or fi
HHS considers use of the model notice to
requirements to inform an individual of ex
is provided as a means of facilitating comp
some form of notice, including the provisi
patient-provider dispute resolution process

NOTE: The information provided in these
summary of technical legal standards. It is
formal policy guidance upon which it is ba
regulations, and other interpretive material
available.]

Health care providers and facilities shou
to patients.

Paperwork Reduction Act Statement
According to the Paperwork Reduction Ac
information unless it displays a valid Offic
valid OMB control number for this inform
complete this information collection is esti
review instructions, search existing data re
information collection. If you have comme

OMB Control Number [XXXX-XXXX]
ExpirationDate [MM/DD/YYYY]

[NAME OF CONVENING PROVIDER OR CONVENING FACILITY]

Good Faith Estimate for Health Care Items and Services

Patient

Patient First Nam
Patient Date of B
Patient Identificat
Patient Mailing A
Street or PO Box
City
Phone
Email Address
Patient's Contact
Patient Diagnos
Primary Service
Patient Primary D
Patient Secondary Diagnosis

OMB Control Number [XXXX-XXXX]
ExpirationDate [MM/DD/YYYY]

If scheduled, list the date(s) the Primary Service or Item will be provided:

[ ] Check this
Date of Goo
Provider Nar
Provider Nar
Provider Nar

The following
OR ITEM], sc
items or servi
from the date

OMB Control Number [XXXX-XXXX]
ExpirationDate [MM/DD/YYYY]

[Provider/Facility 1] Estimate

Provider/Facility Name		Provider/Facility Type
Street Address		
City	State	ZIP Code
Contact Person	Phone	Email
National Provider Identifier		Taxpayer Identification Number

Details of Services and Items for [Provider/Facility 1]

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service Code Type: Service Code Number]		

Total Expected Charges from [Provider/Facility 1] $

Additional Health Care Provider/Facility Notes

Provider/Facility Name		Provider/Facility Type
Street Address		
City	State	ZIP Code
Contact Person	Phone	Email
National Provider Identifier		Taxpayer Identification Number

Patient Protections

Patient Dispute Resolution

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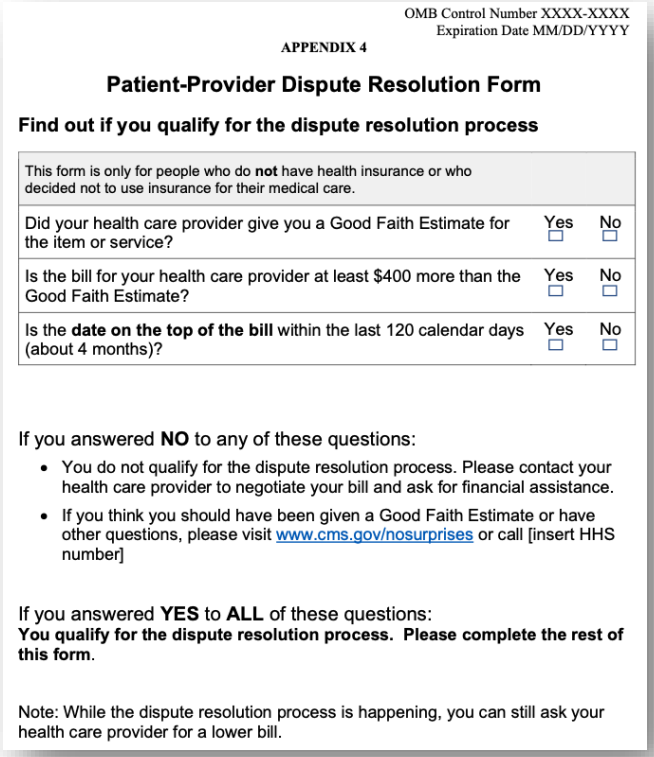
If the GFE provided to the patient is exceeded by a substantial amount, the patient has the right by law to seek resolution:

- This Act defines a substantial amount as $400 or more
- Notably, this threshold remains the same regardless if additional unforeseen services were added to the plan of care after the GFE was provided.
- HHS will choose up to there Selected Dispute Resolution Entities (SDREs) in 2022 to resolve claims between patients and providers
- They will establish a portal online for patients to submit disputes with an administrative processing fee of $25

Patient Provider Dispute Resolution Form

This 5-page form is what the patient would complete to initiate a dispute. The first three questions are qualifier questions. A “no” for any of these will require them to reach out directly to CMS for more information or to the provider to negotiate the bill.



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Expiration Date MM/DD/YYYY

APPENDIX 4

Patient-Provider Dispute Resolution Form

Find out if you qualify for the dispute resolution process

This form is only for people who do **not** have health insurance or who decided not to use insurance for their medical care.		
Did your health care provider give you a Good Faith Estimate for the item or service?	Yes ☐	No ☐
Is the bill for your health care provider at least $400 more than the Good Faith Estimate?	Yes ☐	No ☐
Is the **date on the top of the bill** within the last 120 calendar days (about 4 months)?	Yes ☐	No ☐

If you answered **NO** to any of these questions:

- You do not qualify for the dispute resolution process. Please contact your health care provider to negotiate your bill and ask for financial assistance.
- If you think you should have been given a Good Faith Estimate or have other questions, please visit www.cms.gov/nosurprises or call [insert HHS number]

If you answered **YES** to **ALL** of these questions:
You qualify for the dispute resolution process. Please complete the rest of this form.

Note: While the dispute resolution process is happening, you can still ask your health care provider for a lower bill.

CMS Provider Toolkit

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- Right to receive a GFE of Expected Charges Notice (to post)
- GFE Template
- SDRE Declining Eligibility or Need More Information Notice
- PPDR – Dispute Initiation Form
- HHS – Appendix SDR Entity Certification Data Elements
- HHS – Appendix Vendor Management (VM) Data Elements
- HHS – Appendix PPDR Data Elements for Patients and Providers
- PPDR – SDRE Determination Notice
- PPDR – SDRE Selection Notice
- PPDR – Payment Settlement Form
- HHS – Appendix – Good Faith Estimate Data Elements
- HHS – PRA Supporting Statement

https://www.cms.gov/regulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791

Resources

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- CMS "No Surprises"
  - www.cms.gov/nosurprises
- AMA "Summary of Interim Final Rule (Part 2)"
  - https://www.ama-assn.org/system/files/ama-summary-nsa-interim-final-rule-part-2.pdf
- MGMA "Implementing the No Surprises Act"
  - https://www.mgma.com/resources/government-programs/implementing-the-no-surprises-act-federal-regulati
- CMS' list of certified IDR Entities
  - https://www.cms.gov/nosurprises/Help-resolve-payment-disputes/certified-IDRE-list
- HHS GFE Sample
  - https://www.omb.report/icr/202109-0938-015/doc/original/115257801.pdf

Now What?

Charge Description Master (CDM)

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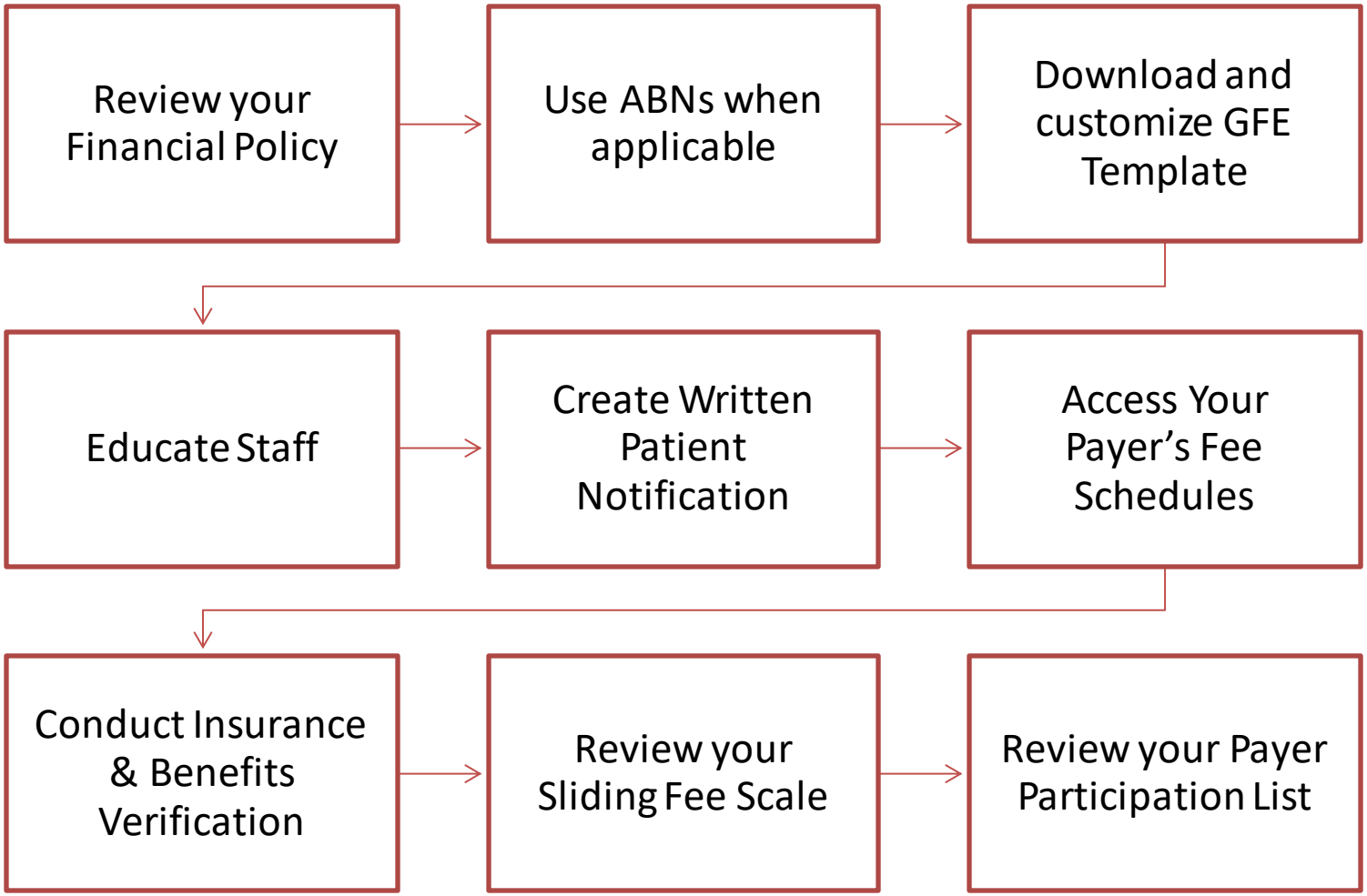
CPT Codes	Description	Charge
99203	NP L3	145.00
99204	NP L4	220.00
99205	NP L5	250.00
99213	Estab L3	100.00
99214	Estab L4	125.00
99215	Estab L5	150.00
93000	EKG w/Interp	50.00
94010	Spiro w/TC mod	50.00
99354	Prolonged / 1st hr	160.00
99490	CCM 20 min	75.00
99491	CCM 30 in	120.00
99495	TCM Med complex	200.00
99496	TCM High complex	300.00

- Rates for Services
- Use a Uniform CDM for all payers
- Update in PM Annually

Internal Modernization for NSA



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CMS 2023 Final Rule

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2023 MEDICARE REIMBURSEMENT & FEE SCHEDULES

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

2023 Conversion Factor

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CONVERSION FACTOR (CF)							
2016	2017	2018	2019	2020	2021	2022	**2023**
$35.80	$35.89	$35.99	$36.04	$36.09	$34.89	$34.61	**$33.89**
Increase	Increase	Increase	Increase	Increase	Decrease	Decrease	**DECREASE**

Anesthesia Conversion Factor			
2020	**2021**	**2022**	**2023**
$22.20	**$20.05**	**$20.93**	**$20.61**

Medicare Physician Payment Formula

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[(Work RVU x Work GPCI) + (PE RVU x PE GPCI) + (MP RVU x MP GPCI)] x CF = Medicare Physician Payment

Work Relative Value Unit X Work Geographic Practice Cost Indices

+

Practice Expense Relative Value Unit X Practice Expense Geographic Practice Cost Indices

+

Malpractice Relative Value Unit X Malpractice Geographic Practice Cost Indices

X

Conversion Factor

÷

MIPS or AAPM

X

Sequestration

=

Medicare Physician Payment

Fee Schedule

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CPT Codes	Charge	Medicare	Payer #1	Payer #3
99203	145.00	**117.01**	**125.00**	**110.00**
99204	220.00	**177.92**	**190.00**	**185.00**
99205	250.00	**223.39**	**239.00**	**200.00**
99213	100.00	**80.46**	**70.00**	**65.00**
99214	125.00	**117.58**	**119.00**	**115.00**
99215	150.00	**157.40**	**160.00**	**125.00**
93000	50.00	**18.65**	**25.00**	**30.00**
94010	50.00	**30.06**	**Not listed**	**25.00**
99354	160.00	**139.94**	**32.00**	**125.00**
99490	75.00	**44.88**	**38.00**	**41.00**
99491	120.00	**88.83**	**100.00**	**85.00**
99495	200.00	**177.78**	**150.00**	**150.00**
99496	300.00	**250.82**	**275.00**	**225.00**

- Established by the Payer
- Payer Assigns CPT/HCPCS Codes
- Payer uses formulas to establish rates
- Upload to PM Software for Payment Posting

Novitas JL MAC Fee Schedule Access

Check our local Medicare fee schedules using the following steps:

- www.novitas-solutions.com
- Select: ○ Part B: Physicians & other healthcare professionals
- □ Accept Terms and Conditions
- Select: Fee Schedules
- Select: Search & Download Fee Schedules

Localities for Jurisdiction L (JL)

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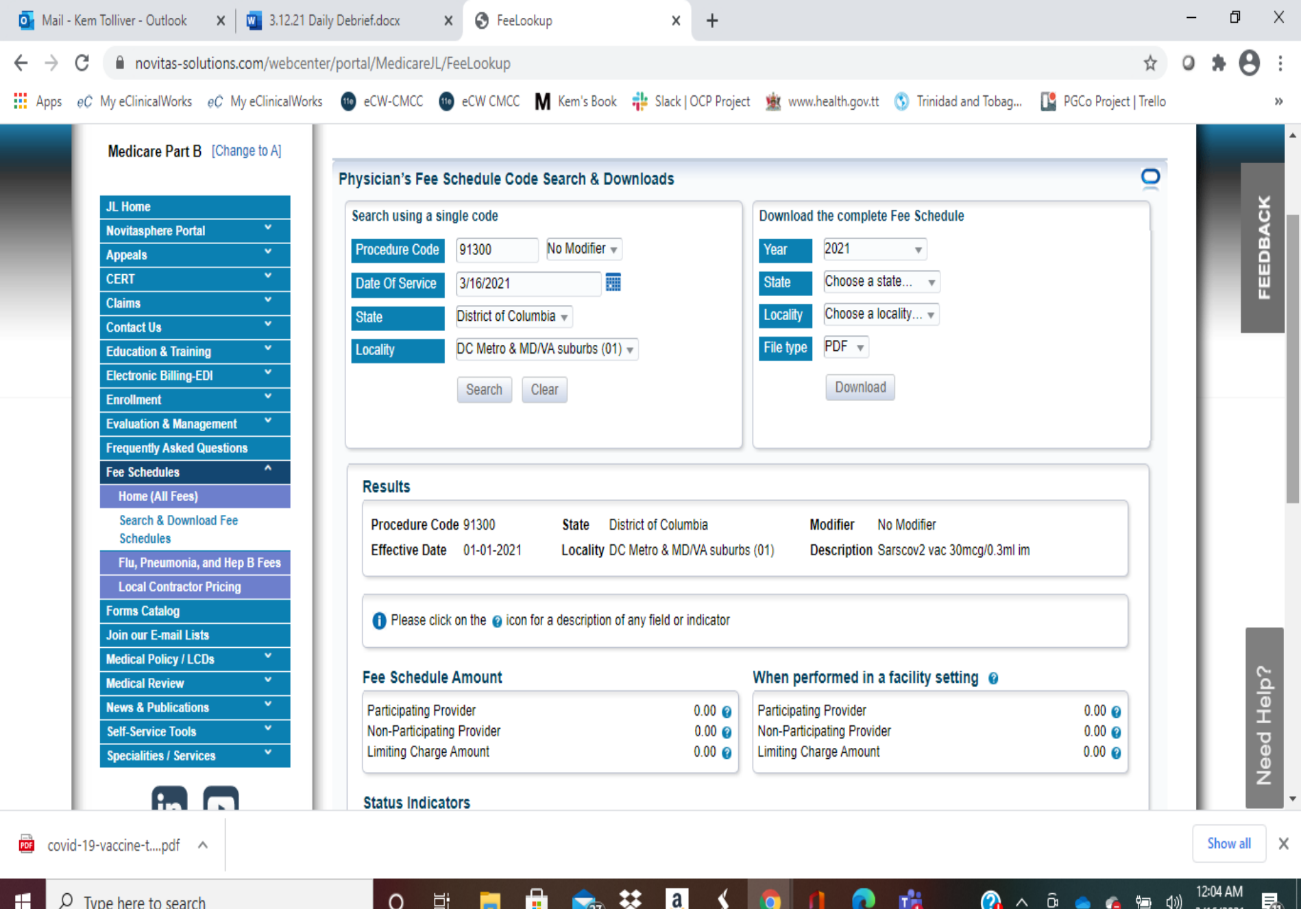
Locality #	State	Fee Schedule Area	Counties
01	DC	DC + MD/VA Suburbs	District of Columbia, Alexandria City, Arlington
01	MD	Baltimore / Surrounding Counties	Anne Arundel, Baltimore, Baltimore City, Carroll, Harford, Howard
99	MD	Rest of State	All Other Counties EXCEPT Montgomery and Prince George's



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Let's Take a Virtual Fieldtrip to:

www.novitas-solutions.com

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CMS 2023 Key Coding Updates

Evaluation & Management Guideline & Definition Updates

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Effective 1/1/2023

New descriptor times (where relevant).

Revised interpretive guidelines for levels of medical decision making.

Choice of medical decision making or time to select code level (except for a few families like emergency department visits and cognitive impairment assessment, which are not timed services).

Eliminated use of history and exam to determine code level (instead there would be a requirement for a medically appropriate history and exam).

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-final-rule

Colorectal Cancer Screening

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Effective 1/1/2023

- Minimum age for payment and coverage from 50 years old to 45 years old
- Regulatory definition and coverage after a non-invasive stool-based colorectal cancer screening is positive.
  - Cost sharing will not apply for either the initial stool test or the follow up colonoscopy

Opioid Treatment Program (OTP) Updates

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- CMS is finalizing a policy to allow OTP add on code to be furnished via two-way audio-video to initiate buprenorphine treatment
- Periodic audio-only assessments when video is not available throughout CY 2023
- In accordance with SAMHSA and DEA regs; OTPs can bill CMS for medically necessary services provided in a mobile unit

Medical Decision Making

Elements of Medical Decision Making			
Level of MDM (Based on 2 out of 3 Elements of MDM)	**Number and Complexity of Problems Addressed at the Encounter**	**Amount and/or Complexity of Data to Be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 Below**	**Risk of Complications and/or Morbidity or Mortality of Patient Management**
Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**
Low	**Low** • 2 or more self-limited or minor problems; or • 1 stable, chronic illness; or • 1 acute, uncomplicated illness or injury; or • 1 stable, acute illness; or • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Limited** *(Must meet the requirements of at least 1 out of 2 categories)* **Category 1: Tests and documents** **Any combination of 2 of the following:** • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test or **Category 2 Assessment requiring an independent historian (s)**	**Low risk of morbidity from additional diagnostic testing or treatment**
Moderate	**Moderate** • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; or • 2 or more stable, chronic illnesses; or • 1 undiagnosed new problem with uncertain prognosis; or • 1 acute illness with systemic symptoms; or • 1 acute, complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** Any combination of 3 from the following: • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test; • Assessment requiring an independent historian or	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health

Medical Decision Making

		Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other QHP (not separately reported); or **Category 3: Discussion of management or test interpretation** • Discussion of management or test interpretation with external physician/other QHP/appropriate source (not separately reportable)	
High	**High** • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or • 1 acute or chronic illness or injury that poses a threat to life or bodily function	**Extensive** *(Must meet the requirements of at least 2 out of 3 categories)* **Category 1: Tests, documents or independent historian(s)** **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) or **Category 2: Independent interpretation of tests** • Independent interpretation of a test performed by another physician/other QHP (not reported separately) or Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/QHP/appropriate source (not separately reported)	**High risk of morbidity from additional diagnostic testing or treatment** *Examples only*: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances

Prolonged Clinical Staff Time

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AMA AMERICAN MEDICAL ASSOCIATION

Reporting Prolonged Clinical Staff Time			
Code	**Typical Clinical Staff Time**	**99415 Time Range (Minutes)**	**99416 Start Point (Minutes)**
99202	29	59-103	104
99203	34	64-108	109
99204	41	71-115	116
99205	46	76-120	121
99211	16	46-90	91
99212	24	54-98	99
99213	27	57-101	102
99214	40	70-114	115
99215	45	75-119	120

New Modifiers

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AMA AMERICAN MEDICAL ASSOCIATION

63 **Procedure Performed on Infants less than 4 kg:** Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure number. **Note:** Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20100-69990 code series and 92920, 92928, 92953, 92960, 92986, 92987, 92990, 92997, 92998, 93312, 93313, 93314, 93315, 93316, 93317, 93318, 93452, 93505, 93563, 93564, 93568, 93569, 93573, 93574, 93575, 93580, 93581, 93582, 93590, 93591, 93592, 93593, 93594, 93595, 93596, 93597, 93598, 93615, 93616 from the Medicine/ Cardiovascular section. Modifier 63 should not be appended to any CPT codes listed in the **Evaluation and Management Services, Anesthesia, Radiology, Pathology and Laboratory,** or **Medicine** sections (other than those identified above from the Medicine/Cardiovascular section).

93 **Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System:** Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located away at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.

Split/Shared Visits

For CY 2023, we finalized a year-long delay of the split (or shared) visits policy we established in rulemaking for 2022. This policy determines which professional should bill for a shared visit by defining the "substantive portion," of the service as more than half of the total time. Therefore, for **CY 2023, as in CY 2022, the substantive portion of a visit is comprised of any of the following elements**:

- ❑ History
- ❑ Performing a physical exam
- ❑ Medical Decision Making
- ❑ Spending time (more than half of the total time spent by the practitioner who bills the visit)

As finalized, clinicians who furnish split (or shared) visits will continue to have a choice of history, or physical exam, or medical decision making, or more than half of the total practitioner time spent to define the "substantive portion" instead of using total time to determine the substantive portion, until CY 2024.

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-final-rule

Split / Shared Visits

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CMS's 2022 definition and the 2023 definition of "Substantive Portion"

TABLE 26: Final Definition of Substantive Portion for E/M Visit Code Families

E/M Visit Code Family	2022 Definition of Substantive Portion	2023 Definition of Substantive Portion
Other Outpatient*	History, or exam, or MDM, or more than half of total time	More than half of total time
Inpatient/Observation/Hospital/Nursing Facility	History, or exam, or MDM, or more than half of total time	More than half of total time
Emergency Department	History, or exam, or MDM, or more than half of total time	More than half of total time
Critical Care	More than half of total time	More than half of total time

Acronyms: E/M (Evaluation and Management), MDM (medical decision-making).
*Office visits will not be billable as split (or shared) services.

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Value Based Payment Programs

Merit-based Incentive Payment System (MIPS)

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	MIPS 2021	MIPS 2022	MIPS 2023
Quality	40%	30%	30%
Improvement Activities	15%	15%	15%
Promoting Interoperability	25%	25%	25%
Cost	20%	30%	30%

No cost measure for APM's because they receive risk-based MSSP Distributions

www.qpp.cms.gov

MIPS Value Pathways (MVP)

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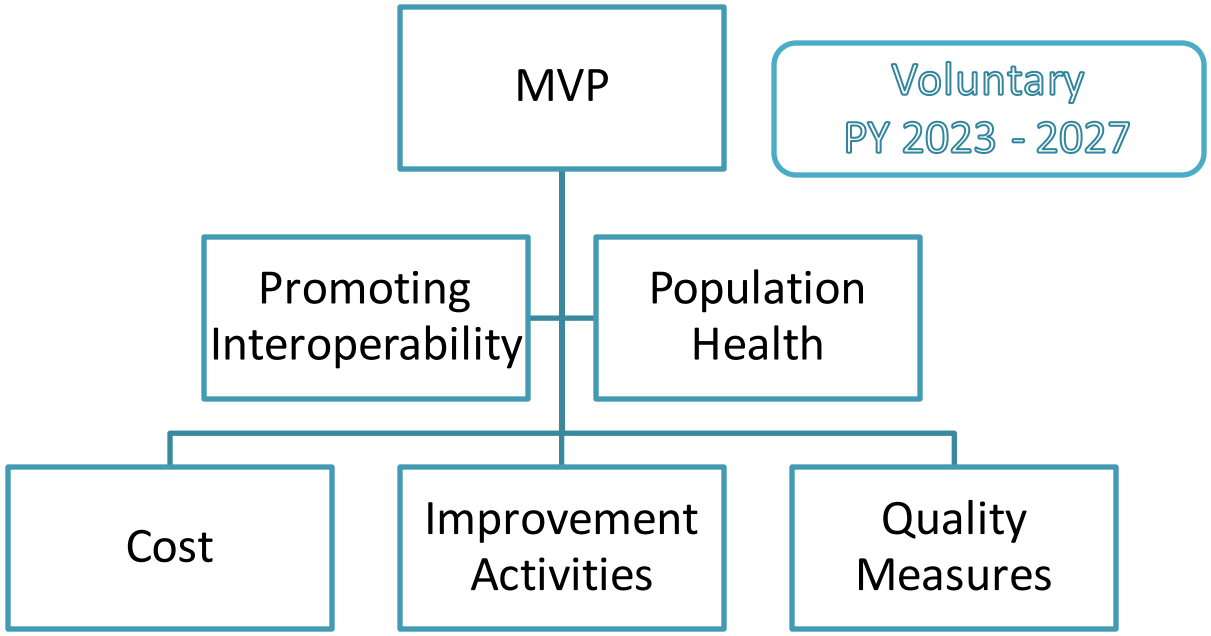
MIPS Value Pathways (MVP)

- CMS will allow eligible clinicians (ECs) report on a smaller set of measures (MVPs) based on specialty and outcomes in alignment with new alternative payment models (APMs) and the Medicare Shared Savings Program.
- ECs will be measured on a unified set of measures and activities around a clinician condition or specialty, built on a base of population health measures, which would be included in virtually all of the MVPs.



MIPS Challenges

www.qpp.cms.gov/mips/mips-value-pathways

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Regulatory Updates

Stark Law, AKS and Safe Harbors

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Stark Law

Prohibits Providers from referring Medicare and Medicaid beneficiaries for health services to facilities in which that Provider and/or their immediate family member has a financial association.

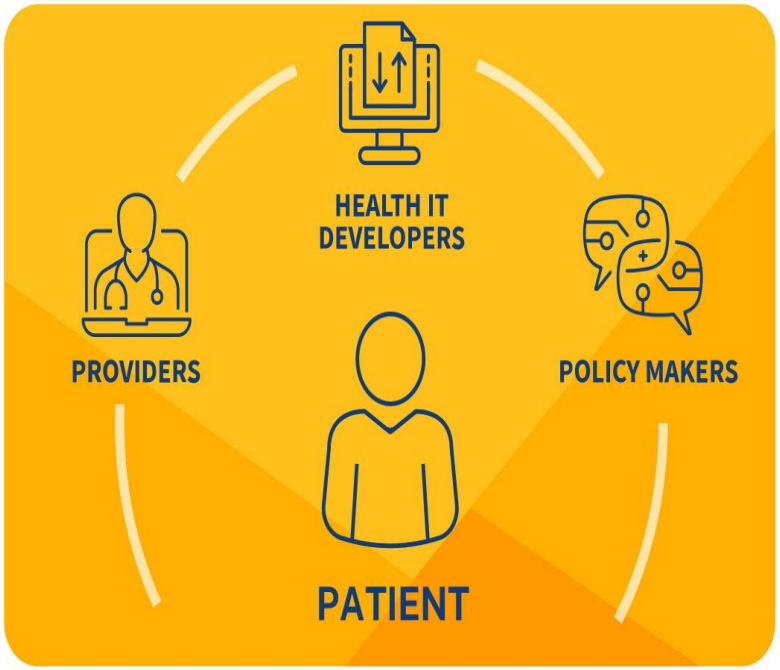
Anti-Kickback Statute

Prohibits something of value being given to reward or induce referrals of services that are reimbursable by Medicare and Medicaid.

Safe Harbors

Exceptions for permitted activities that may not be subject to punishment or sanctions under the AKS.

Who must comply with CURES Act



Patients right to access their EHI

Providers make it easy and inexpensive for patients to access their data and give providers a choice to change software

Providers & Hospitals improve patient safety

Health IT Developers – Reduce maintenance costs and allow for interoperability

Electronic Access to the Following:

View the **full USCDI**

Eight (8) types of clinical notes that must be shared with Patients

- Consultation notes
- Discharge summary notes
- History & physical
- Imaging narratives
- Laboratory report narratives
- Pathology report narratives
- Procedure notes
- Progress notes

https://www.healthit.gov/isa/united-states-core-data-interoperability-uscdi

Information Blocking Examples

- Restricting authorized access, exchange, or use of information for treatment and other permitted purposes including transitions between certified health information technologies (health IT);
- Implementing health IT in nonstandard ways that are likely to substantially increase the complexity or burden of accessing, exchanging, or using EHI;
- Implementing health IT in ways that are likely to—
  - Restrict the access, exchange, or use of EHI with respect to exporting complete information sets or in transitioning between health IT systems; or
  - Lead to fraud, waste, or abuse, or impede innovations and advancements in health information access, exchange, and use, including care delivery enabled by health IT.

https://www.healthit.gov/topic/information-blocking

How to Avoid Information Blocking

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Update internal medical record release policies	Update medical record copying pricing	Conduct Security Risk Assessment
Update Patient Portal permissions	Sign off on Notes in a Timely Manner	Update Notice of Privacy Practicess

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What's Next for You

1. Analyze the entire 2023 CMS Final Rule
2. Review your Fee schedule
3. Outline 2023 Coding Updates that impact your specialty
4. Apply necessary MIPS program requirements
5. Implement regulatory compliance measures

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Public Health Emergency Expiration **May 11, 2023**

Photo Credit: Pintrist

HHS Announces End of COVID-19 Public Health Emergency

"Based on current COVID-19 trends, the Department of Health and Human Services (HHS) is planning for the federal Public Health Emergency (PHE) for COVID-19, declared under Section 319 of the Public Health Service (PHS) Act, to expire at the end of the day on May 11, 2023."

https://www.hhs.gov/coronavirus/covid-19-public-health-emergency/index.html

HHS COVID-19 Statistics

"As a result of this and other efforts, since the peak of the Omicron surge at the end of January 2022:"

- Daily COVID-19 reported cases are down 92%,
- COVID-19 deaths have declined by over 80%, and
- New COVID-19 hospitalizations are down nearly 80%.

https://www.hhs.gov/about/news/2023/02/09/fact-sheet-covid-19-public-health-emergency-transition-roadmap.html

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What's Leaving on May 11, 2023?

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PHE Expiration May 11, 2023

What CMS Waivers are Leaving?

- Free over-the counter (OTC) COVID-19 tests will end
- Part-B beneficiaries will not have cost-sharing (copay/co-insurance) for laboratory conducted COVID-19 tests when ordered by a provider
- State Medicaid programs must provide coverage without cost sharing for COVID-19 testing until the last day of the first calendar quarter that begins one year after the last day of the COVID-19 PHE. That means with the COVID-19 PHE ending on May 11, 2023, this mandatory coverage will end on September 30, 2024, after which coverage may vary by state.

https://www.hhs.gov/about/news/2023/02/09/fact-sheet-covid-19-public-health-emergency-transition-roadmap.html

PHE Expiration May 11, 2023
What Waivers are Leaving?

- Waived HIPAA penalties for technology used to furnish Telehealth

Image Credit: www.rccd.edu

PHE Expiration May 11, 2023
What Waivers are Leaving?

- Remote prescribing of Controlled Substances – Ryan Haight Act (in-person exam requirement)

  DEA will Publish Rules

"The Ryan Haight Act requires practitioners issuing a prescription for a CS to conduct an in-person medical evaluation or conduct a video/audio communication in a DEA-registered facility at a minimum of once every 24 months."

https://nabp.pharmacy/news

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What's Staying Until December 31, 2024?

Medicaid telehealth flexibilities will not be affected.

https://www.hhs.gov/about/news/2023/02/09/fact-sheet-covid-19-public-health-emergency-transition-roadmap.html

States already have significant flexibility with respect to covering and paying for Medicaid services delivered via telehealth. State requirements for approved state plan amendments vary as outlined in CMS' Medicaid & CHIP Telehealth Toolkit - PDF.

This flexibility was available prior to the COVID-19 PHE and will continue to be available after the COVID-19 PHE ends. Similar to Medicare, these telehealth flexibilities can provide an essential lifeline to many, particularly for individuals in rural areas and those with limited mobility.

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The process for states to begin eligibility redeterminations for Medicaid will not be affected.

https://www.hhs.gov/about/news/2023/02/09/fact-sheet-covid-19-public-health-emergency-transition-roadmap.html

During the COVID-19 PHE, Congress has provided critical support to state Medicaid programs by substantially increasing the federal matching dollars they receive, as long as they agreed to important conditions that protected tens of millions of Medicaid beneficiaries, including the condition to maintain Medicaid enrollment for beneficiaries until the last day of the month in which the PHE ends.

However, as part of the Consolidated Appropriations Act, 2023 Congress agreed to end this condition on March 31, 2023, independent of the duration of the COVID-19 PHE.

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PHE Expiration May 11, 2023

What Stays....Until December 31, 2024?

- CMS Coverage of Audio-Only Services

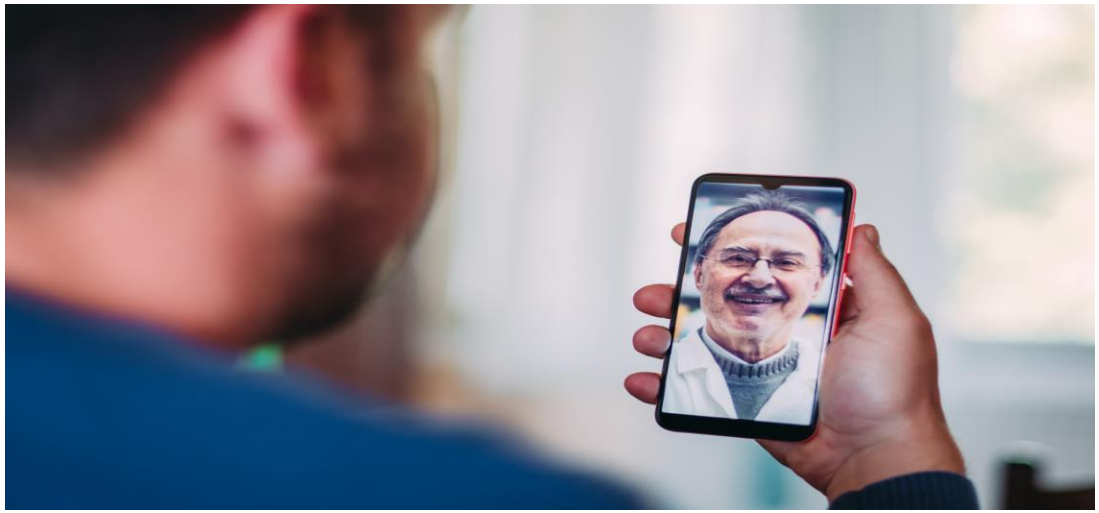

Image Credit: www.reviewob.com

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PHE Expiration May 11, 2023

What Stays....Until December 31, 2024?

- Telehealth services can be provided by a physical therapist, occupational therapist, speech language pathologist, or audiologist.

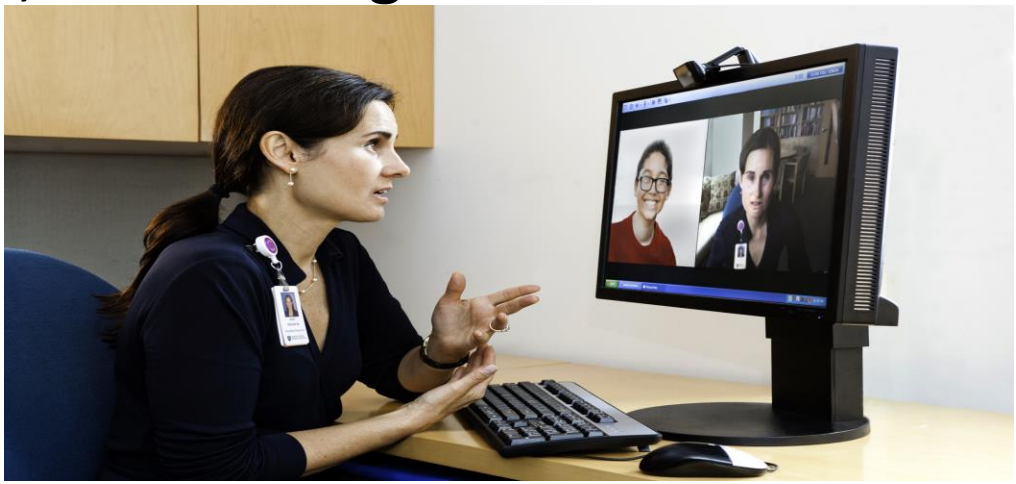

Image Credit: chathamchatlist.com

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PHE Expiration May 11, 2023

What Stays....Until December 31, 2024?

- Medicare patients can receive telehealth services authorized in the Calendar Year 2023 Medicare Physician Fee Schedule in their home.
  - This is includes but is not limited to Evaluation and Management Services

https://www.cms.gov/files/zip/list-telehealth-services-calendar-year-2023.zip

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Permanent Medicare Changes

- Medicare patients can receive telehealth services for behavioral/mental health care in their home.
- There are no geographic restrictions for originating site for behavioral/mental telehealth services.
- Behavioral/mental telehealth services can be delivered using audio-only communication platforms.

https://telehealth.hhs.gov/providers/policy-changes-during-the-covid-19-public-health-emergency/policy-changes-after-the-covid-19-public-health-emergency

Commercial Payers

- Not all commercial Payers will follow Medicare's guidelines so please check with them

The requirement for private insurance companies to cover COVID-19 tests without cost sharing, both for OTC and laboratory tests, will end.

Coverage may continue if plans choose to continue to include it.

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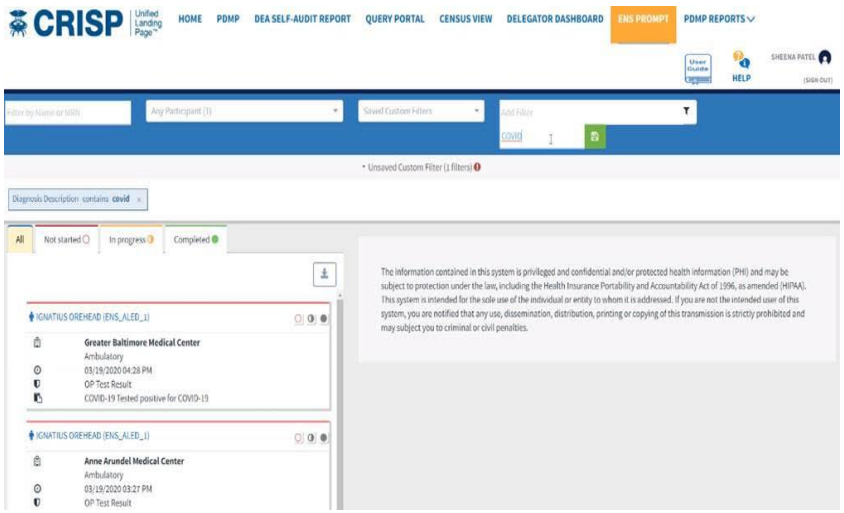
What's Next for You?

- Utilize Social Determinants of Health (SDoH) in Medical Decision Making
- Review commercial payer websites and provider manuals
- Respond to contract amendments
- Look for trends in commercial payer adjustment codes and denials
- Audit provider enrollment portals such as: NPPES, CAQH, PECOS, ePrep

Health Information Exchange (HIE)



Become a participant to get access tools, clinical data, understand your target population through its data reporting and analysis services.

- List of confirmed cases (Department of Health)
- Positive and Negative test results from participating labs.
- Risk stratification and data analytic report to prioritize what patients to follow-up and call.
- Access the Unified Landing Page
- Receive Encounter Notifications
- View the Patient's Clinical History
- Receive referral documents securely

Meet Our LHD Project Team

Tiera Buchanan, CPC, CPPM – Lead Billing & Coding Specialist

Taya Gordon, MBA, FACMPE, CMOM – Technology Specialist

Nick Seidel - Project Coordinator

Kem Tolliver, CMPE, CPC, CMOM – Project Manager

Natalie Henry – Program Specialist

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Stay In Touch With Us

- General Email: MDLHD@Medrevenuecycle.com
- Online: www.medrevenuecycle.com
- Phone: (301) 249-8500
- Fax: (301) 249-8511

Billing & Coding Questions
Tiera Buchanan, CPC, CPPM
Consult@medrevenuecycle.com

Compliance Questions
Kem Tolliver, CMPE, CPC, CMOM
Kem@medrevenuecycle.com

LHD Survey

Open Until March 28, 2023

https://docs.google.com/forms/d/e/1FAIpQLScZrxYgc-MoAmqNowktu_wjoD_uIbz8ZmB_XgF7Cc7j3Dxaew/viewform

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First Office Hours:
April 5, 2023
12:00 pm – 1:00 pm

Next Training:
Wednesday, 9/13/23
1 pm – 3 pm

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Audience Questions/Comments

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Thanks For Attending!