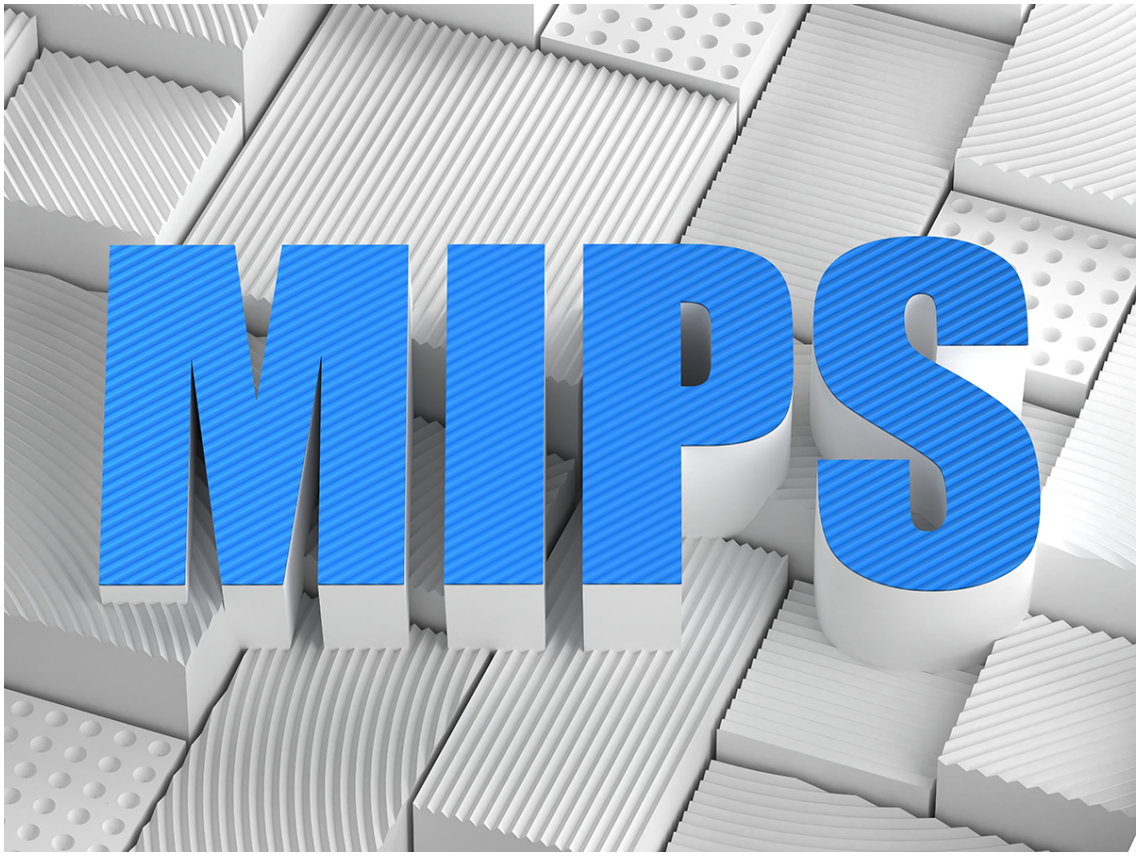
Scores Available for Medicare's Quality Payment Program



By Elizabeth Woodcock, MBA, FACMPE, CPC

The federal government recently released the scores for the Quality Payment Program.

Feedback about your performance as reported for 2022 is provided - along with your 2024 payment adjustment. Audits are available by request; these targeted reviews must be requested by October 9, 2023, at 8:00 pm EST. The penalties are high – a 9% cut to Medicare reimbursement – so it's worth your time to examine your report to be sure you're not being penalized unnecessarily. To retrieve your scores and associated feedback, log in to the program here.

For more information (including how to log in), download the guide available via the

program's main website. (See the section, "MIPS Performance Feedback Is Available.")

Patient Messages: Pathway to Payment

By Elizabeth Woodcock, MBA, FACMPE, CPC

Once documented and clipped neatly to the patient's chart, messages today primarily arrive in an electronic format. Like the days of paper, electronic messages represent a record of the patient's request. They are inherently accompanied by the record, accessible with just a few keystrokes. The advantages of electronic messaging are many, however, there are some drawbacks. The only individuals in a medical practice without a job description- physicians- are often the victim of the electronic dumping ground. The messages are left in the pool to manage – and physicians are normally the ones to address them.

Given the increasing popularity of patient messages, it's an opportune time to review some guardrails to consider:

Set the parameters. Be intentional about the use of messages – don't just issue some announcements and hope that patients will read - and abide - by them. Embed parameters

into the messaging system. Review your solution, and determine the best settings for character limits, required data fields, disclaimers, automated responses, and other key protocols. Establish appropriate limits around access – for example, use is limited to established patients only who have been seen in the past 12 months or have an upcoming appointment on the books. Close threads after no activity for 30 days. Sit down with your vendor: bring your requests to the table for the workflow you seek – and ask for their feedback about best practices using their solution.

Prompt for a visit. Integrate an alternative path to care into the messaging system. Consider prompting the patient about handling prescription refills, test results and referrals so those can be routed appropriately, and not get dumped into a message. (Distribute refill requests to the nurse to handle, for example.) Communicate that appointments are available, with a frictionless link to self-schedule. On the backend, allow the physician to respond to the patient prompting a request for a visit. (Some messages may not be appropriate for a written response, but rather the patient needs to be seen.) Consider enabling on-the-fly telemedicine encounters.

Charge for it. There is a clear path to billing for messages, and it's time to use it. After some negative press last year, the idea has taken off. Most large health systems are billing for the provider's time, and patients are responding positively. Most importantly, physicians are grateful for the recognition of the (hard) work. Here's how to charge: (1) be transparent with patients; for example, "most messages are free; however, if a response requires medical expertise – and more than a few minutes of your doctor's time, it may be billed to your insurance;" and insert a prompt to which patients must agree when they start a new message; and (2) use online digital evaluation and management services, as represented by CPT® codes 99421, 99422, and 99423, to bill for messaging. (See SIDEBAR for current Medicare reimbursement rates – and tips for reimbursement.)

- 99421: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes
- 99422: Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 11– 20 minutes
- 99423: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes.

As noted, the codes require an accounting of time; it's very difficult to manage it manually. (For example, you must measure the time over a 7-day period.) Meet with your vendor to discuss how to automate.

Mature the message. Determine how to best staff for messages – the answer should *not* be the physician. Like any type of work, messages should be handled based on working to the top of the license. Consider a focus on "maturing" the message – this refers to how messages are addressed. A medical assistant or LPN may be in the best position to screen and sort messages, curating them while doing so. For example, a message about a troublesome side effect from a medication may prompt the staff to inquire about the nature of the side effect and/or the medication, if the information is left out. Further, some

messages may be handled at that initial screen and/or distributed to the appropriate party to address. In sum, develop an internal air-traffic control system for messages. To be effective, the efforts to mature messages require staff training. Take the same approach to message handling as one would for rooming patients in the clinic – create policies, procedures, and protocols for the work. Train staff – and hold them accountable. Larger practices have developed teams of staff who do nothing but handle messages.

Messaging may be challenging to manage, but there is a silver lining. You are leveraging your free employee – your patient. In the past, you had to pay someone to take the message. While it's frustrating to stare at a voluminous in-box, you didn't have to pay anyone to fill it. Although certainly not all messages are billable, there is now a pathway to be reimbursed for your time and effort.

2023 Medicare Reimbursement (National Payment Amount)

CPT	Payment
99421	$14.91
99422	$29.48
99423	$47.10

Source: **Physician Fee Schedule. Centers for Medicare & Medicaid Services.**

Reimbursement Tips for Online Digital E/M Codes

- Neither appointment requests nor standard prescription refills qualify; the communication should represent an evaluation and management service.
- If the communication is less than five minutes, it is not billable. Post-operative care in the midst of the global period is not eligible, unless unrelated to the surgical event.
- The patient must generate the initial inquiry, although the practice may advertise the availability of the service.
- Like any billable service, the interaction must be medically necessary.

- The time-based codes represent communication that may occur over a seven-day period; the time should be combined.
- The patient must consent to receiving the services, so be sure to address that in your messaging workflow.
- Coinsurance and deductibles generally apply.

Consult the CPT® Manual and payer guidance for additional information.

Risk Matters: Minimizing Risk with Temporary Employees

By Jeffrey A. Woods, JD

As reported by many news outlets and industry experts, the healthcare profession is suffering a severe shortage of workers at every level. This crisis was only worsened by the COVID-19 pandemic and is projected to continue for the foreseeable future. As a result, healthcare institutions and medical practices are hiring travel nurses and other temporary labor to offset the staffing shortages that currently exist. While temporary personnel can provide a much-needed stopgap, they can sometimes increase potential liability for providers and affect patient safety due to a lack of stability and continuity.

Travel nurses and other temporary staff are typically highly trained and experienced; but they often come from other states or regions of the country. For example, they may have previously practiced in a large urban facility or teaching hospital, whereas now they are being asked to work in a small rural community health center which often has limited

resources. Policies and procedures as well as technology (such as the EHR) can differ between these locations. Tasks which may be legally delegated can vary from community-to-community, and routine procedures such as when to contact the on-call provider can be inconsistent. Moreover, the standard of care in the current community may differ from that of their usual community. These differences can and should be addressed through discussion and training at the outset by the facility/employer to minimize risk.

Providers should also take affirmative steps to integrate the temporary staff and reduce risk:

- Use effective communication to ensure you are on the same page
- Be clear in your instructions
- Do not make assumptions about proficiency regardless of the level of experience
- Do not be afraid to follow-up
- Be approachable - invite questions and encourage contact
- Document, document, document

The Most Important Thing

By John T. Ryman, JD

“The single biggest problem in communication is the illusion that it has taken place.” George Bernard Shaw

In real estate, it is often said that the most important thing is location, location, location. In healthcare often the most important thing is communication, communication, communication. The following case is an unfortunate illustration of that principle.

Eve Adams (not real name) presented to her primary obstetrician on May 23, where she was found to be eleven weeks pregnant with a history of pre-term delivery and uterine fibroids. She had blood drawn that day, and a referral was made to a cardiologist for a maternal heart murmur. She was also referred to maternal fetal medicine (“MFM”) specifically for her history of pre-term labor and uterine fibroids. Patient records were faxed to the MFM office that same day. Labs received the following day indicated an abnormal anti-Kell result. These results were sent to the MFM office by fax along with

other records on May 25. The lab results showing the abnormal anti-Kell results and other records were placed in the patient's chart at the MFM office.

On June 9, Eve had her first MFM visit via telemedicine with Dr. Smith. Dr. Smith reviewed the patient's records from the OB's office, but only reviewed the records that were sent in the first fax. She thought that the records sent in the second fax were duplicates. A report of that visit was sent to the referring OB. The stated indications for the visit were fibroids, maternal heart murmur, and history of premature delivery. There was nothing in the report about the anti-Kell.

At the next visit with her primary OB, Eve was seen by a PA. She entered a note in their system stating that she reviewed the MFM notes from Dr. Smith. She noted that Eve was referred to MFM for Kell antibodies, and other concerns, and it appeared that they did not address the Kell antibodies issue. The PA put in that note that she called the MFM office to alert them to the Kell issue and to make a new appointment. The MFM office had no record of this call.

Eve saw the same PA at her primary OB office again a week later during which the PA recorded that Eve would see MFM the following week and that she would follow up on the anti-Kell test results after the MFM visit.

Over the following few months, Eve saw various physicians at the MFM office as well as regular visits with her OB. She did not see Dr. Smith, the original MFM physician, again for any of these visits. Each of the MFM providers relied on the notes from the immediately preceding office visit. None of the subsequent MFM providers reviewed all the records in the chart. Thus, there was never a comprehensive review of the chart that would have revealed the abnormal labs.

On September 19, a routine ultrasound by a MFM physician indicated hydropic changes. Eve was promptly admitted to a hospital for observation and testing, with the plan for an intrauterine transfusion. Based on her condition at the hospital, the treating physician decided it would be best to proceed with a caesarian section rather than the planned intrauterine transfusion. The infant was delivered at approximately 28 weeks. The child had permanent neurologic deficits.

The parents of the child filed a lawsuit alleging that the primary OB, her PA, Dr. Smith and all the other MFM providers who treated the patient were negligent.

SVMIC insured the MFM providers and their group. The allegations against the MFM providers were that they had received the labs with the abnormal anti-Kell test results, and they failed to act appropriately in response to the information. Actions by the MFM would have included diligent monitoring and intrauterine transfusions if anemia appeared. This responsibility appeared to fall primarily on Dr. Smith as the first MFM specialist in the group to see the patient. It was not customary for subsequent treating physicians to review the records other than the last visit notes and any new information. At a mediation, Dr. Smith and her group reached an agreement with the parents to settle the case. Based on

the facts of the case it was reasonable that subsequent MFM physicians relied on previous notes prepared by members of their group. The physicians who saw Eve after Dr. Smith did not settle and were dismissed from the lawsuit.

There was no dispute that the fax with the abnormal labs was received by the MFM practice, and those results were in the patient's chart. Dr. Smith did not completely review the records having relied on the stated reasons for the referral. She thought she had all the information available and necessary to evaluate the concerns prompting referral. Dr. Smith also assumed the records were duplicates of the first batch of records. The patient never brought any other concerns to the attention of Dr. Smith or the other MFM providers. Although the PA documented a call to the MFM practice to alert them to the need for anti-Kell test follow up, there was no record of the call in the MFM records and no further follow up by the PA or OB. It is not certain that more intensive management would have resulted in a better patient outcome, but if the MFM providers had known about the lab results, they would have acted differently. It is clear to see multiple examples of ineffective communication in this case that resulted in treatment opportunities being missed, and a very unfortunate outcome.
