

Reimbursement 2013

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Agenda

- What's Going On Right Now
- Medicare PFS Final Rule 2013
- HOPPS Final Rule 2013
- PQRS and E-Prescribing
- Meaningful Use/ HIT
- The Value-Based Modifier
- Audit Mania
- CPT 2013
- Your To Do List

Disclaimer

- Payers differ on their guidelines. Please verify coding for each payer and claim.
- All Medicare information is derived from the the Proposed Rule. This information will change in the Final rule.
- This is not legal or payment advice.
- This content is abbreviated for Medical Oncology Part B. It does not substitute for a thorough review of code books, regulations, and Carrier guidance.
- This information is good for the date of the information and may contain typographical errors.
- CPT is the trademark for the American Medical Association. All Rights Reserved.
- This is based on regulations located at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1590-FC.html>

Medicare Physician Payment Basics

- Payments are based on RVUs for each code ($WRVUs + PERVUs + MalRVUs$)
- RVUs are multiplied times $GPCIs$ for your area. There is a work GPCI floor in some areas of 1.00. ($W * WGPCI + PE * PEGPCI + Mal * MalGPCI$)
- The Medicare conversion factor determines the overall level of Medicare payments ($W * WGPCI + PE * PEGPCI + Mal * MalGPCI$) times CF = \$Your Total Allowable for your area
- A formula spelled out in the Medicare statute determines the annual update to the **conversion factor** and that has been a disaster.

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1590-FC.html>

SGR Update

- The 2012 conversion factor was \$34.0376
- Without Congressional Action, the following was to happen:
 - Reduction of 26.5%
 - Resulting in a conversion factor of \$25.0008;
 - The new conversion factor for 2013 is actually \$34.0230.
- Imaging Reductions
 - \$800 million from Advanced Imaging starting in 2014.
 - \$300 million from hospital-based Radiation Therapy starting in 2014.

SEQUESTRATION!

- Sequestration put off until March 1, 2013
 - Medicare due for 2% across the board on April 1
 - Will impact everything including drugs
 - Will the 2% come out of the Medicare portion.
 - 104.304% ASP
 - All patient payments excluded
 - Will come out of EHR incentives and probably out of other incentives paid during the sequestration period.
 - For no-PAR practices, this will come out of patient payments

Specialty Impact (w/o Sequester)

- Hematology Oncology = +2%
- Radiation Oncology = -7%
- Radiation Therapy Centers = -9%
- Family Practice = +7%
- PA = +3%
- NP = +4%

Drug Admin Changes in RVU's Only 2013 w/ 2012 CF

| HCP | Modifier | Description | RVU Variance | Variance Dollars per Unit |
|-------|----------|------------------------------|--------------|---------------------------|
| 96360 | | Hydration iv infusion init | 2.38% | \$0.81 |
| 96361 | | Hydrate iv infusion add-on | 0.00% | \$0.00 |
| 96365 | | Ther/proph/diag iv inf init | 4.23% | \$1.44 |
| 96366 | | Ther/proph/diag iv inf addon | 1.59% | \$0.54 |
| 96367 | | Tx/proph/dg addl seq iv inf | -1.05% | -\$0.36 |
| 96368 | | Ther/diag concurrent inf | -1.79% | -\$0.61 |
| 96369 | | Sc ther infusion up to 1 hr | 13.45% | \$4.58 |
| 96372 | | Ther/proph/diag inj sc/im | 7.04% | \$2.40 |
| 96374 | | Ther/proph/diag inj iv push | 3.05% | \$1.04 |
| 96375 | | Tx/pro/dx inj new drug addon | 0.00% | \$0.00 |
| 96401 | | Chemo anti-neopl sq/im | 3.72% | \$1.27 |
| 96402 | | Chemo hormon antineopl sq/im | -3.03% | -\$1.03 |
| 96409 | | Chemo iv push sngl drug | 0.92% | \$0.31 |
| 96411 | | Chemo iv push addl drug | 0.55% | \$0.19 |
| 96413 | | Chemo iv infusion 1 hr | 3.44% | \$1.17 |
| 96415 | | Chemo iv infusion addl hr | 0.00% | \$0.00 |
| 96416 | | Chemo prolong infuse w/pump | 3.20% | \$1.09 |
| 96417 | | Chemo iv infus each addl seq | 0.00% | \$0.00 |



GPCIs

- Geographical indices were updated to exclude the GPCI floor, except in Frontier States, Alaska, and Hawaii. This is a Work RVU of 1.00.
- Other changes were made based on the Institute of Medicine report.

Radiation Takes A Hit

- Radiation is truly impacted by two codes in reduction:
 - 77418 = IMRT
 - 77373 = SBRT
 - Not impacted in the hospital setting
 - Better reimbursement than proposed
- Plus for imaging, there is another MPPR (MULTIPLE PROCEDURE) reduction to the professional component (25%), if two or more physicians of the same specialty do the same service on the same day. Must be in the same group.

MPFS 2013

- **Practice Expense**: This is the final year of the four-year phase-in of the implementation of the American Medical Association (AMA) Physician Practice Information Survey (PPIS) data administered in 2007/08 for practice expense (PE) indirect per hour rate. Oncology is still using the AMA SMS data series.
- In 2013, this process of 5-year review will end and CMS will focus on mis-valued codes. These include 96413, 96367, and 96365. Surveys are being done now .There will be changes in 2014.
- ASH and ASCO have asked for these increases.

<https://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp#TopOfPage>

Primary Care and Care Coordination 2013

- This is payment for post-discharge care coordination. The payment would reflect the costs of comprehensive transition of the patient after they leave the hospital.
- Medicare is going to use the new CPT codes: 99495-99496.
- They must be billed ONCE within the 30 days following discharge.
- In the proposal, the discharge physician billing 99238-99239 would not be eligible to bill these. Same for 99217, 99234-99236, 99281-99285, 99315-99316—this is not true in the Final Rule.
- But, follow the unbundling rules on these codes.

Transitional Care Coordination 2013

- The service would include the following:
 - Assuming responsibility for the patient care including: obtaining and reviewing the discharge summary, reviewing tests, reviewing treatment, and updating the medical record within 14 days of discharge;
 - Establishing and/or adjusting the plan of care to reflect the patient's health status, medical needs, functional status, pain control, and psychosocial needs following discharge;
 - Assessment and support for treatment regimen adherence and medication management;
 - Communication between the patient within 2 business days of discharge with adjustment of the medication list to reconcile pre- and post-discharge medications;
 - Coordinating with other caregivers and community resources; and,
 - Assistance with scheduling of appointment, facilitating access to care and services.

Use of the Codes 99495-99496

- Will be different for other payers
- May be used for Transitional Care Coordination as described in the Final Rule. But, you must be the patient's home, in terms of transition or other folks will bill
- Must have a FTF visit within specified timeframes.
- Contact with patient must occur within 2 days of discharge
- Must bill on the 30th day after discharge and the documentation is non-FTF, but similar to Care Plan Oversight

Molecular Pathology Codes

- Paid under stacking codes right now—many of our personalized medicine codes fall under these.
- Usually billed by the lab not by the doctor
- There is a new G-code for interpretation and report of a molecular pathology service—was 83912 and now, for Medicare, is G0452

Preventive Services

| HCPCS | Descriptor | NCD # | CMS CR |
|-------|--|--------|---------|
| G0442 | Annual alcohol misuse screening, 15 min | 210.8 | CR7633 |
| G0443 | Brief FTF behavioral counseling for alcohol misuse, 15 min | 210.8 | CR7633 |
| G0444 | Annual Depression Screening, 15 min | 210.9 | CR7637 |
| G0445 | High intensity behavioral counseling to prevent STDs, FTF, semi-annual, 30 min | 210.10 | CR 7610 |
| G0446 | Annual FTF behavioral therapy for cardiovascular disease, 15 min | 210.11 | CR7636 |
| G0447 | FTF behavioral counseling for obesity, 15 min | 210.12 | CR 7641 |

MPFS 2013

- Drugs

- Average Manufacturers' Price will be price substitution for drugs where AMP is 5% or more below ASP for 2 consecutive quarters prior to the current quarter or for 3 out of the preceding 4 quarters.
- CMS emphasized that 103% of AMP will be the price substitute if the threshold is exceeded per the guidelines. Before implementation, 103% of AMP and 106% of ASP will be compared.
- This substitution will not take place in the face of drug shortages.

<https://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp#TopOfPage>

MPFS 2013

- Specialty or In-house Pharmacy Drugs in the Office
 - Example in the Final Rule is very vague and is directed to implanted pumps and DME vendors, not Oncology
 - But of concern are the following statements:
 - “We believe that fraud and abuse risk is minimized by requiring that the drug and administration are billed by the same entity”.
 - “...our guidance is clear that the entity that dispenses the drug needs to furnish it directly to the patient for whom a prescription is written. An arrangement whereby a pharmacy (or supplier) ships a drug to a physician’s office for administration to a patient does not constitute furnishing the drug directly to the patient.”
 - “Moreover, the incident to benefit category does not permit pharmacy billing for the incident to drug.”

DME Face-To-Face Requirement

- A provider must see the patient 180 days before the order for DME is written
- An assessment for the DME must be part of this encounter.
- Physicians must document that a PA, NP, or CNS performed the encounter, if that is true. They will be compensated with a G-code, G0454.
- DME must cost over \$1000. The most likely service ordered in a cancer situation would be oxygen equipment.

Elimination of the Requirement for Termination of non-Random Pre-payment Audits

- Currently there is a one-year deadline or when there is an improvement of 70% over the previous error rate deadline to terminate pre-payment review
- This has been reversed and gives contractors full discretion over when these audits are terminated without national directive

HOPPS 2013

HOPPS Rule

- CMS proposes to implement several new policies:
 - Change from median to geometric mean-based relative weights
 - **Payment for separately payable drugs, biologicals, and diagnostic radiopharmaceuticals without pass-through status paid at ASP+6%**
 - Increase packaging threshold for drugs and biologicals from \$75 to \$80
 - Payment reductions for certain Ambulatory Payment Classifications (APCs), including Abdomen/Pelvis CTs and Proton Beam Therapy
 - Payment adjustment policy for radioisotopes derived from non-highly enriched uranium sources

Select APC Payment Rates

| HCPCS | APC | 2012 Rate | 2013 Nat'l Rate | % Difference |
|-------|------------|-----------|-----------------|--------------|
| 96360 | 0438 | \$72.76 | \$74.84 | 2.86 |
| 96361 | 0436 | \$24.83 | \$27.08 | 9.06 |
| 96365 | 0439 | \$126.76 | \$146.11 | 15.27 |
| 96366 | 0437(0436) | \$34.85 | \$27.08 | -22.30 |
| 96401 | 0437 | \$34.85 | \$39.10 | 12.20 |
| 96406 | 0439 | \$126.76 | \$146.11 | 15.27 |
| 96411 | 0438 | \$72.76 | \$74.84 | 2.86 |
| 96413 | 0440 | \$207.95 | \$230.81 | 10.99 |
| 96422 | 0440 | \$207.95 | \$230.81 | 10.99 |
| 96440 | 0439 | \$126.76 | \$146.11 | 15.27 |
| 96542 | 0438 | \$72.76 | \$74.84 | 2.86 |



Medicare Physician Fee Schedule

PQRS and E-Prescribing

2012

COMPARISON OVERVIEW – EHR, eRx and PQRS

| | Medicare EHR | Medicaid EHR | Medicare eRx | PQRS |
|---|--|--|---|---|
| Eligible Professional | MD, DO, Dentist, Podiatrist, Optometrist or Chiropractor, EXCEPT hospital-based | Physician, Dentist, Midwife, NP and some PAs, EXCEPT hospital-based. | MD, DO, Dentist, Oral Surgeon, Podiatrist, Optometrist, Chiropractor, PA, NP, Nurse Sp., Social Worker, Psychologist, Dietician, Nutritionist, Audiologist, PT, OT, ST. | Same as eRx |
| Patient Volume Requirement | None | 30% Medicaid; 20% for Peds; special rules if practice in FQHC or RHC | At least 10% of allowed charges in designated codes | No, but must have sufficient Medicare patients to meet reporting thresholds. |
| General Requirements for Incentive Payment | Meaningful use, including clinical data reporting | Meaningful use, clinical data reporting (BUT in 1 st year can buy, implement or upgrade). | 25 e-prescriptions in designated codes | <u>For Individual Measures:</u> Claims: At least 3 measures for 50% of eligible patients Registry and EHR: At least 3 measures for 80% of eligible patients. <u>For Group Measures:</u> See Table 74 in final PFS Rule (11/29/10 Fed Reg) |
| Group Practice | EPs can assign payment to group | No specific provision | Yes, if participating in PQRS. | Yes, apply for |
| Payment | \$24,000 - \$44,000 (+ 10% if HPSA) | \$63,750 | 2011 and 2012 – 1% add-on 2013 – 0.5% add-on | 2011 – 1% add-on 2012-2014 – 0.5% add-on Additional 0.5% add-on for MOC participation |
| Incentive Start | 1/1/11 | 1/1/11 | 2009 | 2007 |
| Penalties (only apply if qualify for incentive) | 2015 - 1% decrease 2016 - 2% decrease 2017 - 3% decrease 2018 - 3-5% decrease | None | 2012 - 1% decrease 2013 - 1.5% decrease 2014 and after - 2% decrease | 2015 – 1.5% decrease 2016 and after – 2% decrease |

PQRS 2013

- The PQRS pays bonuses equal to a 0.5% bonus for reporting years in 2012 through 2014. This is for all fee schedule services, excludes drugs, labs, and DME.
- In 2015, providers who don't participate in PQRS will suffer a payment decrease. Beginning in 2015, EPs who do not satisfactorily report Physician Quality Reporting System measures will be subject to payment adjustments
 - 2015: -1.5% payment adjustment
 - 2016 and beyond: -2% payment adjustment
- **BOTTOM LINE: If you do not report in 2013, you will be fined in 2015, BUT take heart---there are lots of ways to do this.**

PQRS 2013

- PQRS Changes (Proposed)
 - CMS is making an effort to consolidate PQRS reporting with ARRA HIT incentives for Quality Indicator Reporting.
 - Time frame—a six month reporting period will only be available for **Measures Groups through a Registry**. All other reporting must be for **the full twelve-month period**
 - You can just bill one measure or one measure group in 2013 if you are trying this out
 - Changes GPRO options that our outlined in the next few slides.
 - There are 264 measures; 26 measures groups.

PQRS Reporting

- Individual reporting exists for those who want it
 - Criteria for EPs is the same, except the 1 measure or measures group to AVOID PENALTY
 - 50% (Claims only) or 80% for 3 measures, with exceptions for incentive and penalty
 - Elect options, if desired
- Expanded Group Options
 - New definition of GPRO as ≥ 2 physicians through self-nomination process before 10/15/2013
- Administrative claims option for all practices
 - Effective for 2 years
 - Extraction of data by CMS
 - For penalty only—not for incentive

A Measures Group for Oncology!

- Report 20 consecutive over 18 years old FFS Medicare patients who meet criteria for one or all measures per EP as applicable:
 - 71 Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor /Progesterone Receptor (ER/PR) Positive Breast Cancer
 - 72 Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients
 - 110 Preventive Care and Screening: Influenza Immunization (Patients over 50)
 - 130 Documentation of Current Medications in the Medical Record
 - 143 Oncology: Medical and Radiation – Pain Intensity Quantified
 - 144 Oncology: Medical and Radiation – Plan of Care for Pain
 - 194 Oncology: Cancer Stage Documented
 - 226 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- **Registry only**

Want to Report Measures Group?

- Select a qualified Medicare PQRS Registry
- Report 20 mostly Medicare FFS per the instructions of your Registry per Eligible Provider. This can be any time before the end of the reporting period (end of February 2014).
- Pay the Registry bill after data submitted.
- You're done!

Oncology Measures Changed

- Some of our existing measures are changed. Please take another look at these before your report:
 - Colon Cancer & Chemo: 18-80 years age criteria
 - Oncology Stage Documented: Broadened the denominator
 - Melanoma Overutilization of Imaging: Cancer staging added
- Measure 124 deleted (EMR use) along with G8447.

2013 PQRS/VBM Matrix

| Size of Group | 1 NPI/ EP | 2-24 NPIs/ TIN | 25-99 NPIs/TIN | 100+ NPIs/ TIN |
|-----------------------------------|--|--|---|--|
| PQRS Individual Reporting Options | <ul style="list-style-type: none"> •Yes, Claims, Registry, Groups, EHR •Admin Claims | <ul style="list-style-type: none"> •Yes, Claims, Registry, Groups, EHR •Admin Claims | <ul style="list-style-type: none"> •Yes, Claims, Registry, Groups, EHR •Admin Claims | No! This will cause a fine of 1% in 2015 |
| PQRS Group Reporting (GPRO) | No access | <ul style="list-style-type: none"> •Yes, Registry, Groups •Admin Claims | <ul style="list-style-type: none"> •Yes,, Registry, Groups •Admin Claims • GPRO Web Tool interface | <ul style="list-style-type: none"> • GPRO Web Tool interface •Administrative claims •No claims, registry or EHR option |
| Application of 2015 VBM | N/A | N/A | N/A | <ul style="list-style-type: none"> • -1% if reporting not satisfactory as a GROUP •0% if report with option of doing quality tiering |

GPRO Nomination

- Self-nominate by 10/15/2013
 - Web interface
 - May be extended
- Size of group will be determined at nomination
- Select reporting mechanism right then
- Opt out through 4/1/2013

PQRS Group Reporting Options

- Group Reporting (GPRO Web Interface)
 - Group size \geq 25 NPIs/ TIN
 - Report 18 measures on an assigned sample of patients
 - CMS attributes patients retrospectively based on E/M codes
 - Aligns with ACO and MSS reporting
- Administrative claims
 - Group size \geq 25 NPIs/TIN
 - CMS analyzes claims data for measures
 - Avoids penalty but no incentive
 - Lasts for 2 years only and for penalty only—no incentive

Group Reporting: 2-99 NPIs/TIN

- Claims Reporting

- Submit a G-code on claims data
- Report 3 measures on at least 50% of Group's Medicare Part B FFS patients for incentive
- Report on at least ONE measure to avoid penalty

- Registry Reporting

- Submit data through a CMS-approved registry
- Report 3 measures on at least 80% of the Group's Medicare Part B FFS patients
- Report at least ONE measure to avoid penalties

Group Reporting: 2-99 NPIs/TIN

- EHR Options
 - 2013
 - EPs report data directly from EHR (direct EHR product) OR through intermediary (EHR submission vendor)
 - Remove the 'qualified' EHR for PQRS, as long as qualified for MU
 - 2 sets of criteria for incentives
 - Report 3 CQMs from Core plus 3 additional measures for Medicare Part B FFS patients
 - Report 3 measures for 80% of patients
 - 2014
 - Similar to 2013, but first option will align with EHR incentives (maybe)

GPRO Web Interface

- Patients attributed by E/M services
 - Plurality of E/M assigned in a certain period
 - Might be more consistent with ACO assignment in the future—up in the air
- Will have to report on a sample of patients
 - 2-99 NPIs/ TIN = report first 218 beneficiaries
 - 100+ NPIs/TIN =report first 411 beneficiaries

Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS)

- For all GPRO Groups, not just groups using the GPRO interface
- CMS will administer and pay for this survey
- CG-CAHPS will measure:
 - Getting timely care, appointments, information
 - How well Doctors communicate
 - Patients' rating of doctors
 - Access to Specialists
 - Health promotion and education
 - Shared decision-making
- Will be posted publicly on PHYSICIAN COMPARE

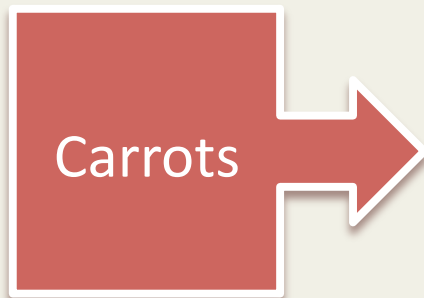
Why Participate?

- Performance will be the basis for payment in the near future
- Physician Compare beginning in 2013
 - <http://www.medicare.gov/find-a-doctor/provider-search.aspx>

Physician Compare Web Site

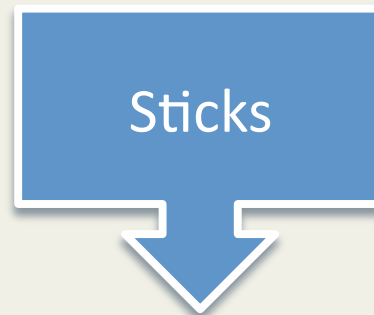
- Initial phase included reporting of 2009 PQRS, if the EP was successful.
- Now reportedly included 2010 e-prescribers and PQRS successful reporting.
- Will report GPRO Quality reporting from 2012.
- More quality reporting to come.
- Check the information on your providers.

How It Fits Together



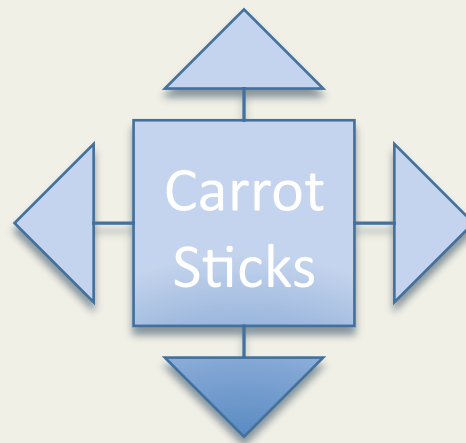
2007-2011

- PQRS
- E-Rx
- EHR



2012-2015

- E-Rx Penalties
- PQRS Penalties
- EHR Penalties



2015-2017

- Value Modifier

Section 3007 of the Affordable Care Act

- Payment Modifier under fee schedule based on cost versus quality of care comparison
 - Quality and cost composite measures
 - Outcome measures risk-adjusted
 - Costs risk-adjusted and exclude geographic adjustments
 - Budget neutral, so will be quoted each year
 - Timing
 - 2015—Specific large groups ≥ 100
 - Not later than 2017---all physicians and groups

Relationship of PQRS and VM??

2013 & 2014 Incentive = 0.5%

2015 Penalty
-1.5%

2016 Penalty
-2.0%

2017 Penalty
= 2.0%

2015 VM
only for
GPRO ≥ 100

2016 VM \geq
GPRO 100
Only?

2017 VM for
everybody

VM—Quality Tiering

- Quality Tiering: What is it?
 - Differential pay based on quality and cost performance
 - Optional for large groups in 2015
- Quality/Cost Scores
 - Scores standardized and compared to a national benchmark
 - Individual measures roll up into domains
 - Domains weigh equally
 - Minimum of 20 patients included in scoring
 - Providers placed in categories: high, average, low

Value Modifier Composite

Cost

- Total overall costs
- Total costs for beneficiaries with specific conditions

Quality

- Clinical Care
- Patient experience
- Community Health
- Patient Safety
- Care Coordination
- Efficiency

Value
Modifier
Score

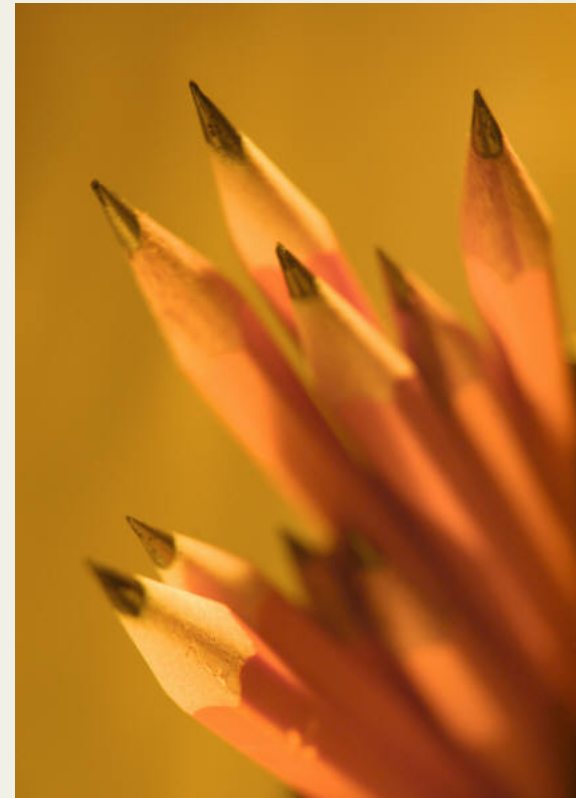
Feedback Results

- Fall of 2013
 - Reports to GPROs ≥ 100 EPs/NPI
 - “First look”
- Fall of 2014
 - Real 2013 data
 - What can you do about it?

Bet You Didn't Know...

About The VBM

- The fine or bonus comes out or goes into the Medicare portion.
- **ONLY** doctors are subject to the VBM. NPPs are not included, except in the provider count.



E-Prescribing 2013

E-Prescribing – Incentive & Penalties

- Incentives = 0.5% through 2013 and then ends as it is part of MU
- Penalties
 - 2013 – **1.5%** reduction
 - 2014 – **2%** reduction

E-Prescribing 2012-2013 By EP

| Reporting Year | Report 10 Encounters | Report 25 Encounters |
|----------------|----------------------|----------------------|
| 2011 | No penalty in 2012 | No penalty in 2013 |
| 2012 | No penalty in 2013 | No penalty in 2014 |
| 2013 | No penalty in 2014 | No penalty in 2015 |

<https://www.cms.gov/PhysicianFeeSched/PFSFRN/list.asp#TopOfPage>

E-Rx Reporting

- For successful claims-based reporting in 2012, a single code should be reported (numerator)
 - G8553 – At least one prescription created during the encounter was generated and transmitted electronically using a qualified e-Rx system
- Must be on the same claim **for INCENTIVE** (denominator)
 - 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109

eRx – Penalties 2013

- Penalty Exceptions:
 - New Hardship exceptions proposed for penalties through 2014
 - Attest to meaningful use; OR
 - Attempting to achieve meaningful use by registering and adopting CEHRT
 - CMS plans to check this data
 - For CEHRT exception, you must register the number of the product.
 - Must complete the registration by 1/31/2013 for 2013 exception AND by June 30, 2013 for 2014 exception.
 - Other exemptions
 - Limited internet or pharmacies with e-prescribing
 - Can't e-prescribe due to State and Federal regulations
 - Have ≤ 100 prescriptions in a 6-month period (1/1-6/30/2013)
 - All must be registered by 1/31/2013

Meaningful Use: Stage 2

Meaningful Use Stage 2

- Final Rule published
- Stage 2 was supposed to start in 2013---but won't
- Stage 2 starts in 2014 if you started in 2011-2012
- First year is 90 days MU, like it was for Stage 1

Stage 2 Time Line Through 2017

| 1 st Yr | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 |
|--------------------|------|------|------|------|------|------|------|
| 2011 | 1 | 1 | 1 | 2 | 2 | 3 | 3 |
| 2012 | | 1 | 1 | 2 | 2 | 3 | 3 |
| 2013 | | | 1 | 1 | 2 | 2 | 3 |
| 2014 | | | | 1 | 1 | 2 | 2 |
| 2015 | | | | | 1 | 1 | 2 |
| 2016 | | | | | | 1 | 1 |
| 2017 | | | | | | | 1 |

Core and Measure Objectives

- Some measures eliminated in Stage 2
- EPs must
 - Meet 17 Core Objectives and
 - Three Menu Objectives = for 20 Objectives Total
- New Core Objectives
 - Use secure messaging to communicate with patients on relevant health information
 - Automatically track medications from order to administration using assistive technologies in conjunction with an electronic medication record

Core and Measure Objectives

- Patient Access Objectives
 - Provide patients with the ability to view on-line and transmit their health information within four days of it being available to the EP
 - Provide patients the ability to view on-line, download, and transmit their health information within 36 hours of discharge from a hospital
- Coordination of Care
 - For more than 10% of transitions and referrals, EP that transition or refer their patient to another setting or provider of care must provide a summary electronically
 - There also must be health exchange.

New Menu Items

- New Menu Selections:
 - Record notes electronically in patient records
 - Imaging results available through CEHRT
 - Record patient family health history
 - Identify and report cancer cases to cancer registry
 - Identify and report to other registries

CQMs Under Stage 2

- No longer a Core Objective, but still must report on them, regardless of stage of MU
- EPs must report on 9 out of 64 CQMs
- All providers must report on 3 of 6 health care policy domains from these
 - Patient and Family Engagement
 - Patient Safety
 - Care Coordination
 - Population and Public Health
 - Efficient Use of Healthcare Resources
 - Clinical Processes/Effectiveness

Audit Mania

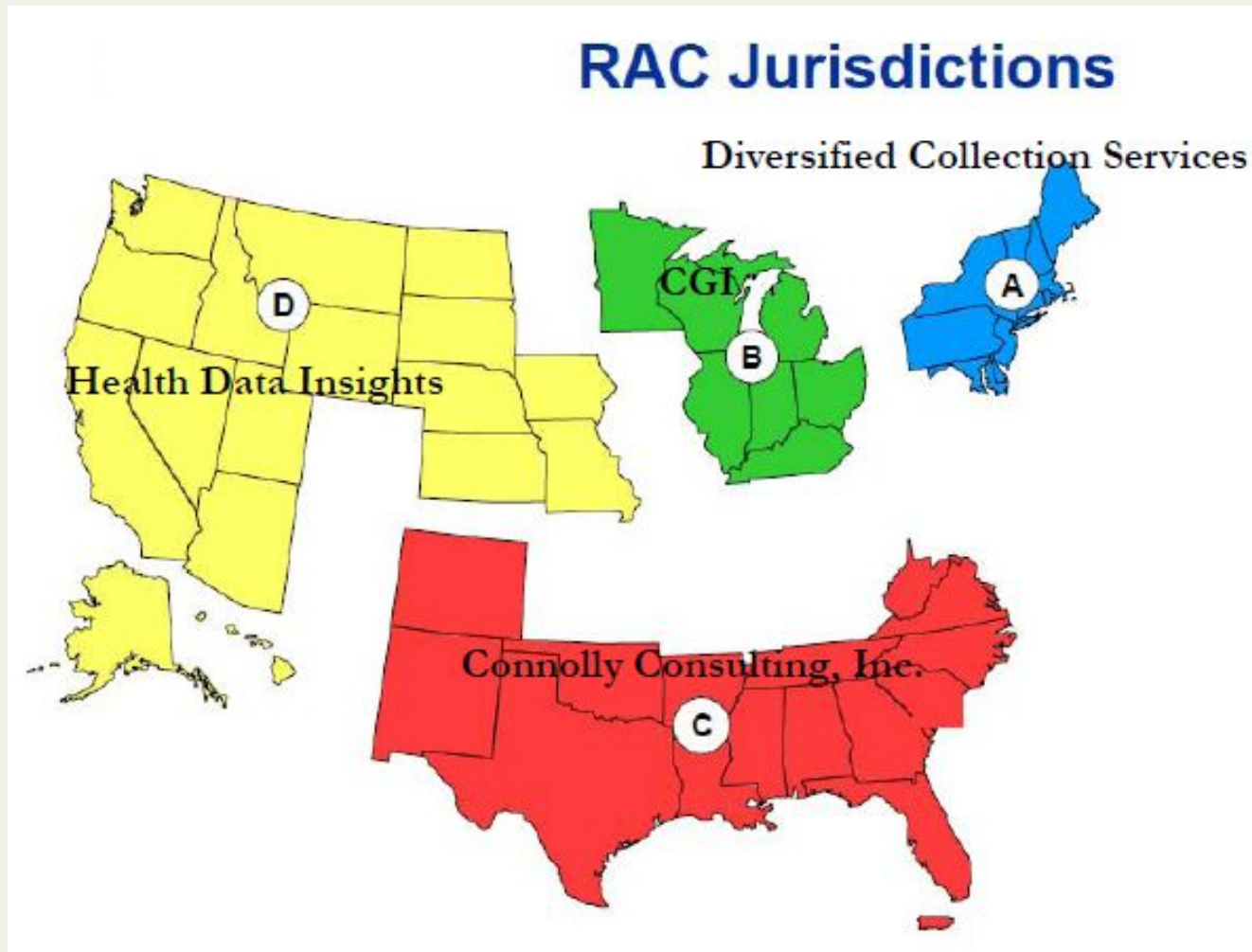
Multiple Layers of Audits – Federal Medicare

| | Incorrectly Billed Claims | Processing Errors | Medical Necessity | Incorrect Payment Amounts | Non-covered Services | Incorrectly Coded Services | Duplicate Services |
|---------------------------------|---------------------------|-------------------|-------------------|---------------------------|----------------------|----------------------------|--------------------|
| RAC | X | X | X | X | X | X | X |
| MAC | X | X | X | X | X | X | X |
| PSC/ZPIC | | | X | X | X | X | X |
| CERT | X | | | X | X | X | X |
| MAC Billing Audits | X | X | | X | X | X | X |
| Office of Audit Services Audits | | | | X | X | X | X |
| Annual Work Plan Projects | X | | X | X | X | X | X |
| Large \$ Items | X | | X | | | | X |

Five year look-back for all except RACs and fraud

Understand Alphabet Soup

| Acronym | Title | Area |
|---------|---------------------------------------|--------------|
| MAC | Medicare Administrative Contractor | |
| MPIC | Medicaid Program Integrity Contractor | Fraud |
| RAC | Recovery Audit Contractor | Overpayments |
| ZPIC | Zone Program Integrity Contractor | Fraud |



RAC Basics

- **Purpose:** Detect and correct past improper payments so CMS and the MACs can prevent such problems in the future.
- **Employer:** RACs are hired as contractors by the government, and they can collect “contingency fees”.
- **Scope:** The maximum RAC lookback period was three years, and they cannot review claims paid prior to Oct. 1, 2007. Could go to four years at some point.

RAC Review Process

- RACs review claims on a post payment basis
- RACs use the same Medicare policies as FIs, Carriers and MACs
 - NCDs, LCDs & CMS manuals
- Two types of review:
 - Automated (no medical record needed)
 - Complex (medical record required)
- RACs are required to employ a staff consisting of nurses, therapists, certified coders & a physician CMD

RAC Transparency

- New issues are posted to the web
- Major Findings are posted to the web
- RAC claim status web interface
- Detailed Review Results Letter following all Complex Reviews

Sample RAC Issues for Hem-Onc Physicians

- Disclaimers
 - These are for physicians only
 - These are NOT inclusive lists
 - Just recent, sample issues
 - It is up to you to research this for your practice

Recent RAC Issues Relevant to Physicians

- Region A
 - MUE issues not corrected
 - Duplicate claims
 - Correct Coding Initiative errors
 - Add-on codes without primary procedure
 - Hepatic panel testing
 - Bevacizumab injections that are not medically necessary (Hospital Outpatient)

Recent RAC Issues Relevant to Physicians

- Region B
 - Correct Coding Initiative errors
 - Pharmacy Supply Dispensing fee charged in error
 - SNF consolidated billing
 - E/M services with mammography
 - Rituximab billing wrong units/ medical necessity

Recent RAC Issues Relevant to Physicians

- Region C
 - Incorrect billing of E/M 9/12/2012
 - Pemetrexed by diagnosis
 - Incorrect billing of ESAs
 - 3D interpretation of imaging
 - Colony Stimulating Factors utilization
 - Excessive Units billed
 - Visits to patients in SNF
 - Treatment frequency of Sandostatin LAR
 - Multi-dose waste: Herceptin

Recent RAC Issues Relevant to Physicians

- Region D
 - Aldesleukin wastage
 - Observation codes for inpatients
 - Bevacizumab 1 unit per 10 mg
 - Observation codes for less than 8 hours
 - Multi-use vials for HERCEPTIN
 - MUE edits
 - Rituximab 1 unit per 100 mg
 - Recast once per year @ 1 mg
 - Initial hospital E/M once per day includes all E/M
 - Neulasta the same day as chemo
 - Only one hospital visit per day per specialty

Know the Facts About Self Audit

- If self-audit identifies improper payments, you should:
 - ✓ report the improper payments to your MAC
 - ✓ remit any necessary refunds.
 - ✓ you now have 60 days??

“The RAC will be aware of the adjustment, but the refund does not preclude future review.”

Source: RAC FAQs

RAC Sites

| Region | States | Contractor | Approved Issues Page |
|--------|--|--------------------------------------|---|
| A | CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT | DCS Healthcare | http://www.dcsrac.com/IssuesUnderReview.aspx |
| B | IL, IN, KY, MI, MN, OH, WI | CGI Technologies and Solutions, Inc. | http://racb.cgi.com/Issues.aspx |
| C | AL, AR, CO, FL, GA, LA, MS, NC, NM, OK, SC, TN, TX, VA, WV | Connolly Healthcare | http://www.connolly.com/healthcare/pages/ApprovedIssues.aspx |
| D | AL, AZ, CA, HI, IA, ID, KA, KS, MO, ND, SD, UT, WA, WY, Guam, Am Samoa, N Marianas | HealthDataInsight, Inc. | https://racinfo.healthdatainsights.com/Public1/NewIssues.aspx |

MAC Reviews

- Pre-payment
 - Example: WPS High Dollar Claims—all claims over a dollar figure
 - Example: NGS 99215 for Hem-Onc based on CERT Audits
- Post-payment
 - Requests for Additional Documentation (ADRs)—lots of these for miscellaneous J-codes
 - Modifier -25—based on CERT audits

CPT Changes 2013

Transitional Care Codes

99487* Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with no face-to-face visit, per calendar month

99488* Complex chronic care coordination services; first hour of clinical staff time directed by a physician or other qualified health care professional with one face-to-face visit, per calendar month

99489* Complex chronic care coordination services; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

99495 Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge

99496 Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge

***--Not paid by Medicare**

3/24/13

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TCM Codes (CPT Definition)

- TCM starts the date of discharge and continues until the 30th day after discharge
- Requires contact with patient or caregiver within 2 business days of discharge---can be electronic, face to face, or by phone
- Requires a face-to-face visit with the patient within 7 or 14 days
- Codes vary as to Medical Decision-making
- See bundling edits as they occur and check if payers will only pay one provider for these services. Medicare only pays one.

Some CPT Changes

- Because of the role of NPPs, E/M code language changes to:
 - Counseling and/or coordination of care with other physicians, ~~other providers~~ qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
 - Usually, the presenting problem(s) are of moderate to high severity. ~~Physicians typically spend~~ Typically, 60 minutes are spent face-to-face with the patient and/or family.
- Typical times are added to hospital codes

Some CPT Changes

- Care Plan Oversight (99374-99380)
 - ~~Physician supervision~~ Supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more

Some CPT changes

- Deleted are codes for removal of lung fluid 32420-32422
- Added are the following:
 - 32554, Thoracentesis, needle or catheter aspiration of pleural space; without imaging guidance
 - 32555...with imaging guidance
 - 32556, Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance
 - 32557...with imaging guidance

Some CPT Changes

- Transplantation
 - 38240 Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic
 - TO: Hematopoietic progenitor cell transplantation (HPC); allogeneic transplantation per donor
 - 38241 Bone marrow or blood-derived peripheral stem cell transplantation; autologous
 - TO: Hematopoietic progenitor cell transplantation (HPC); autologous transplantation
 - 38242 Bone marrow or blood-derived peripheral stem cell transplantation; allogeneic donor lymphocyte infusion
 - TO: lymphocyte infusions; allogeneic donor lymphocyte infusions
 - 38243 Hematopoietic progenitor cell; HPC boost

New Lab Codes

- CA-125
 - 81500 Oncology (ovarian), biochemical assays of two proteins (CA-125 and HE4), utilizing serum, with menopausal status, algorithm reported as a risk score
 - 81503 Oncology (ovarian), biochemical assays of five proteins (CA-125, apolipoprotein A1, beta-2 microglobulin, transferrin, and pre-albumin), utilizing serum, algorithm reported as a risk score

New Lab codes

- Circulating tumor cells
 - 86152 Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood)
 - 86153 Cell enumeration using immunologic selection and identification in fluid specimen (eg, circulating tumor cells in blood); physician interpretation and report, when required
- Minor changes to lab panel language

New Vaccine Codes

- 90653 Influenza vaccine, inactivated, subunit, adjuvanted, for intramuscular use
- 90672 Influenza virus vaccine, quadrivalent, live, for intranasal use
- 90739 Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use
- Language and dosing changes for other vaccines

New HCPCS 2013

| | | |
|-------|--|------------------------------|
| C9290 | Injection, bupivacaine liposome, 1 mg | Inj, bupivacaine liposome |
| C9292 | Injection, pertuzumab, 10 mg | Injection, pertuzumab |
| C9295 | Injection, carfilzomib, 1 mg | Injection, carfilzomib |
| C9296 | Injection, ziv-aflibercept, 1 mg | Injection, ziv-aflibercept |
| G0454 | Physician documentation of face-to-face visit for durable medical equipment | MD document visit by NPP |
| J0131 | Injection, acetaminophen, 10 mg | Acetaminophen injection |
| J0178 | Injection, aflibercept, 1 mg | Aflibercept injection |
| J0221 | Injection, alglucosidase alfa, (lumizyme), 10 mg | Lumizyme injection |
| J0257 | Injection, alpha 1 proteinase inhibitor (human), (glassia), 10 mg | Glassia injection |
| J0485 | Injection, belatacept, 1 mg | Belatacept injection |
| J0490 | Injection, belimumab, 10 mg | Belimumab injection |
| J0588 | Injection, incobotulinumtoxin a, 1 unit | Incobotulinumtoxin a |
| J0712 | Injection, ceftaroline fosamil, 10 mg | Ceftaroline fosamil inj |
| J0716 | Injection, centrurides immune f(ab)2, up to 120 milligrams | Centrurides immune f(ab) |
| J0840 | Injection, crotalidae polyvalent immune fab (ovine), up to 1 gram | Crotalidae poly immune fab |
| J0890 | Injection, peginesatide, 0. 1 mg (for esrd on dialysis) | Peginesatide injection |
| J0897 | Injection, denosumab, 1 mg | Denosumab injection |
| J1050 | Injection, medroxyprogesterone acetate, 1 mg | Medroxyprogesterone acetate |
| J1557 | Injection, immune globulin, (gammalex), intravenous, non-lyophilized (e. G. | Gammalex injection |
| J1725 | Injection, hydroxyprogesterone caproate, 1 mg | Hydroxyprogesterone caproate |
| J1741 | Injection, ibuprofen, 100 mg | Ibuprofen injection |
| J1744 | Injection, icatibant, 1 mg | Icatibant injection |
| J2212 | Injection, methylnaltrexone, 0. 1 mg | Methylnaltrexone injection |
| J2265 | Injection, minocycline hydrochloride, 1 mg | Minocycline hydrochloride |
| J2507 | Injection, pegloticase, 1 mg | Pegloticase injection |
| J9002 | Injection, doxorubicin hydrochloride, liposomal, doxil, 10 mg | Doxil injection |
| J9019 | Injection, asparaginase (erwinaze), 1,000 iu | Erwinaze injection |
| J9042 | Injection, brentuximab vedotin, 1 mg | Brentuximab vedotin inj |
| Q2034 | Influenza virus vaccine, split virus, for intramuscular use (agriflu) | Agriflu vaccine |
| Q2049 | Injection, doxorubicin hydrochloride, liposomal, imported lipodox, 10 mg | Imported lipodox inj |
| S0119 | Ondansetron, oral, 4 mg (for circumstances falling under the medicare statute, | Ondansetron 4 mg |

To Do List

- If you have not done so, you must participate in PQRS in 2013. For neophytes, Registry is the way to go.
- Have a compliance plan and stick to it. Fines have been issued and few practices can afford million dollar hits.
- EMRs are great. But, make sure your providers are not templating every note.
- Understand how your patients perceive you. More and more, those perceptions say something about quality and translates to payment.
- Do not use office-administered pharmacy drugs in your practice for Medicare patients, unless you have legal proof that your relationship meets **Medicare** requirements.
- Participate in the struggle.

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