



# Louisiana Lagniappe

*The Official Newsletter of MGMA Louisiana*

Dec. 2016 • Issue 03

## Upcoming Events

### UPCOMING



**December 14**

**“Getting Ready for 2017: The Reimbursement Landscape for Medical Practices”**



### SAVE THE DATE

**MGMA-Louisiana and MGMA Mississippi 2017 Southern Conference**

**August 16-18, 2017**

**Hilton Riverside • New Orleans, LA**



**For more information, visit [www.lmgma.org](http://www.lmgma.org)**

## From the President



**President**  
**Mary Alice Stanford, MBA, CMPE**  
**Renal Associates Baton Rouge**  
**Baton Rouge, LA**

Dear Friends,

Here we are again in the middle of the holiday season! My perspective on the holidays, and relationships has been challenged this year, as my husband and I narrowly escaped the Gatlinburg forest fires unharmed. I have never knowingly been that close to imminent life threatening danger, and it does, indeed, change one’s perspective on life. I will be hugging my family a little tighter, tolerating their eccentricities with a lighter heart, and appreciating of my friends and colleges a little more this year. I truly value my MGMA-LA colleges, and I wish you well throughout the season!

I am so pleased to welcome three new MGMA-LA Board members and to announce our 2017 officers. New board members beginning January 1, 2017 are:

Steve Winker of Hematology Oncology in Baton Rouge

Kathy Oubre of Ponchartrain Cancer Center in Covington

Tashsa Cieslak of Gastroenterology Clinic of Acadiana in Lafayette

Crystal Williams, FACMPE of Cardiovascular Institute of the South will be our ACMPE Representative. I am honored to serve as your president for one more year. Other 2017 officers are:

Crystal Williams, FACMPE, Vice-President/President-Elect

Diane Wiess, Secretary

Tim Barrett, CPA, Treasurer

A great big THANK YOU to this dynamic group of volunteers who are an absolute pleasure to work with!

I wish each of you a very Merry Christmas, and a splendid 2017!

Yours,

**Mary Alice**



## Legislative Update

Greg Ivey, *The Pediatric Center, Sulphur, LA*

On November 10th Greg Albrecht, the legislature's chief economist, delivered an assessment of the state's financial woes estimating a \$315 million dollar shortfall from 2016. Mr. Albrecht suggests that the deficit from last year was mainly driven by continuing dips in employment and lower collections from personal and business income taxes.

Friday, November 18th the Joint Legislative Committee on the Budget held a meeting to discuss how the state got into this situation and what cuts would need to be made to close the deficit gap. Below is an article from *The Times-Picayune* by Julia O'Donoghue that highlights the expected conversation of the Joint Legislative Committee on the Budget.

### Louisiana Budget Deficit comes in at \$313 million

## Louisiana budget deficit: Higher education, Medicaid providers likely to be affected

By Julia O'Donoghue, *NOLA.com | The Times-Picayune*  
November 17, 2016 at 12:54pm, updated November 17, 2016 at 1:21pm

Gov. John Bel Edwards is expected to propose the state delay payments to Medicaid providers and cut higher education by \$18 million to deal with a \$315 million budget deficit on Friday (Nov. 18).

Gov. John Bel Edwards will be proposing that higher education be cut by \$18 million and the state delay Medicaid payments again to health care providers to deal with the state's \$315 million midyear budget deficit.

Edwards staff will be formally proposing a plan for how to deal with the budget deficit Friday morning (Nov. 18) at a hearing with the Louisiana Legislature's financial committees. Lawmakers are expected to vote on some aspects of the proposal at Friday's meeting.

Documents show Edwards' proposal includes midyear cuts to higher education (\$18 million), wildlife and fisheries (\$2.5 million), the health department (\$12 million), K-12 education (\$2.2 million) as well as Edwards's own executive department (\$3.1 million). The government has also managed to move about \$117 million around to avoid making deeper cuts.

But the bulk of the \$315 million midyear budget deficit will be dealt with by pushing off \$152 million worth of financial payments to Medicaid providers into the next year. The payments will eventually have to be made -- so the expense doesn't go away -- but delaying them will help the state avoid substantial cuts in the short term.

This is the second year in a row these Medicaid payments have been delayed to deal with a midyear budget deficit. Gov. Bobby Jindal also pushed off the payments a year ago to cope with a \$500 million midyear budget shortfall last November.

Under Jindal, the state government made just 11 payments to Medicaid providers in 2015, instead of the required 12. To make up for that, the Edwards administration was supposed to make an extra payment, 13 in 2016. But now, Edwards' administration will make just 12 payments -- leaving the extra payment that wasn't made during the Jindal administration still outstanding.

"It's the Jindal payment that seems to be lingering," said House Appropriations chairman Cameron Henry, R-Metairie. "We are just pushing the payment so we are not really fixing the problem."

Last year, Jindal had initially tried to sell the Medicaid payment delay as a "fraud detection" measure -- claiming the payment needed to be pushed so the state government could check for criminal activity in the Medicaid program.

Eventually, the Jindal administration admitted the Medicaid delay was also done to avoid more extensive budget cuts. The Edwards administration has been more upfront about why the Medicaid delay payment may be used this year -- to deal with the midyear budget deficit.

Jindal's delayed payment last year amounted to \$126 million, but the Edwards payment totals \$152 million because the rates charged by Medicaid providers have increased since 2015.

To deal with Louisiana's ongoing financial problems, the Edwards administration also suggested the state bond commission examine restructuring state debt, something it did previously in March to avoid budget cuts.

Yet last spring, Louisiana's financial adviser said a restructuring of state debt should be done only one time to produce savings. "I recommend don't do this again," Renee Boicourt told the state bond commission right before their vote to approve the first debt restructuring in March.

With this in mind, Henry opposed Edwards' plan to look at debt restructuring again this week. And Henry -- as a member of the bond commission -- was able to block the body from formally investigating debt restructuring for a second time, despite the governor's suggestion. The bond commission needs unanimous approval to make such a move, and Henry refused to give his support.

But State Treasurer John Kennedy, the head of the bond commission, asked the staff to look into debt restructuring informally, even if they couldn't do so officially. Kennedy, who is running for U.S. Senate, made his suggestion at the end of the bond commission meeting Thursday -- right after Henry's vote blocked the formal request.

# Welcome New Board Members



## Steven Winkler

Raised in Dalton, GA. the Carpet Capital of the World

High School in Rome, GA - Darlington School '72

College in Nashville, TN - Vanderbilt University '76

Masters in Health Care

Administration in Durham, NC - Duke University '78

Career Started at Tepper Hospital and Clinic in Chattanooga, TN '78-'82 Administrator

Humana Hospital Brandon in Brandon, FL '82-'84 Associate Executive Director

Humana Hospital Bennett in Plantation, FL '84 Associate Executive Director

Baton Rouge General Medical Center in Baton Rouge, LA '84-'05 Vice President of Operations

Earl K Long Medical Center in Baton Rouge, LA '06 Director of Ancillary Services

LSU School of Veterinary Medicine in Baton Rouge, LA '07-'09 Hospital Director

Hematology Oncology Clinic in Baton Rouge, LA '09 to Present Administrator

Married to Monica Nijoka, BSN, RN, MHA who is the VP of Patient Care Services at Baton Rouge General, Three daughters, Megan Winkler Stines, DPT is a physical therapist in Lake Charles, Sara Winkler, MPH, works in Administration for LA Children's' Medical Center in New Orleans, and Alyssa Winkler is a senior at Episcopal High School in Baton Rouge.



## Tasha Cieslak

Mrs. Cieslak, a native of Pecan Island, graduated from the University of Louisiana in Lafayette in 2002 with a Bachelor of Science Degree. She joined Gastroenterology Clinic of Acadiana (The Gastro Clinic) in 2003. She first started as the Scheduling Coordinator and Project Director

before becoming the Practice Manager in 2011. Mrs. Cieslak is a nominee with the American College of Medical Practice Executives.

Mrs. Cieslak is a member of the following professional organizations:

American College of Medical Practice Executives

Medical Group Management Association

Medical Group Management Association - Louisiana Chapter

Medical Group Management Association – Acadiana Chapter

American Society for Gastrointestinal Endoscopy

Tasha was the Acadiana MGMA local chapter president for three years. She was also recently recognized by ASGE Excellence in a GI practice for operation and is on the advisory board for the medical record Modernizing Medicine for the gastro division. Tasha is very active and participates in half marathons and traveling with her family on vacations.



## Kathy W. Oubre, MS

Kathy Oubre has been the Chief Operating Officer for Pontchartrain Cancer Center since September 2005. In this role, she provides non-clinical leadership for all aspects of the practice, including financial counseling, policy/procedure development, billing, nutrition programs and survivorship

care. Kathy is currently overseeing the newest addition to PCC – the integration of clinical trials for individuals looking to receive access to new treatment options for cancer or blood disorders.

After graduating from Louisiana State University, Kathy received her Masters of Science from Southeastern Louisiana University. She is the President of MGMA Northlake Chapter and the President-Elect of the Coalition of Hematology Oncology Practices (CHOP.) Other memberships include the Association of Community Cancer Centers, Medical Group Managers Association, Community Oncology Alliance, and the Junior League of Greater Covington (past board member.) Kathy was also the co-chair for the 2015 Relay for Life in East St. Tammany.



MGMA-LA Webinar

December 14

## *“Getting Ready for 2017: The Reimbursement Landscape for Medical Practices”*

Join us for a webinar on Dec 14, 2016 at 12pm

MGMA-LA webinars are FREE for members! (\$75 non-members)

Visit our website to register now!

### **ABOUT THE WEBINAR**

Discover how shifts in the health care landscape will impact your practice in 2017 - and beyond.

In this dynamic presentation, national speaker, trainer and author Elizabeth Woodcock gives you the lowdown on emerging trends that can pose both opportunities and threats to your practice in the coming year. You'll have a front row seat as Elizabeth shares today's hot button topics, such as the:

- Final Medicare reimbursement for 2017 - what specialties will feel pain, which ones gain
- Summary of the CPT® changes for 2017
- Massive revisions to coding and billing for care management services
- Payment cuts for the government's "voluntary" incentive programs, including the value-based payment modifier
- Compliance with the Merit-based Incentive Payment System in 2017

### ***Are you ready for 2017?***

You'll walk away from this webinar armed with information and knowledge to understand how your practice can weather the storms and take advantage of the opportunities in the coming year.



### **ABOUT OUR SPEAKER:**

Elizabeth Woodcock is a professional speaker, trainer and author specializing in medical practice management. Elizabeth has focused on medical practice operations and revenue cycle management for more than 20 years. Combining innovation and analysis to teach practice operations, she has delivered presentations at regional and national conferences to more than 200,000 physicians and managers. In addition to her popular email newsletters, she has authored 16 best-selling practice management books, and published dozens of articles in national healthcare management journals. Elizabeth is a Fellow in ACMPE and a certified professional coder.

After registering, you will receive a confirmation email containing information about joining the webinar.



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Bayou

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New Orleans

Northlake

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- Vice President, Tom Baggett
- Treasurer, AnnaBeth Scarle
- Secretary, Lee Cox
- 1st Past President, Steven Winkler
- 2nd Past President, Edie Tucker
- 3rd Past President, Barbara LaBauve

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Directors*

**President**

Mary Alice Stanford, MBA, CMPE  
 Renal Associates Baton Rouge  
 Baton Rouge, LA

**Vice President**

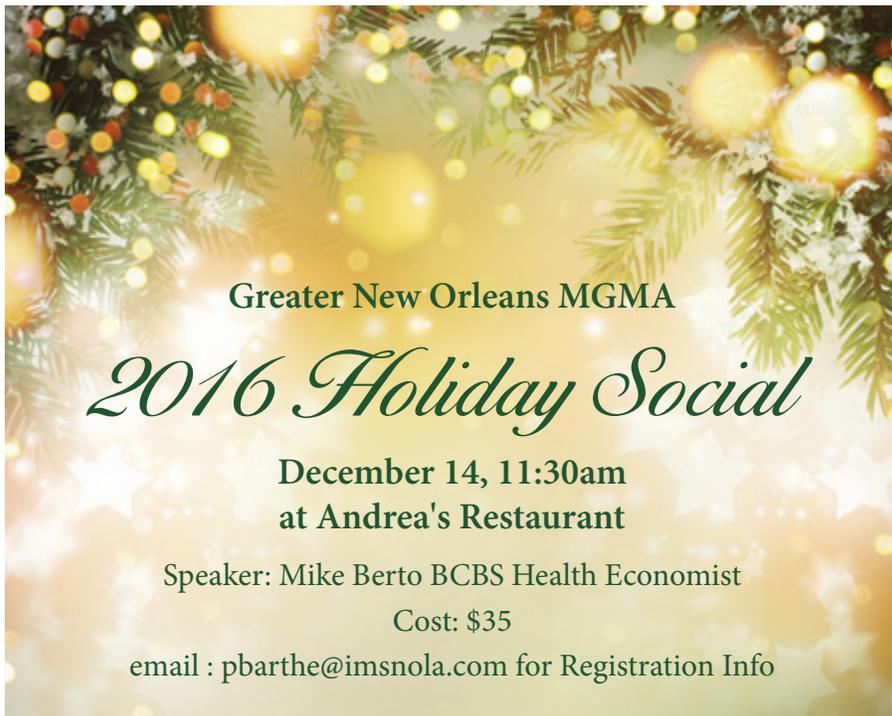
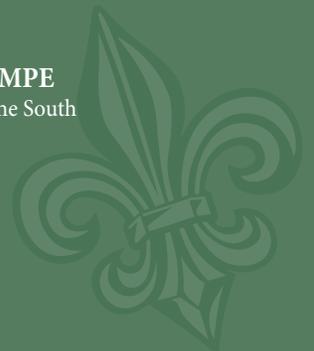
Crystal Williams, FACMPE  
 Cardiovascular Institute of the South  
 Thibodaux, Louisiana

**Treasurer**

Tim Barrett  
 Radiology Associates  
 Baton Rouge, LA

**Secretary**

Diane Weiss, CPC, CPB  
 Wound Care Specialists  
 Metairie, LA



Greater New Orleans MGMA

*2016 Holiday Social*

**December 14, 11:30am  
at Andrea's Restaurant**

Speaker: Mike Berto BCBS Health Economist

Cost: \$35

email : pbarthe@imsnola.com for Registration Info

# ACPME Update

## ACMPE EXAM ENHANCEMENTS



*Board Member*  
**CRYSTAL WILLIAMS,**  
**FACMPE**

Cardiovascular  
Institute of the South  
Thibodaux, Louisiana

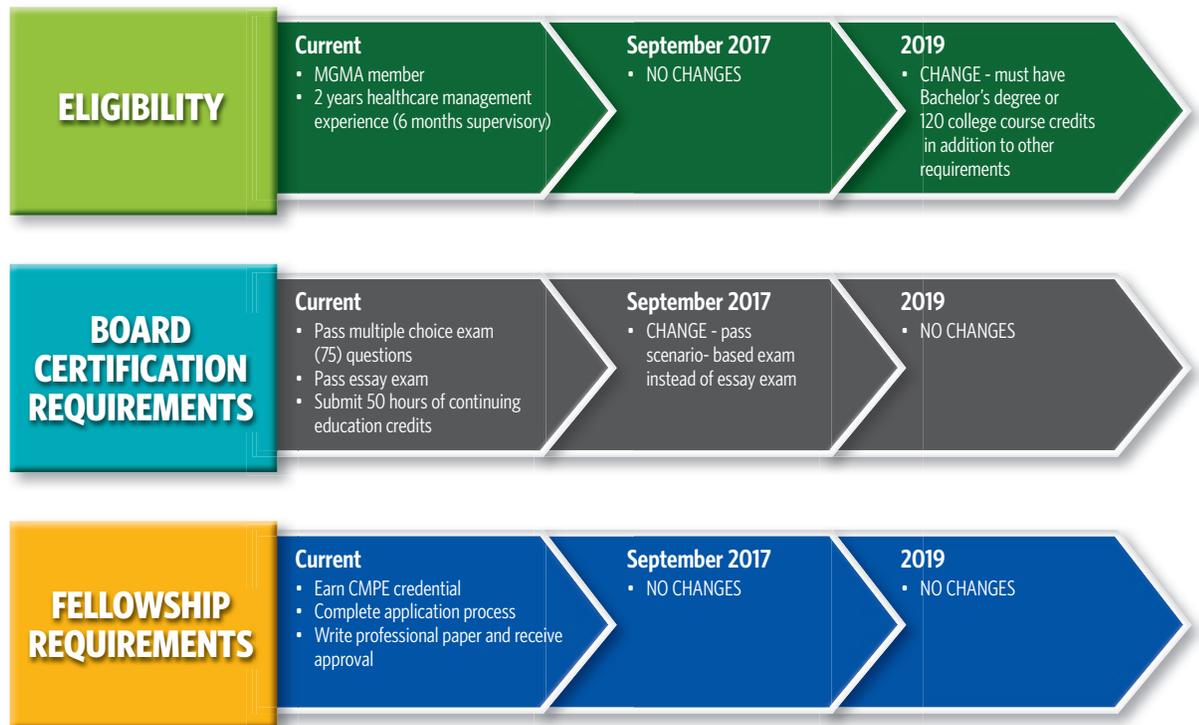
The American College of Medical Practice Executives (ACMPE) is pleased to announce enhancements to the board certification program as a means to strengthen the recognition of certification in the marketplace.

The enhancements were proposed by the ACMPE Certification Commission, with support from a national certification consultant, and approved by the MGMA Board of Directors. The Certification Commission’s work with the consultant highlighted the psychometric strength of the certification requirements and the examinations process and identified areas of improvement to enhance the program.

**These enhancements include:**

1. Transition of the essay exam to a scenario-based, objectively scored exam
2. Implementation of an education requirement for entry into the certification program

**Crosswalk of changes/Timeline:**





## ACMPE FAQs

### Examination updates

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#### **What specifically is changing and when?**

The existing essay exam is being replaced with a new objectively scored examination, which will present the examinee with scenarios, much as our current essay exam proposes a scenario for which the examinee must craft a response. Instead of having the examinee write an essay to respond to the scenario, the examinee will answer 5-7 questions based on the scenario.

The new scenario-based exam will be delivered beginning with the September 2017 exam window. The June 2017 exam window will be the last opportunity to take the essay exam in its current form.

#### **Why change the essay exam?**

To align with best practices and standards in the certification industry and to provide a more reliable, valid and psychometrically sound certification program. This change follows careful and extensive consideration of changes recommended by an outside consultant's review of our certification requirements.

#### **Is the multiple choice exam changing?**

No. The multiple choice portion of the examination will remain the same. You must still take and pass the multiple choice exam as part of the board certification requirements.

#### **If I have already taken and passed the essay exam, will I need to also take and pass the scenario-based exam?**

No. If you have already passed the essay exam, you do not need to pass the scenario-based exam as well. You will only need to complete those requirements that you have not yet met.

#### **How many questions will I need to answer for the scenario-based exam? How long is the exam?**

The scenario-based exam will present examinees with 18-25 scenarios. The scenarios will be real-life situations that you may face as a practice executive. You will be asked to answer five to seven questions in response to each scenario. Examinees will have two hours to complete the exam.

#### **How will the scenario-based exam questions be written and what will constitute a passing grade?**

ACMPE is partnering with its examination vendor, Castle Worldwide, to facilitate the exam-writing process. An Exam Development Committee, consisting in part of current and previous Examinations Committee members, will write questions. Castle Worldwide and other volunteer groups will review and validate those questions. A standard-setting study will then be completed to determine the passing point for the scenario-based exam.

#### **Are there any grandfathering provisions?**

ACMPE will offer the current essay examination through the June 2017 examination window. Beginning in September 2017, examinees who have not passed the essay exam must take the scenario-based exam.

*Advancing Leaders. Advancing Practices.™*

## Education requirement updates

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### **What is the new education requirement for board certification and when does it take effect?**

As of Jan. 1, 2019, a bachelor's degree or the equivalent of 120 college course credit hours will be required to enter the board certification program.

### **Why implement an education requirement?**

An education requirement will take effect in order to elevate the certification and increase its relevance and value in the marketplace.

### **Will I still be required to demonstrate two years of healthcare management experience?**

Yes, the existing eligibility requirements will remain the same. You must still submit a \$250 application fee and demonstrate two years of healthcare management experience, including six months of supervisory experience. The education requirement is in addition to these existing requirements.

### **Are there any grandfathering provisions?**

CMPEs and Fellows who do *not* hold at least a bachelor's degree (or 120 hours of college course credit hours) will be grandfathered into the change.

### **I am a nominee who doesn't have a bachelor's degree. What do I need to do to become compliant?**

Any existing nominees who advance to CMPE status prior to Jan. 1, 2019, will *not* be subject to the education requirement. Effective Jan. 1, 2019, all nominees will be required to meet the education requirement.

## Fellowship requirements

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### **Are the Fellowship requirements affected by this change?**

No. The Fellowship requirements will remain unchanged.

# MACRA final rule: Four tenets to establish a proactive quality payment program strategy

Written by Justin Barnes, Partner and Chief Growth Officer,  
iHealth Innovations | October 31, 2016

With final rule on the Medicare Access and CHIP Reauthorization Act now in hand, physician practices across the nation are preparing for the most dramatic healthcare payment reform this generation has seen.

MACRA and its associated Quality Payment Programs replace former Sustainable Growth Rate provisions for physician Medicare reimbursement and signal the industry's tipping point in the move to value-based care. Fee for Service Models in place today will quickly transform to reflect the seriousness of a cost-conscious era of quality-based reimbursement.

Research conducted in early 2016 suggests that only 43 percent of practices have compensation tied to quality or value of care heading into MACRA. The study also cites regulatory and paperwork burden as the biggest deterrent to practice satisfaction among physicians. The Centers for Medicare and Medicaid Services new policy framework, more than eight years in the making, works to address those concerns, combining several previously unintegrated healthcare reporting initiatives into a unified QPP that most healthcare providers will qualify for.

With pick-your-pace options, flexible measure selection, reporting period flexibility and small-practice provisions cemented by the final rule, providers have a unique opportunity to engage new value-based strategies slowly without penalty. The march toward MACRA is officially underway. This article lays out four key focus areas to help providers successfully navigate the new pay-for-performance model in 2017's inaugural reporting year: financial, clinical, technical and staff training.

## Understanding the MACRA landscape: two paths to participation

Under MACRA, eligible clinicians can begin collecting performance data on care given and technology utilized anytime between Jan. 1, 2017 and Oct. 2, 2017. Data captured by providers during the 2017 reporting period is due by Mar. 31, 2018. Eligible clinicians have two reporting track options to participate in QPPs under MACRA which are the Merit-based Incentive Payment System and the Advanced Alternative Payment Model. Of those eligible clinicians, 90 percent are expected to participate in MIPS and 10 percent in APMs

**MIPS:** This QPP option combines outcome and quality-based payments with reduced fee-for-service reimbursement. MIPS integrates three payment programs—the Physician Quality Reporting System, Meaningful Use, and Value-based Payment Modifier—with an assessment of clinical practice improvement initiatives to establish an annual Composite Performance Score that reflects a physician's standing relative to reporting peers, on a scale of 1-100. That score determines Medicare incentive or penalty payments for physicians at a 4 percent adjustment rate starting in 2019, and up to a 9 percent adjustment rate by 2022.

While cost will be tracked by CMS in 2017, cost category determinants will not be factored into payment adjustments until 2018. Under MIPS, providers can choose quality reporting objectives and measures that best align with medical practice specialty and workflow specifics. Only physicians practicing under Medicare for the first time in 2017 and those who anticipate billing less than \$30,000 for fewer than 100



Medicare Part B patients are exempt (unless of course you are in a CMS Advanced APM).

Clinicians have four “pick-your-pace” avenues for payment program participation in MIPS:

### Option 1: Nonparticipation

Providers who do not submit 2017 QPP data will suffer a 4 percent negative payment adjustment.

### Option 2: Submit partial data

Providers who submit QPP data on at least one quality measure or improvement activity, or the required measures in advancing care information can avoid a negative payment adjustment.

### Option 3: Partial reporting period

Providers who submit more than one quality measure, more than one improvement activity, or more than the required measures in advancing care information for a period of 90 days can earn a neutral or small positive payment adjustment.

### Option 4: Full reporting

Providers who submit for a full 90-day period or a full year of 2017 data in all categories may earn a moderate (or full) positive payment adjustment.

Clinicians can report MIPS data independently or with a group entity. For the initial transition year under MIPS, reporting thresholds have been lowered and an additional \$500 million has been provisioned annually for “exceptional performance” bonuses to clinicians who achieve a final score of 70 or higher.

**Advanced APMs:** The second category of QPP under MACRA is Advanced APMs. Less than 10 percent of MACRA-eligible providers are expected to qualify for an Advanced APM in the first reporting year under this regulation. Physicians who qualify to report under an Advanced APM get a 5 percent bonus each of the first six years of

Continued on page 8

*Continued from page 7*

MACRA, and base payment updates higher than those under MIPS from 2026 onward, when the reporting party earns significant revenue (25 percent) or sees sufficient patient volumes (20 percent) through qualifying Medicare or payer models.

Payment adjustments based on 2017 performance data will go into effect on Jan. 1, 2019. The MACRA final rule provisions \$20 million each year for five years to fund training and education for small practices of 15 or fewer clinicians and practices in rural areas.

#### Four keys to navigate the transition

Implementing a comprehensive strategy is critical to provider success under MACRA. Assessing infrastructure before layering in payment program initiatives ensures future plans are built on a solid foundation. Practices should focus on four areas in evaluations and strategic planning: financial, clinical, technical and staff training.

##### *Financial success*

The best place to start when evaluating infrastructure is the existing revenue cycle. Stabilize and optimize revenue streams to ensure the practice isn't leaving money on the table. Renewed emphasis on accurate coding, documentation support, self-audits and denial management can help plug revenue leaks, potentially shoring up funds that may serve the practice elsewhere. It's important to understand key performance indicators, trending and the cost of operation heading into QPP participation.

Providers should know how to scrutinize their payer reimbursements. Analyze contracts and variance rates to ensure revenue due to the practice is collected. It's also important to understand any value- and risk-based contracts a practice may qualify for. Reach out to the commercial payers engaged with the practice to determine what is available in the area. Many plan-specific and state-based incentive programs that exist are not advertised.

##### *Clinical success*

With performance on quality targets accounting for 60 percent of MIPS scores in the first year of QPP, quality measures will be an essential aspect of success. Understanding where the practice has performed strongly in previous years and aligning those services to MIPS measures, will influence quality measure focus going forward and can help practices be competitive. Take advantage of measures that appear across multiple categories to reduce reporting burdens.

Population health and care coordination are at the heart of QPP models. Focus on expanding communication with beneficiaries and patient care teams as well as specialists. Much of the care coordination measures center around collecting and sharing patient information with care teams, referred providers and the patient themselves. Optimize outcomes by partnering with facilities across the continuum of care. Be consistent in using existing functionality for electronic data exchange and messaging or identify new, cost-effective opportunities for patient engagement, communication, education and empowerment.

##### *Technical success*

Technology infrastructure is paramount to reporting under MACRA. Establish a firm understanding of the measures and the existing EHR functionality that is available to track for the adopted payment model. Practices will need to integrate data from financial and clinical sources to monitor and report on required measures and factors. In many in-

stances, we have found that providers have not been able to optimize the most recent functionality enhancements in the EHR and health IT systems they already have.

In some cases, EHR template and workflow customization as well as dashboard creation can help practices quickly and routinely target measures and KPIs pertinent to practice objectives. Test the process for submitting reporting metrics ahead of time, streamline workflows and leverage technology wherever possible to create efficiencies for patient engagement and throughput.

##### *Staff success*

Securing inside expertise on new payment models, health information management and technology implementation is a major challenge for practices today. Practices need to align with partners who can help shoulder the burden of expertise and implementation, educating practice stakeholders along the way while still allowing them to focus on patients as priority number one. Look for partners who will keep practice staff informed, proactively evaluate payment models, offer coaching on how to go engage payers and help management flesh out strategic initiatives.

Involve and educate appropriate staff members at different points in the planning process and make sure the team has a collective general understanding of practice objectives so everyone is working toward the same goals. Take advantage of resources such as Medicare's [Physician Compare](#) and [Quality Resource Use Reports](#) to benchmark and compare physician performance and reporting practices.

#### Moving past provider hesitation

Competing priorities, limited resources and general unfamiliarity with MACRA and the final rule have contributed to market hesitation to embrace reform, even with MACRA's commencement close at hand. That said, there will not likely be a more ideal time for physicians to prepare for the QPP transition.

Flexible, scaled participation options mean physicians can stave off first-year losses and potentially earn incentive and bonus payments via partial reporting as clinicians learn to navigate the new system. In re-writing policy, close attention was paid to identifying quality measures that were applicable across multiple models to incentivize providers for improving outcomes while simplifying the reporting process. Diminished reporting data thresholds have been implemented during the first reporting year. CMS also built in small and rural practice training resources to counter market concern.

Care providers who proactively engage with new payment and care delivery models, and cultivate the right partnerships and expertise, will unequivocally have more opportunity in the future. These three steps quickly engage stakeholders and establish proactive momentum for the MACRA journey:

- Take advantage of every resource available to learn about QPP specifics and support practice efforts
- Engage partners with the needed expertise or designate internal resources to lead the charge
- Establish a strong game plan that begins by January 2017

The average practice can easily qualify for incentives under the new QPP, but many lack the internal resources necessary to succeed under MACRA. Proactive leadership and expert partnerships are essential to juggle the new initiatives and cultivate a value-based business strategy.



*Board Member*

**DIANE WEISS,**  
**CPC, CPB**

Wound Care Specialists  
Metairie, LA

Please check out this  
informative article  
**5 Patient Privacy Scenarios  
that May Surprise You**  
*by Marea Aspillaga*  
by clicking [here](#)  
and scrolling to page 42.

*Continued from page 8*

Look for partners that will go “at-risk” with you. Tie them to your success, that way everyone is guaranteed to win.

**Embracing a business approach for value-based care**

There is real opportunity for practices to be a catalyst for change within communities. Patient growth, panel participation, partnership opportunities and care model invitations are among the benefits that proactive practices stand to reap, all of which could have big implications for coordinated care and population health initiatives. Practices that lead the charge, participate in broader patient and community engagement and grow the care ecosystem will have the long-term advantage.

**About the Author:**

Justin Barnes is a nationally recognized business and policy advisor who serves as Chairman Emeritus of the HIMSS EHR Association as well as Co-Chairman of the Accountable Care Community of Practice. As Chief Growth Officer with iHealth, Justin assists providers with optimizing revenue sources and transitioning to value-based payment and care delivery models. Justin has formally addressed Congress and the last two Presidential Administrations on more than twenty occasions on the topics of MACRA, value-based medicine, accountable care, interoperability, consumerism and more. He is also host of the weekly syndicated radio show “This Just In.”

**Justin T. Barnes**

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# Summary of 2017 CPT Changes

## Moderate Sedation

99151-99157 Moderate Sedation code section has been replaced, (prior codes 99143-99150 are deleted). A careful review of Appendix G will prepare practices to separately report Moderate (Conscious) Sedation. This change decreases the value of the codes listed in Appendix G and will require separate documentation of the patient age and sedation time to code 99151-99157. The new codes are based on age groups (younger or older than age 5) and time increments of 15 minutes.

## Evaluation and Management changes

Two new medicine codes have been added to replace 99420 (Administration of Health Risk Assessment instrument). The new codes are found in the *Medicine Section* for a patient focused (96160) or a patient caregiver focused (96161) questionnaire.

## Physical Therapy

New Physical Therapy (PT) Occupational Therapy (OT) and Athletic Training (AT) codes have been introduced and now include reporting of three levels of evaluation and one re-evaluation, based on several factors including a patient history and an examination with development of a plan of care. The three levels of clinical decision making are low, moderate and high complexity using a standardized patient assessment instrument. The definitions of the extent of physical examination and complexity of decision making are unique to Physical Medicine and Rehabilitation and do not match the Evaluation and Management definitions of these terms.

The tiered evaluation codes provide the opportunity to base coding on decision making instead of the episode of care (old codes were described as "initial" and "Re-Evaluation"). Codes 97161-97164 (PT), 97165-97168(OT), and 97169-97172 (AT) are resequenced code numbers that appear before the Modalities subsection.

## Surgery changes

Spinal Instrumentation codes have been replaced to identify intervertebral biomechanical devices and interspinous process stabilization devices. Refer to section 22853-22859 and 22867-22870.

Laryngoplasty code 31582 has been replaced by 4 new codes describing surgery for laryngeal stenosis (congenital or acquired) by several methods (31551-31554). New codes 31591 and 31592 describe procedures on the larynx to treat weakness or stenosis.

Endovenous ablation therapy code report a combination of mechanical and chemical methods to ablate the veins (36473 and 36474)

New Dialysis Circuit codes (36901-369096) A new subsection of nine codes report services that allow repeated access to blood vessels to perform hemodialysis. CPT code report two segments of this service, the peripheral dialysis segment and the central dialysis segment. The definitions and guidelines for the new codes cover

2 full pages and should be reviewed before using the new codes. Watch for bundling of imaging and radiological supervision and interpretation (S&I) required to perform the angioplasty

Spinal injections (62320-62327) series reports epidural and subarachnoid injections, with or without imaging guidance, reported by spinal region. These codes replace 62311-62318.

Transluminal balloon angioplasty codes have been replaced with four new codes (37246-37249) that replace the eight deleted codes that streamline reporting and include all necessary imaging and radiological S&I.

## Radiology

Mammography codes have been simplified and there are new three new codes to replace five deleted codes. Each of the three new codes include computer-aided detection (CAD). Two codes report diagnostic mammography (77065 unilateral and 77066 bilateral) and 77067 reports bilateral screening mammography with CAD detection when performed.

## Pathology and Laboratory

Drug screening codes have been expanded to report screening based on the method (J80305-80307). New guidelines say to report the new codes only one per test regardless of the number of drugs classes tested. New codes for genomic sequence analysis have been added to identify cardiac conditions, fetal chromosomal abnormalities and central nervous system infection.

## Medicine Section

Several vaccination codes have been revised to eliminate age from the description, such as nine influenza codes, and are now reported by dosage.

Psychotherapy codes 90832-90838 have been revised to include time with informants. CPT 90846 and 90847 are reported with "utilizing family psychotherapy techniques focusing on family dynamics" with or without the patient present. Time duration for this code is 50 minutes, and may be reported with the time exceeds 26 minutes (rounding rule).

Cardiovascular codes have been introduced to report repair of paravalvular leak, based on the site of the leak (mitral valve or aortic valve) using 93590-+93592.

## Nancy M. Enos, FACMPE, CPC-I, CPMA, CEMC, CPC

58 Sevilla Avenue

Warwick, RI 02889

Tel: 401-738-1123 Cell: 401-486-8222

Email: nancy@enosmedicalcoding.com

Website: www.enosmedicalcoding.com