Reimbursement & Coding 2016

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2016 Trends To Watch

- Everybody wants a piece of the drug spend
- MACRA* changes the paradigm for all physician payment? Just Medicare?
- Continued Penalties for poor reporting
- Consolidation Into Mega-Groups
- Mega-data (sometimes known as Big Data)
- More info to patients
- Bundling and Other Alternative Models
- More $$ for Coordination of Care
- Telemedicine for Non-Medicare Patients
- Pathways Still Spread
- But, Episodes of Care May Win

*--"**Medicare Access and CHIP Reauthorization Act** of 2015"

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Average Sales Price—Proposed Rule Phase I

- The proposed model would test whether changing the add-on payment to 2.5 percent plus a flat fee payment of $16.80 per drug per day changes prescribing incentives and leads to improved quality and value
- The proposed change to the add-on payment is budget neutral.
- Applies to hospital outpatient and offices, not drugs used in DME
- It will be used in selected geographical regions called PCSAs
- May not be applicable to small practices?
- This is Phase I, which is proposed to last from August to indefinitely

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Average Sales Price—Proposed Rule Phase II

- **Various Models will be tested—how and when is really not known, but it all is proposed to tart 1/1/2017**
  - **Discounting or eliminating patient cost-sharing.** Patients are often required to pay for a portion of their care through cost-sharing. This proposed test would decrease or eliminate cost sharing to improve beneficiaries' access and appropriate use of effective drugs.
  - **Feedback on prescribing patterns and online decision support tools.** This proposed test would create evidence-based clinical decision support tools as a resource for providers and suppliers focused on safe and appropriate use for selected drugs and indications. Examples could include best practices in prescribing or information on a clinician's prescribing patterns relative to geographic and national trends.
  - **Indications-based pricing.** This proposed test would vary the payment for a drug based on its clinical effectiveness for different indications. For example, a medication might be used to treat one condition with high levels of success but an unrelated condition with less effectiveness, or for a longer duration of time. The goal is to pay for what works for patients.
  - **Reference pricing.** This proposed model would test the practice of setting a standard payment rate—a benchmark—for a group of therapeutically similar drug products. Once called the Least Costly Alternative.
  - **Risk-sharing agreements based on outcomes.** This proposed test would allow CMS to enter into voluntary agreements with drug manufacturers to link patient outcomes with price adjustments.
  - **Comments to Bring Back CAP Program**

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Commentary

- Geographical differences in pricing
  - Must bill with a G-code
  - May change patient access in tested areas
  - Could encourage 'cash strapped' physicians to provide generics or cheaper older drugs
  - Sequestration is still an issue, which will add to Community physician distress
- Phase II
  - Too many alternatives; will cause chaos
  - Practices are subject to a lot of other value-based programs (the Value Modifier, PQRS, MU, etc.) > hard to keep up
  - Time frame is completely unrealistic

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PART ONE: Physician Fee Schedule and Hospital Outpatient Prospective Payment 2016

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Web Sites for 2016 Regulations

- This presentation is based on published rules
  - PHYSICIANS: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1631-FC.html?DLPage=1&DLEntries=10&DLSort=2&DLSortDir=descending
  - HOPPS: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.html

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Definitions

- RVUs = Relative Value units
- GPCIs = Geographical Cost Indices
- CF = Medicare Conversion Factor
- RBRVS = Resource-based Relative Value Scale/System
- HOPPS = Hospital Outpatient Prospective Payment System
- APCs = Ambulatory Payment Classifications

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Medicare Physician Payment Basics

- Payments are based on RVUs for each code (WRVUs+PERVUs+MalRVUs)
- RVUs are multiplied times GPCIs for your geographical location (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

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Final Fee Schedule 2016

- MACRA* authorized a 0.5% increase in the current conversion factor for services 7/1/2015-12/31/2015
- CMS stated the conversion factor for 2016 to be $35.8279 down from $35.9335
- Medical Oncology will be flat for 2016 without decreases with Radiation taking a projected 2% decrease

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Fee Schedule: Does Not Include Sequestration

- Sequestration:
  - Medicare 2% across the board started on April 1, 2013
  - Impacts everything including drugs
  - The 2% comes out of the Medicare portion (80%)
    - Drugs are paid at 104.304% ASP
    - All patient payments excluded
- Murray-Ryan Budget Deal extended the Sequester until 2023; PAMA extended it to 2024, and the latest budget deal extends it to 2025

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Creation of the SGR

- The sustainable growth rate (SGR) was created by the *Balanced Budget Act of 1997* as a means to control Medicare spending by tying Medicare clinician payments to increases in the gross domestic product (GDP).
- When health spending outpaced GDP, negative payment updates were threatened as a result.
- Due to the inability to find sufficient offsets, the SGR was unable to be repealed for nearly two decades.

Congress passed 17 patches to avoid cuts
(implementing cuts twice)

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Elimination of the SGR

- **Early 2014**: Congressional leaders from the House and Senate, in close collaboration with the physician community, drafted legislation which would repeal the SGR and reward physicians for the value of the services they provided.
- **Spring 2015**: Speaker of the House John Boehner and Minority Leader Pelosi struck a deal on the offsets and the *Medicare and CHIP Reauthorization Act of 2015* (MACRA) was born.

Virtually the entire House of Representatives united to pass MACRA, followed by the Senate.
President Obama signed the now-law on **April 16, 2015.**

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Medicare and CHIP Reauthorization Act of 2015 MACRA

- Delays enforcement of the “two-midnight” rule until October 1, 2015
- Extends the Children’s Health Insurance Program (CHIP) for two years (until 2017)
- Extends the Teaching Health Center Graduate Medical Education Program (THCGME) for two years (until 2017)
- Declares a national objective to achieve interoperable electronic health records by December 31, 2018
- Prevents quality program standards and measures (such as PQRS/MIPS) from being used as a standard or duty of care in medical liability cases

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Changing the Payment Landscape

Pre-MACRA

- 21% payment cut in 2015, continued uncertainty
- Separate quality reporting programs
- Some regulatory flexibility for alternative payment model participation

Post-MACRA

- Eliminates SGR; implements stable payment increases
- Streamlined quality reporting program
- Incentives for alternative payment model participation

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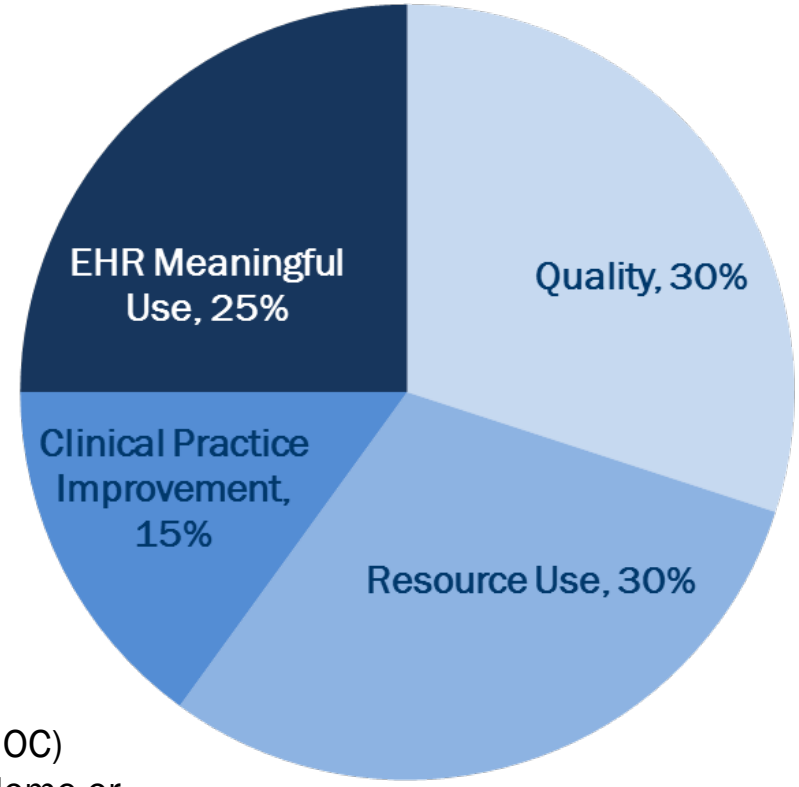
Merit-Based Incentive Payment System (MIPS):

- Under MIPS the Secretary must develop a methodology to assess EP performance and determine a composite performance score based on a scale of 0 – 100.
- Features of PQRS, the Value Modifier and the EHR Meaningful Use program are included in MIPS
- The composite score will be used to determine and apply a MIPS payment adjustment factor for 2019 onward
- Adjustment Can Be Positive, Negative, or Zero

MIPS Composite, Year 1

- Meaningful Use requirements
- Meaningful Use weight may be adjusted down to 15 percent if 75% or more EPs are meaningful users



- PQRS measures
- eCQMs
- QCDR measures
- Risk-adjusted outcome measures

- Expanded Practice Access
- Population Management
- Care Coordination
- Beneficiary Engagement
- Patient Safety
- Practice Assessment (ex. MOC)
- Patient-Centered Medical Home or specialty APM

- Value-Based Modifier measures
- Risk-adjusted outcome measures
- Part D drug cost (if feasible)

Quality and Resource Use weights will increase over time

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Clinical Practice Improvement Activities

The Secretary is required to specify clinical practice improvement activities. Subcategories of activities are also specified in the statute, some of which are:

Expanded Practice Access

- Same day appointments for urgent needs
- After hours clinician advice

Population Management

- Monitoring health conditions & providing timely intervention
- Participation in a qualified clinical data registry

Care Coordination

- Timely communication of test results
- Timely exchange of clinical information with patients AND providers
- Use of remote monitoring
- Use of telehealth

Beneficiary Engagement

- Establishing care plans for complex patients
- Beneficiary self-management assessment & training
- Employing shared decision making

Secretary shall give consideration to practices <15 EPs, rural practices, & EPs in underserved areas.

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MACRA Payment Adjustments

Negative Adjustment | Neutral Adjustment | Positive Adjustment

	2015	2016	2017	2018	2019	2020	2021	2022+
PQRS+VM+EHR Adjustments (combined)	~+ 5% 3.5%	TBD - 6%	TBD -9%	TBD -10% or more	TBD -11% or more	TBD -11% or more	TBD -11% or more	TBD -11% or more
MIPS Bonus/Penalty (max)					+4%* -4%	+5%* -5%	+7%* -7%	+9%* -9%
APM Bonus					+5%	+5%	+5%	+5%

* May be increased by up to 3 times to incentivize performance
$500 mil funding for bonuses allocated through 2024

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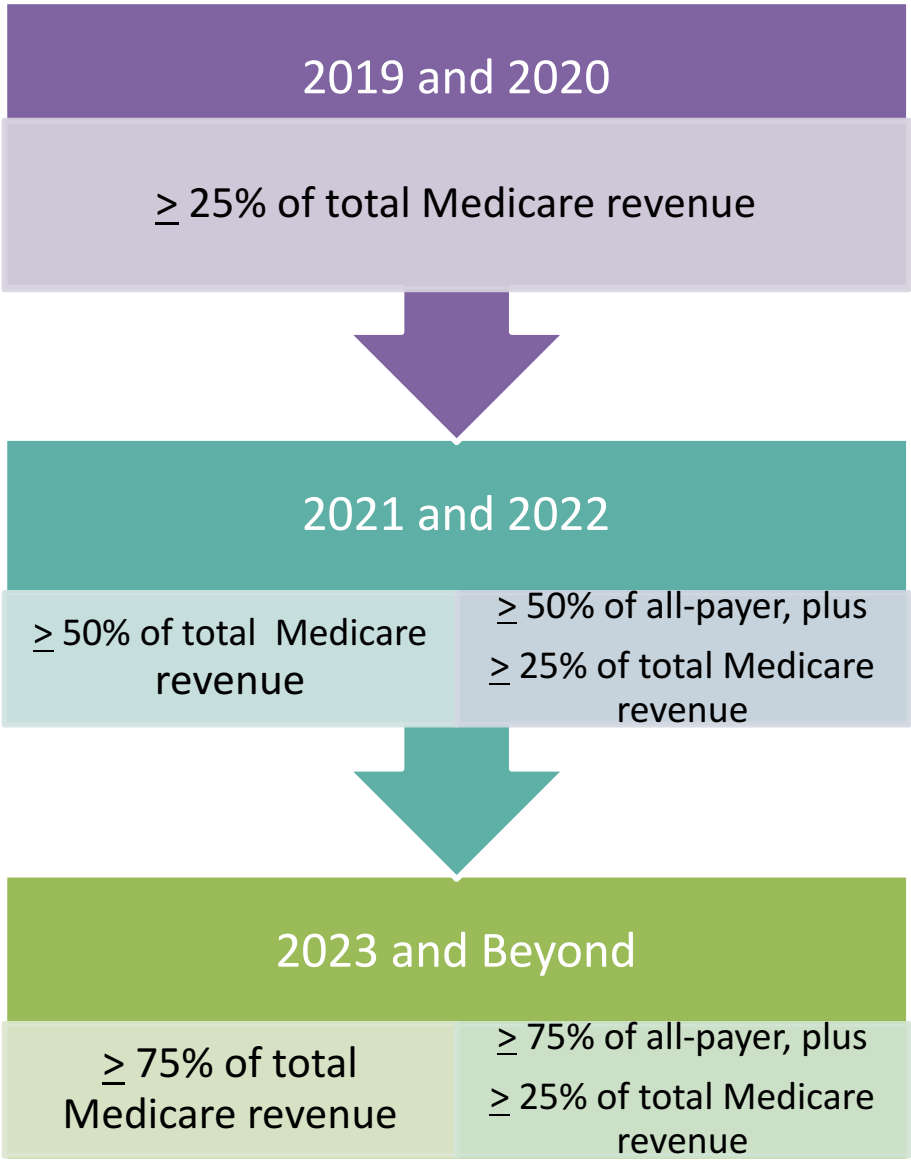
Alternative Payment Model



- 2019-2024: 5% bonus
- CMS/CMMI models (except Healthcare Innovation Awards)
- Other possible eligible models
  - Requires CEHRT
  - Payment based on quality measures
  - Financial risk or a Patient Centered Medical Home
- APM participants meeting threshold are MIPS-exempt

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Misvalued Services

- Medicare will look at codes that 'cost too much per year', e.g. over $10 million. Codes impacting you are:
  - 38221- Bone marrow biopsy, needle or trocar
  - 96360- Intravenous infusion, hydration; initial, 31 minutes to 1 hour
  - 96401- Chemotherapy admin, subcutaneous or intramuscular; non-hormonal anti-neoplastic
  - 96402- Chemotherapy admin, subcutaneous or intramuscular; hormonal anti-neoplastic
  - 96409- Chemotherapy admin; intravenous, push technique, single or initial substance/drug
  - 96411- Chemotherapy admin; intravenous, push technique, each additional substance/drug (List separately in addition to code for primary procedure
  - 96372- Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular
  - 96374- Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug
  - 96375- Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); each additional sequential intravenous push of a new substance/drug (List separately in addition to code for primary procedure)
- Codes 96360, 96402, 96409, 96372, and 96375 are tentatively scheduled to be reviewed by the American Medical Association in October 2016

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Medicare Telehealth Services 2016

- The definition of these services has not changed
- Expanded the services included in them to include
  - Prolonged Inpatient Services 99356-99357
  - ESRD Services 90933-90936
- No expansion of telehealth services beyond HPSA (Healthcare Provider Shortage Area) areas as designated by CMS
- 2016 Medicare telehealth originating site fee is $25.10, compared to $24.83 in 2015

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Why I Absolutely Love Telehealth

- May be part of ”Clinical Quality Improvement” under MIPS
- Private payers are covering it in many instances where you might use E/M
- In an Episode of Care or OCM environment, how will you reduce costs and keep quality up? This is one way to bring costs down…

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"Incident To": Final Rule

- There is a provision that states that the supervising physician/NPP be the 'incident to' provider and must bill for it
  - Supervising physician must bill for these services now
  - The overseeing physician may not bill for these services, unless they directly supervise the services
- Auxiliary personnel may not be excluded from any federal programs

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Biosimilars 2016

- Effective January 1, 2016, the payment amount for a biosimilar product is the sum of the average sales prices for all NDCs within the same billing and payment code, plus 6% of the reference product
- Before ASP data is available, WAC*-based payment will be used for payment or they will ask for invoices for office-based practices
- Billing and coding of similar products
  - Reference product will have its own code
  - Biosimilars will have another
  - Distinguishing biosimilar manufacturers will be by modifier
    - Modifier –ZA will be used for ZARXIO. This is now official. See https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/Part-B-Biosimilar-Biological-Product-Payment.html

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Advance Care Planning ("ACP")

- Medicare recognizes and provides separate payment for ACP with or without a E/M service
  - CPT code 99497, ACP including explanation of advance directives by the physician or other qualified health professional; first 30 minutes, face-to-face with patient, family members and/or surrogate and
  - CPT code 99498, ACP, each additional 30 min
- Here are the fee schedule payments for a GPCI of 1.00:
  - CPT code 99497 – approximately $80 (facility) and $86 (nonfacility))—National Average
  - CPT code 99498 – approximately $75 (facility and nonfacility))—National Average

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Advance Care Planning

- CMS states that this discussion can occur between the patient and their primary care physician or specialist in a variety of settings
- Codes can be billed with other E/M services
  - Use -33 if it is done with the Annual Medicare Visit
  - Must be face-to-face and must be 'incident to' a physician service

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More Advance Care Planning ("ACP")

- ACP may be billed by physicians and non-physician practitioners (NPP) only. However, ACP may be furnished incident to the services of the billing physician or NPP, meaning other clinical staff may perform the service under the direct supervision of the physician or NPP. All requirements for "incident to" billing must be met, and the clinical staff providing the service must be qualified under state licensure laws.

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Advance Care Planning Codes

What do practitioners talk about?

- Quality of life expectations through transitions in health
- Patient's preferences for treatment and options for achieving goals
- Advance care planning tools – e.g., living wills, health care proxies, and more
- Advance care planning forms

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Other ACP Characteristics

Who starts the conversation?

- Patient can initiate conversation
- Physician can initiate when there has been a change in status or a transition in care
- Advance care planning is voluntary, patient's discretion
- Face-to-face only; no telemedicine (Medicare, of course)
- Patient must be present unless he or she lacks capacity

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Medicare Support for ACP

Why are there two codes?

- 99497 applies to the first 30 minutes of an advance care planning discussion
- 99498 applies to each additional 30 minutes (in conjunction with 99497)
- Codes do not exclude other members of a practice from taking part, but
- Billing practitioner must "manage, participate and meaningfully contribute to the provision of these services"

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Medicare Support for ACP

When can the codes be used? Again--

- Same day as other evaluation/management (E/M) visits, transitional care management (TCM), or chronic care management (CCM) visit
- Annual Wellness Visit (AWV) – no cost sharing
- No limit on number of times matter is discussed
- Codes ***cannot*** be used in certain critical care and intensive care situations

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Radiation Oncology

- These rules clearly stated that the temporary G-codes would remain in place for another year. The following reasons were some listed for continuing use of the G-codes previously created:
  - Need for the development of a code set that recognizes the difference in costs between different kinds of imaging guidance modalities;
  - Verification of the code set facilitates valuation incorporating the cost of imaging, based on how frequently it is actually provided; and
  - Intent to develop treatment delivery codes structured to differentiate payment based on the equipment resources utilized

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Appropriate Use Criteria for Advanced Imaging

- Includes MRIs, PETs, CT (1/1/2017)
  - Must be uniform Clinical Decision-making Systems for using imaging by specialty
  - These CDS' must be supported by Provider-led Entities (PLEs), e.g. NCCN
  - CDS' will not be required 1/1/2017, but criteria may be

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Appropriate Use Criteria

- Appropriate use criteria (AUC) are a set of individual criteria that link a specific clinical condition or presentation, one or more services, and an assessment of the appropriateness of the service(s)
- PAMA directed CMS to establish a program to promote the use of AUC for advanced diagnostic imaging services
  - Establishment of AUC; finalized definition of provider-led entity
  - Mechanisms for consultation with AUC; will be addressed in 2017 PFS
  - AUC consultation by ordering physician and reporting on AUC consultation by furnishing professionals; anticipated to address in 2017 and 2018 PFS
  - Annual identification of outlier ordering professional for services furnished after January 1, 2017 and prior authorization requirement beginning January 1, 2020
- Exceptions for certain emergency services, inpatient services and
- ordering professional hardship exemptions

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HOPPS Final Rule 2016

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HOPPS Rule

- Released October 30, was published on November 13, Federal Register
- Market basket increase of 2.4%, but -0.3% final update
  - 0.5% decrease due to productivity cut from ACA
  - 0.2% additional market basket cut due to ACA
  - 2.0% decrease due to packaged labs inflation adjustment
- Average payment decrease of -0.4% for hospitals reporting quality measures
  - 0.4% for urban
  - 0.6% for rural
- Conversion Factor going from $74.173 to $73.725
- A decrease of $133 million compared to CY 2015

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Drug Payments (2016)

- Drugs will continue to be paid at ASP, plus 6% (minus the Sequester)
- The packaging threshold for drugs will be $100 per encounter as defined by Medicare
- Biosimilars are similar to offices…

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Blood and Blood Products

- CMS continues to establish payment rates for blood and blood products using the blood-specific cost-to-charge ratios (CCRs) for those hospitals with blood-specific cost centers and simulated blood-specific CCRs for those hospitals without a blood- specific cost center.
- Simulating a blood-specific CCR more accurately captures the true costs of blood and blood products.
- **NOTE:** In the proposed rule the wrong CCR was used for blood and blood products
- The table on the following slide compares the 2015 payment rates for blood and blood products to the 2016 rates.

Blood and Blood Products

- New HCPCS Codes for Pathogen-Reduced Blood Products
  - P9070 (Plasma, pooled multiple donor, pathogen reduced, frozen, each unit); (Crosswalked to P9059-FFP, 8-24 hrs - $73.08)
  - P9071 (Plasma (single donor), pathogen reduced, frozen, each unit); (Crosswalked to P9017 - FFP w/in 8 hrs, single donor - $72.56)
  - P9072 (Platelets, pheresis, pathogen reduced, each unit). (Crosswalked to P9037 – Platelets, pheresis, LR,IR – $641.85)
  - These are interim payment rates

Comprehensive APCs (C-APCs) for CY 2016

Brief Overview

Comprehensive APC (C-APC) – classification for provision of a primary service and all adjunctive services provided to support delivery of the primary service – J1

Adjunctive Services – all other items and services reported on the hospital outpatient claim with a primary service identified as a C-APC and considered integral, ancillary, supportive, dependent, and adjunctive to the primary service. – Packaged into C-APC.

Exclusions – Non-Covered Services (SADS)

- Separately payable by Statute (for example)
  - Mammograms, Therapy performed under a POC
  - Pass-through drugs and devices

Comprehensive APCs (C-APCs) for CY 2016

- Only one C-APC is paid per claim
  - If more than one primary service (J1) is provided during the same encounter, the primary services are ordered by their J1 hierarchy (based upon cost)
  - Certain J1 combinations will point to a single C-APC payment of a higher paying C-APC within the same family – *Complexity Adjustment*
  - Certain add-on services in combination with certain C-APC primary services will result in a higher single C-APC payment within the same family
  - A higher paying APC (promotion) is the result of a complexity adjustment due to code pairs described above
    - Must be a minimum of 25 claims submitted with the same code pair combination (frequency threshold)
    - Promotion may not create a 2-times rule violation (cost threshold)
    - Promotion may only be within the same clinical family
  - Addendum J on the CMS OPPS FR website provides a complete list of code pairs eligible for an adjusted payment under the C-APC Complexity Adjustment calculation.

Comprehensive APCs (C-APCs) for CY 2016

Observation Comprehensive (C-APC – 8011)

- Represents an expansion of the definition of a C-APC
  - A specific combination of services performed ***in combination with each other*** (rather than as adjunctive to one primary service)
  - Created a new Status Indicator "J2" to designate specific combinations of services that when performed in combination with each other will allow for all ***other*** OPPS payable services reported on the claim to be deemed adjunctive services to the primary code combinations resulting in a single payment based on the costs of all reported services on the claim.

Comprehensive APCs (C-APCs) for CY 2016

Observation Comprehensive (C-APC – 8011)

- CMS finalized the qualifying criteria with *modification*
  - *Composite* APC 8009, Extended Assessment and Management, has been deleted
  - Claim contains 8 or more units of hours of observation billed under G0378
  - Claim must contain an E&M visit CPT/HCPCS code on the day before or the day of observation. ***Any emergency E&M visit code will qualify for a C-APC payment 8011 if all other criteria are met.***
    - G0379, 99281-99285, G0381-G0384, 99291, G0463
  - Claim may not contain a status indicator "T" HCPCS code. (*This is a revision to the original proposal which excluded claims with status T procedures on the day before and the day of observation but not on subsequent days)*
  - Claim may *not* contain a HCPCS code that has been assigned SI "J1"

Comprehensive APCs (C-APCs) for CY 2016

CY 2016 Policies for Specific C-APCs (continued)

- **Stereotactic Radiosurgery (SRS) – C-APC 5631**
  - CMS will require the use of a modifier to report adjunctive services related only to C-APC SRS primary services 77371 and 77372.
  - **Modifier "CP"** (Adjunctive service related to a procedure assigned to a comprehensive ambulatory payment classification (C-APC) procedure, but reported on a different claim) must be assigned to all **SRS adjunctive services** provided but reported on a different claim. (The adjunctive services CPT codes that will require modifier "CP" is provided on a day other than the primary services CPT 77371 or 77372 are listed on the previous slide)

Comprehensive APCs (C-APCs) for CY 2016

CY 2016 Policies for Specific C-APCs (continued)

- C-APC 5881 – Ancillary Outpatient Services When Patient Expires
  - Status C (Inpatient only) procedures provided to a patient who expires prior to admission
  - Billed on an outpatient bill type using modifier CA on the Status C procedure
  - Only one payment received for all services on UB.
  - Formerly a composite APC – 0375
  - Payment rate for C-APC 5881 - $6,143.75 ($490.38 above the proposed rate)

Composite APCs

- Definition: Groups of services typically performed together during a single clinical encounter resulting in provision of a complete service are paid under one Composite APC which provides a payment higher than the sole service APC payment rates but lower than the aggregate of the sole service APCs.
- CMS continues composite APCs for LDR prostate brachytherapy, mental health services, and multiple imaging services.

Multiple Imaging Composite

- No changes to the multiple imaging composite policy for 2016
- Current Composite Rule:
  - A single payment will be made each time more than one imaging procedure within the same imaging "family" is billed on the same date of service.
  - Family 1 – Ultrasound – Composite APC 8004
  - Family 2 – CT and CTA w/o contrast – Composite APC 8005
    CT and CTA with contrast – Composite APC 8006
  - Family 3 – MRI and MRA w/o contrast – Composite APC 8007
    MRI and MRA with contrast – Composite APC 8008

Packaging of Ancillary Services

Drugs and Biologicals That Function as Supplies When Used in a Surgical Procedure

- CMS has finalized their proposal to unconditionally package four drugs that were assigned a SI of "G" or "K" in CY 2015, but based on their FDA-approved labels are primarily used as a supply in surgical procedures.
- Three of these drugs will be assigned SI "N" in CY 2016, and one in CY 2018 due to its current pass-through status.

HCPCS Code	Descriptor	CY 2015 SI	Primary Use in Surgical Procedure	First Calendar Year Packaged
J0583	Injection, bivalirudin 1 mg	K	Percutaneous Coronary Intervention [PCI]/PCTA [percutaneous transluminal coronary angioplasty] procedures	2016
J7315	Mitomycin, ophthalmic, 0.2mg	G	Glaucoma surgery	2016
C9447	Injection, phenylephrine and ketorolac, 4ml vial	G	Cataract surgery	2018
J0130	Injection abciximab, 10mg	K	PCI procedure	2016

Packaging of Ancillary Services

Clinical Diagnostic Laboratory Tests (continued)

The following proposals regarding clinical diagnostic tests paid under the CLFS have been finalized without modification.

- All molecular pathology tests will be excluded from the packaging policy and assigned status indicator "A".
- All preventive laboratory tests will be excluded from the packaging policy and assigned status indicator "A".
- Laboratory tests provided during the same outpatient stay (rather than specifically provided on the same date of service) will be packaged into payment for the primary service unless ordered by a different practitioner for a different diagnosis.

Adjustment for Cancer Hospitals

- CMS continues to provide payment adjustments to cancer hospitals in 2016 to make them "whole"
- Adjustment will be made to ensure that the cancer hospital's payment-to-cost ratio (PCR) is equal to the weighted average PCR for other OPPS hospitals
- CMS estimates that OPPS payments to non-cancer hospitals in CY 2016 are approximately 92 percent of reasonable cost, so the adjustments will bring each cancer hospital's PCR to 0.92
- Table 15 on the following slide lists the 11 approved cancer hospitals and their payment adjustments for 2016

Adjustment for Cancer Hospitals

FINAL RULE: TABLE 15.—ESTIMATED CY 2016 HOSPITAL-SPECIFIC PAYMENT ADJUSTMENT FOR CANCER HOSPITALS TO BE PROVIDED AT COST REPORT SETTLEMENT (DISPLAY COPY)

Provider Number	*Hospital Name*	*Estimated Percentage Increase in OPPS Payments for CY 2016*
050146	*City of Hope Comprehensive Cancer Center*	*21.6*
050660	*USC Norris Cancer Hospital*	*21.9*
100079	*Sylvester Comprehensive Cancer Center*	*25.1*
100271	*H. Lee Moffitt Cancer Center & Research Institute*	*27.3*
220162	*Dana-Farber Cancer Institute*	*51.1*
330154	*Memorial Sloan-Kettering Cancer Center*	*46.9*
330354	*Roswell Park Cancer Institute*	*31.4*
360242	*James Cancer Hospital & Solove Research Institute*	*35.4*
390196	*Fox Chase Cancer Center*	*23.7*
450076	*M.D. Anderson Cancer Center*	*50.9*
500138	*Seattle Cancer Care Alliance*	*57.3*

Hospital OP Outlier Payments

- CMS will continue to use the same methodology for calculating outpatient outlier payments
- Outliers are paid if two conditions are met:
  1. Cost of the service exceeds 1.75 times the APC payment amount (multiplier threshold)

  and

  2. Cost of the service exceeds the sum of the APC payment amount plus a fixed dollar threshold
- When both conditions are met, an outlier payment equaling 50% of the amount by which the service exceeds 1.75 times the APC payment amount is made
- CY 2016 fixed dollar threshold is $3,250 – an increase of $475 from current 2015 threshold of $2,775 ($400 less than the proposed threshold)

Beneficiary Copayments

- No changes to the methodology for calculating beneficiary copayments in CY 2016
- Copayments may not exceed 40 percent of the APC payment rate
- Copayments cannot be less than 20 percent of the APC payment rate
- Beneficiary copayment for a procedure cannot exceed the amount of the inpatient deductible for that year
- Copayments are waived for certain preventive services
- The increase in consolidation of services under one APC payment should result in reductions to beneficiary copayments.

What Is The 2-Midnight Rule?

- After many years, CMS decided to establish a firm rule for Hospital Observation Status.
  - Under two midnights, the patient is an outpatient
  - Two midnights and over, the patient is an inpatient
- Hospital cases that deviate were to be reviewed by the Recovery Audit Contractor. This has been changed to the Quality Improvement Organization for the area

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-30-4.html

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Changes to The Two-Midnight Rule Review

- For stays expected to last less than two midnights – CMS is adopting the following policies:
  - For stays for which the physician expects the patient to need less than two midnights of hospital care (and the procedure is not on the inpatient-only list or otherwise listed as a national exception), an inpatient admission may be payable under Medicare Part A on a case-by-case basis based on the judgment of the admitting physician. The documentation in the medical record must support that an inpatient admission is necessary, and is subject to medical review.
  - CMS is reiterating the expectation that it would be unlikely for a beneficiary to require inpatient hospital admission for a minor surgical procedure or other treatment in the hospital that is expected to keep him or her in the hospital for a period of time that is only for a few hours and does not span at least overnight. No change for stays over the two-midnight benchmark:
  - For hospital stays that are expected to be two midnights or longer, <u>the policy is unchanged</u>; that is, if the admitting physician expects the patient to require hospital care that spans at least two midnights, the services are generally appropriate for Medicare Part A payment. This policy applies to inpatient hospital admissions where the patient is reasonably expected to stay at least two midnights, and where the medical record supports that expectation that the patient would stay at least two midnights.

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Hospital Payment for Chronic Care Management

CPT 99490 – Chronic Care Management (CCM) services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements

- Multiple (2 or more) chronic conditions expected to last at least 12 months, or until the death of the patient
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- Comprehensive care plan established, implemented, revised or monitored

CCM is physician-directed

- Hospitals that provide the clinical staff that furnishes the service at the direction of the MD or appropriate NPP may be paid for CCM

Hospital Payment for Chronic Care Management

Additional requirements for CCM

- Hospital must have an established relationship with the patient
  - IP within last 12 months or
  - Registered OP for therapeutic services within last 12 months
- Hospital must maintain copy of patient agreement to have services in the hospital medical record or in a record that the hospital can access
- Hospital must maintain documentation that CCM elements were explained and offered to the patient and that the patient accepted or rejected the services.
- Only one hospital may provide CCM each month

Drug Administration By Setting

Code/Descriptor	Physician Fee Schedule	Hospital Outpatient
96360—Hydration up to 1 hour	$57.68	$93.48
96367—Therapeutic infusion, sequential	$30.81	$49.92
96372—Therapeutic injection	$25.43	$49.92
96411—IV Push Chemo	$62.70	$93.48
96413—Chemo, IV first hour	$136.15	$282.67
96417—Chemo IV, sequential	$63.06	$49.92

Source—National Rates for Appendix B of Both Rules

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QUALITY PROGRAMS: MEDICARE PHYSICIAN FEE SCHEDULE 2016

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HHS Announcement

- Better Care. Smarter Spending. Healthier People

In three words, our vision for improving health delivery is about better, smarter, healthier.

If we find better ways to pay providers, deliver care, and distribute information:

- ✓ We can receive better care.
- ✓ We can spend our health dollars more wisely.
- ✓ We can have healthier communities, a healthier economy, and a healthier country.

Focus Areas	Description
Incentives	▪ Promote value-based payment systems – Test new alternative payment models – Increase linkage of Medicaid, Medicare FFS, and other payments to value ▪ Bring proven payment models to scale
Care Delivery	▪ Encourage the integration and coordination of clinical care services ▪ Improve population health ▪ Promote patient engagement through shared decision making
Information	▪ Create transparency on cost and quality information ▪ Bring electronic health information to the point of care for meaningful use

Source: CMS

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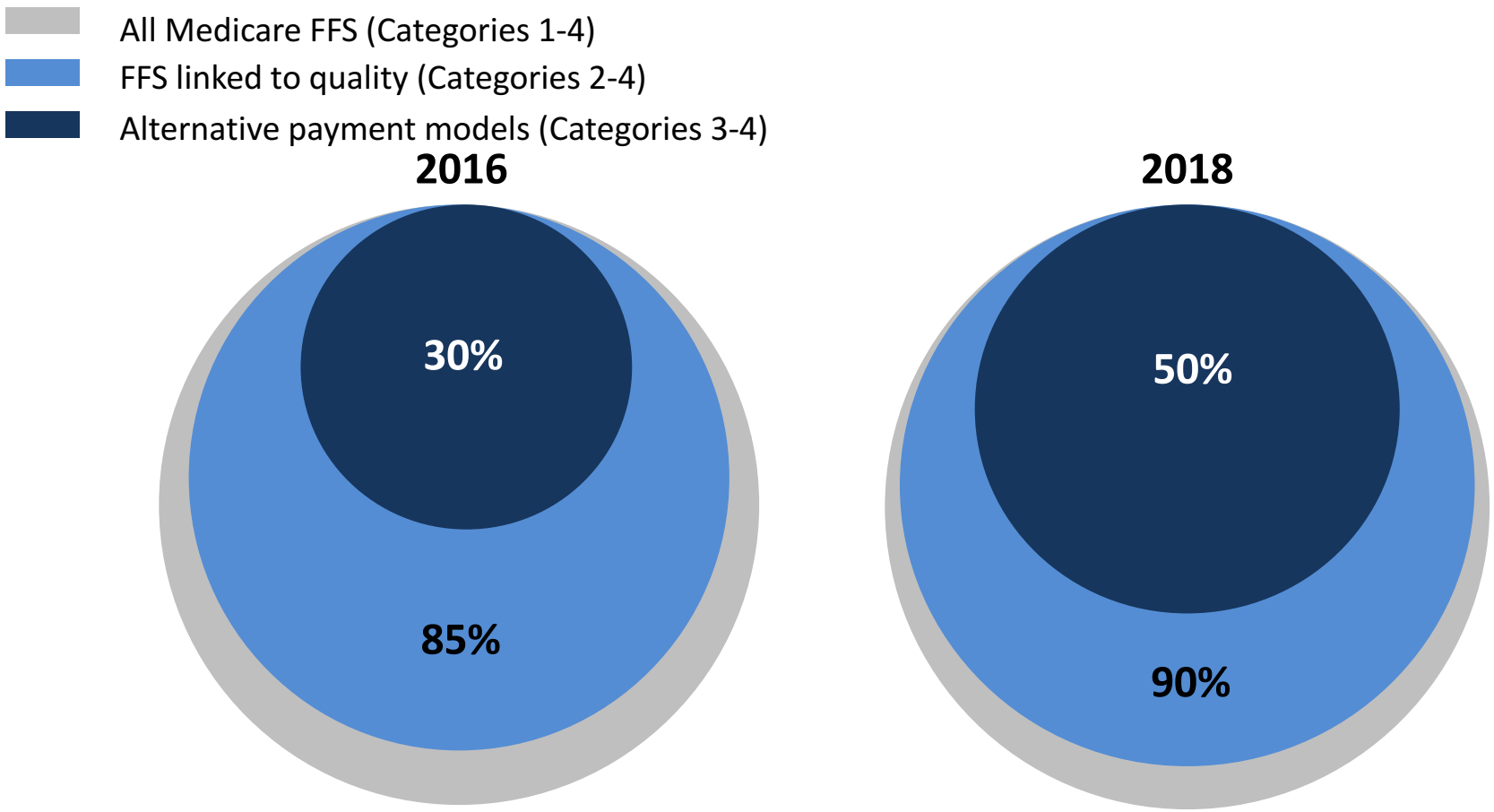
Target percentage of Medicare FFS payments linked to quality and alternative payment models



Source: CMS

Where The Value-Based Modifier Fits

	Category 1: Fee for Service—No Link to Quality	Category 2: Fee for Service—Link to Quality	Category 3: Alternative Payment Models Built on Fee-for-Service Architecture	Category 4: Population-Based Payment
Description	Payments are based on volume of services and not linked to quality or efficiency	At least a portion of payments vary based on the quality or efficiency of health care delivery	Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk	Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (i.e., ≥1 year)
Medicare FFS	• Limited in Medicare fee-for-service • Majority of Medicare payments now are linked to quality	• Hospital value-based purchasing • Physician Value-Based Modifier • Readmissions/Hospital Acquired Condition Reduction Program	• Accountable care organizations • Medical homes • Bundled payments • Comprehensive primary care initiative • Comprehensive ESRD • Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model	• Eligible Pioneer accountable care organizations in years 3-5

Source: CMS

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Value Modifier Overview

- MANDATORY – we have no choice

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PQRS: The Basis of the VBM/VM

- PQRS is voluntary, so was it taken seriously?
  - Per ASCO, based on 2010 PQRS data released by CMS, 30% of eligible oncologists/hematologists successfully participated in the PQRS program that year, with the average potential incentive payment totaling $3,000. Twenty-two percent of eligible radiation oncologists participated in 2010, with an average potential incentive payment of about $8,000.
  - Per CMS, in 2015, over 20% of Hem-Onc's got a payment adjustment > GAME OVER in the VBM
  - Per CMS, in 2015, over 24% of Rad-Onc's got a payment adjustment > GAME OVER in the VBM

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Overview of PQRS 2016

- Reporting that is favored by CMS
  - EHR Reporting
  - GPRO Website (≥ 25 providers)
  - Registry Reporting
- Best reporting in Oncology
  - Oncology Measures Group Via Registry
  - EHR Reporting

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How to Report PQRS?

- Reporting options depending upon practice type/size

Individual EPs	PQRS Group Practices
EHR direct product that is Certified Electronic Health Record Technology (CEHRT)	GPRO Web Interface (25+ providers)
EHR data submission vendor (DSV) that is CEHRT	Qualified PQRS registry (2+ providers)
• Qualified PQRS registry Submission/Measures Group	EHR direct product that is CEHRT (2+ providers)
Qualified Clinical Data Registry (QCDR)	EHR data submission vendor that is CEHRT (2+ providers)
Medicare Part B claims submitted to CMS; submit Quality Data Codes (QDCs)	CAHPS for PQRS using CMS-certified survey vendor (2+ providers) - CAHPS is supplemental to other reporting mechanisms

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You Can Align PQRS and CQMs

- EPs (individuals and part of a group) who are beyond their first year of Meaningful Use
- EPs with EHR certified to the June 2014 version of the eCQMs
- But, remember you are attesting to a one year period for your CQMs under this scenario

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PQRS Helpful Resources

- CMS Main website
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html
- Measure Codes
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html
- Payment Adjustment Information
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Payment-Adjustment-Information.html
- How to Obtain your QRUR
  - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Obtain-2013-QRUR.html

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Final Policies for the 2018 VM

CY 2018 VM payment adjustment, for physicians, PAs, NPs, CNSs, and CRNAs in groups with 2+ EPs and those who are solo practitioners

PQRS Reporters – 3 types – Category 1

1a. Group reporters : Report as a group via a PQRS GPRO and meet the criteria to avoid the 2018 PQRS payment adjustment

OR

1b.Individual reporters in the group: at least 50% of EPs in the group report PQRS measures as individuals AND meet the criteria to avoid the 2018 PQRS payment adjustment

2. Solo practitioners: Report PQRS measures as individuals AND meet the criteria to avoid the 2018 PQRS payment adjustment

Mandatory Quality-Tiering Calculation

Physicians, PAs, NPs, CNSs, & CRNAs in groups with 2-9 EPs and physician solo practitioners

Upward, no, or downward VM adjustment based on quality-tiering (-2.0% to +2.0x)

Physicians, PAs, NPs, CNSs, & CRNAs in groups with 10+ EPs

Upward, no, or downward VM adjustment based on quality-tiering (-4.0% to +4.0x)

Groups & solo practitioners consisting of non-physician EPs

Upward or no VM adjustment based on quality-tiering (0.0% to +2.0x)

Non-PQRS Reporters – Category 2

1. Groups: Do not avoid the 2018 PQRS payment adjustment as a group OR do not meet the 50% threshold option as individuals
2. Solo practitioners: Do not avoid the 2018 PQRS payment adjustment as individuals

-2.0% (for physicians, PAs, NPs, CNSs, & CRNAs in groups with 2-9 EPs, physician solo practitioners, & groups and solo practitioners consisting of non-physician EPs)
-4.0% (for physicians, PAs, NPs, CNSs, & CRNAs in groups with 10+ EPs)
(Automatic VM downward adjustment)

Note: The VM payment adjustment is separate from the PQRS payment adjustment and payment adjustments from other Medicare sponsored programs.

Acronyms

2018 VM Final Policies for Physicians, PAs, NPs, CNSs, & CRNAs in Groups of Physicians with 2-9 EPs and Physician Solo Practitioners

- Maintain the 2017 VM payment adjustment levels, except apply both upward and downward adjustments under quality-tiering
- An automatic -2.0% VM downward adjustment will be applied for not meeting the satisfactory reporting criteria to avoid the 2018 PQRS payment adjustment
- Under quality-tiering, the maximum upward adjustment is up to +2.0x ('x' represents the upward VM payment adjustment factor), and the maximum downward adjustment is -2.0%

Cost/Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0x*	+2.0x*
Average Cost	-1.0%	+0.0%	+1.0x*
High Cost	-2.0%	-1.0%	+0.0%

** Eligible for an additional +1.0x if reporting PQRS quality measures and average beneficiary risk score in the top 25% of all beneficiary risk scores*

Acronyms

2018 VM Final Policies for Physicians, NPs, PAs, CNSs, & CRNAs in Groups of Physicians with 10+ EPs

- Maintain the 2017 VM payment adjustment levels
- An automatic -4.0% VM downward adjustment will be applied for not meeting the satisfactory reporting criteria to avoid the 2018 PQRS payment adjustment
- Under quality-tiering, the maximum upward adjustment is up to +4.0x ('x' represents the upward VM adjustment factor), and the maximum downward adjustment is -4.0% payment

Cost/Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+2.0x*	+4.0x*
Average Cost	-2.0%	+0.0%	+2.0x*
High Cost	-4.0%	-2.0%	+0.0%

** Eligible for an additional +1.0x if reporting PQRS quality measures and average beneficiary risk score in the top 25% of all beneficiary risk scores*

Acronyms

2018 VM Final Policies for PAs, NPs, CNSs, & CRNAs who are Solo Practitioners or in Groups Consisting of Non-Physician EPs only

- An automatic -2.0% VM downward adjustment will be applied for not meeting the satisfactory reporting criteria to avoid the 2018 PQRS payment adjustment
- Under quality-tiering, the maximum upward adjustment is up to +2.0x ('x' represents the upward VM payment adjustment factor) and held harmless from any downward adjustments for poor performance
  - This policy is consistent with how the VM is applied to groups and solo practitioners during the first year in which they are subject to the VM

Cost/Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0x*	+2.0x*
Average Cost	+0.0%	+0.0%	+1.0x*
High Cost	+0.0%	+0.0%	+0.0%

** Eligible for an additional +1.0x if reporting PQRS quality measures and average beneficiary risk score in the top 25% of all beneficiary risk scores*

Acronyms

Determining Group Size for Applying the VM

- Beginning with the 2016 VM, a TIN's size would be based on the lower of the number of EPs indicated by the Medicare Provider Enrollment, Chain, and Ownership System (PECOS)-generated list or our analysis of the claims data for purposes of determining the payment adjustment amount under the VM

- For the 2018 VM:
  - Identify TINs as non-physician EP TINs if *either* the PECOS-generated list *or* our analysis of the claims data shows that the TIN contains no physicians or that no physicians billed under the Medicare PFS during the performance period.
  - The VM will not be applied to TINs if either the PECOS-generated list or claims analysis shows that the TIN consists only of non-physician EPs who are not PAs, NPs, CNSs, or CRNAs

Acronyms

Who Is Exempt?

- In 2017 and 2018, the application of the VM is waived for
  - groups and solo practitioners, as identified by their TIN, if at least one EP who billed for PFS items and services under the TIN during the applicable VM performance period participated in the
  - Pioneer ACO Model, CPC Initiative, or other similar Innovation Center models (e.g., the Next Generation ACO Model, Oncology Care Model, Comprehensive ESRD Care Initiative).

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VM Informal Review

- The Informal Review submission period will occur during the 60 days following the release of the QRURs for the 2016 VM and subsequent years
- Reclassify a TIN as Category 1 when PQRS determines on informal review that at least 50% of the TIN's EPs meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals for the relevant CY PQRS payment adjustment, or in lieu of satisfactory reporting, satisfactorily participate in a PQRS QCDR for the relevant CY PQRS payment adjustment
- We note that if the group was initially classified as Category 2, then we do not expect to have data for calculating their quality composite, in which case they'd be classified as "average quality"; however, if the data is available in a timely manner, then CMS would recalculate the quality composite

Acronyms

2016 Value Modifier Results

CY 2014 Performance

+15.9% 1x
+31.8% 2x

	Low Quality	Average Quality	High Quality	
Low Cost	6	73	0	79
Average Cost	644	7,351	55	8,090
High Cost	39	226	1	266
	689	7,650	56	

5,418 did not report PQRS!

-2%

Groups with 10 or more eligible professionals

From Brian Bourbeau Presentation, COA 2016

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Coding 2016

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What Is The Medicare ICD-10-CM Flexibility Period?

- There will be no denials for codes that are valid for lack of specificity if they are in the right 3-character category for one year
  - An example is C81 (Hodgkin's lymphoma) – which by itself is not a valid code. Examples of valid codes within category C81 contain 5 characters, such as:
    - C81.00 Nodular lymphocyte predominant Hodgkin lymphoma, unspecified site
    - C81.03 Nodular lymphocyte predominant Hodgkin lymphoma, intra-abdominal lymph nodes
    - C81.10 Nodular sclerosis classical Hodgkin lymphoma, unspecified site
    - C81.90 Hodgkin lymphoma, unspecified, unspecified site
  - During the 12 month after ICD-10 implementation, using any one of the valid codes for Hodgkin's lymphoma (C81.00, C81.03, C81.10 or C81.90) would not be cause for an audit under the announced flexibilities.
- REMEMBER this only applies to Medicare PART B claims—not hospital, Medicare Advantage, or private insurance claims

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Medicare 'Flexibility' Period

- But, read the fine print in the clarification to the CMS guidance:
  - "As such, the recent Guidance does not change the coding specificity required by the NCDs and LCDs. Coverage policies that currently require a specific diagnosis under ICD-9 will continue to require a specific diagnosis under ICD-10. It is important to note that these policies will require no greater specificity in ICD-10 than was required in ICD-9, with the exception of laterality, which does not exist in ICD-9. LCDs and NCDs that contain ICD-10 codes for right side, left side or bilateral do not allow for unspecified side."
  - So, if a Medicare policy requires specific codes, you had better have them on there

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Highest Denial Plans ICD-10-CM (2015 to the Present)

Source: onPoint Oncology focalPoint® database 2000+ physicians

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Drug Denial Rates Under ICD-10-CM

Source: onPoint Oncology focalPoint® database

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Review of Chronic Care Management

- Furnished to patients with 2 or more chronic conditions
  - Conditions must be expected to last 12 months or more and the patient may suffer significant exacerbation, morbidity, or mortality
  - Patients must have 24/7 access to the practice, caregivers and electronic medical records
  - Chronic care management codes include the following:
    - Continuity of care with a healthcare professional
    - Development and revision of a patient-centered care plan
    - Communication with other professionals
    - Medication management
    - Coordination with other professionals
    - Care transition coordination

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Chronic Care Management (2015)

- Billing requirements
  - **Only one physician may bill per month**
  - Cost-sharing will not and cannot be waived
  - Must give the patient the scope of services for billing in writing
  - Must have a copy of their care plan in writing
  - Patient must be informed of their right to stop services
  - Beneficiary must know that only one physician can bill per month
  - Patient must agree to liability for services
  - This agreement must be informed by a discussion
  - Beneficiary may revoke permission

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CPT Update

- 2016 CPT Code Changes
  - 140 New Codes
  - 132 Revised Codes
  - 91 Deleted Codes

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99415-99416

- 99415: Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting ,direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service) ✸ (Use 99415 in conjunction with 99201, 99202, 99203, 99204,99205, 99211, 99212, 99213, 99214, 99215)(Do not report 99415 in conjunction with 99354, 99355)—Medicare $8.95 (National Average)
- 99416: each additional 30 minutes (List separately in addition to code for prolonged service) ✸ (Use 99416 in conjunction with 99415)—Medicare $5.01 (National Average)

Source—CPT 2016 Copyright American Medical Association, All Rights Reserved

Prolonged Clinical Staff Time

- 99415-99416
  - Codes are used when prolonged E/M services are provided in a physician's office or outpatient setting that involves clinical staff time beyond the typical face-to-face time listed on the code descriptor
  - The physician or NPP are there to provide direct supervision of the staff
  - Reported in addition to other E/M services

Source—CPT 2016 Copyright American Medical Association, All Rights Reserved

99415-99416

- Instructions on reporting prolonged services
  - Prolonged services of less than 45 minutes total duration on a given date is not separately reported because the clinical staff time involved is included in the E/M codes.
  - The typical face-to-face time of the primary service is used in defining when prolonged services time begins. For example, prolonged clinical staff services for 99214 begin after 25 minutes, and
  - For a 99214 visit, 99415 is not reported until at least 70 minutes total face-to-face clinical staff time has been performed.
  - When face-to-face time is noncontiguous, use only the face-to-face time provided to the patient by the clinical staff.

Source—CPT 2016 Copyright American Medical Association

Transitional Care Management

- Per the Final Fee Schedule Rule, billing date is no longer the last day of the month—it is the date of the face-to-face visit

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Radiation Oncology

- Many new code changes
- Differing coding between the hospital and the office = CPT versus G-codes
- Great summary of this at this ACR web site: **http://www.acr.org/~/media/ACR/Documents/PDF/News/Complex%202015%20Changes%20to%20Radiation%20Oncology%20Coding.pdf**

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-PO Modifier

- In the CY 2015 Outpatient Prospective Payment System Final Rule (79 FR 66910-66914) CMS created a HCPCS modifier for hospital claims that is to be reported with every code for outpatient hospital items and services furnished in an off-campus provider-based department (PBD) of a hospital. This 2-digit modifier was be added to the HCPCS annual file as of January 1, 2015, with the label ‘‘PO.’’ Reporting of this new modifier was voluntaryfor CY 2015, with reporting required beginning on January 1, 2016.

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-PO Modifier

- According to CMS, the determinative factor is whether or not the item or service is being paid through the OPPS. If an item or service is being provided by an applicable provider and is being paid through the OPPS, then the PO modifier should be applied.
- For instance, a drug with an OPPS status indicator of “K” or a laboratory test that is packaged into an OPPS service should have the PO modifier applied. If a service is not paid through the OPPS, such as a laboratory, then PO is not necessary

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Lung Cancer Screening with Low Dose Computed Tomography

2/5/2015 – NCD for coverage of lung cancer screening with low dose CT (LDCT)

- Coverage includes a lung cancer screening counseling and shared decision making visit, and annual screening for lung cancer with LDCT for certain beneficiaries
- Two HCPCS codes for reporting services
  - G0296 – Counseling visit to discuss need for lung ca screening (LDCT) using low dose CT scan
  - G0297 – Low dose CT scan (LDCT) for lung cancer screening

Lung Cancer Screening

- If NCD requirements are met for counseling and shared decision-making (G0296), services can indeed be billed the same day as a separately identifiable E/M service.
  - Modifier -25 will be used on the G0296
- No patient portion with these services as they are used for screening

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Lung Cancer Screening with Low Dose Computed Tomography

LDCT (continued)

In-office Fees (U.S. Weight of 1), No Copay

- G0296--$28.64
- G0297--$254.93 (-TC plus -26)

APC assignments:

- G0296 – APC 5822, SI S, Payment - $69.65, No Copay
- G0297 – APC 5570, SI S, Payment - $112.49 No Copay

NOTE: Although these HCPCS codes are effective back to 2/5/15, they may not be submitted until 1/1/16.

NOTE: In reply to a submitted comment, CMS agreed that G0296 may be provided on the same day as a medically necessary E/M service. Report the medical E/M with modifier 25.

Selected Non-Oncology HCPCS Added

- -ZA = Novartis/Sandoz
- G0296 Counseling visit to discuss need for lung cancer screening (ldct) using low dose ct scan (service is for eligibility determination and shared decision making)
- G0297 Low dose ct scan (ldct) for lung cancer screening
- J0202 Injection, alemtuzumab, 1 mg
- J0596 Injection, c1 esterase inhibitor (recombinant), ruconest, 10 units
- J0695 Injection, ceftolozane 50 mg and tazobactam 25 mg
- J0714 Injection, ceftazidime and avibactam, 0.5 g/0.125 g
- J0875 Injection, dalbavancin, 5mg
- J1443 Injection, ferric pyrophosphate citrate solution, 0.1 mg of iron
- J1447 Injection, tbo-filgrastim, 1 microgram
- J1575 Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immuneglobulin
- J1833 Injection, isavuconazonium, 1 mg
- J2407 Injection, oritavancin, 10 mg
- J2502 Injection, pasireotide long acting, 1 mg
- J2547 Injection, peramivir, 1 mg
- J2860 Injection, siltuximab, 10 mg J3090 Injection, tedizolid phosphate, 1 mg
- J3380 Injection, vedolizumab, 1 mg

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Hematology-Oncology HCPCS Added

- J7121 5% dextrose in lactated ringers infusion, up to 1000 cc
- J7188 Injection, factor viii (antihemophilic factor, recombinant), (obizur), per i.u.
- J7205 Injection, factor viii fc fusion (recombinant), per iu
- J7503 Tacrolimus, extended release, (envarsus xr), oral, 0.25 mg
- J7999 Compounded drug, not otherwise classified
- J8655 Netupitant 300 mg and palonosetron 0.5 mg
- J9032 Injection, belinostat, 10 mg
- J9039 Injection, blinatumomab, 1 microgram
- J9271 Injection, pembrolizumab, 1 mg
- J9299 Injection, nivolumab, 1 mg
- J9308 Injection, ramucirumab, 5 mg

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Oncology HCPCS Changed

- J0575 Buprenorphine/naloxone, oral, greater than 10 mg buprenorphine
- J1442 Injection, filgrastim (g-csf), excludes biosimilars, 1 microgram
- J7508 Tacrolimus, extended release, (astagraf xl), oral, 0.1 mg

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Oncology Non-C-code Deletions

- J0886 Injection, epoetin alfa, 1000 units (for esrd on dialysis)
- J1446 Injection, tbo-filgrastim, 5 micrograms
- J7302 Levonorgestrel-releasing intrauterine contraceptive system, 52 mg
- J7506 Prednisone, oral, per 5 mg J9010 Injection, alemtuzumab, 10 mg
- Q9975 Injection, factor viii fc fusion (recombinant), per iu
- Q9976 Injection, ferric pyrophosphate citrate solution, 0.1 mg of iron
- Q9977 Compounded drug, not otherwise classified
- Q9978 Netupitant 300 mg and palonosetron 0.5 mg
- Q9979 Injection, alemtuzumab, 1 mg

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More 2016 HCPCS

HCPCS/MOD Code	Action	Short Description	Long Description	Effective Date
Q9981	Add	rolapitant, oral, 1mg	Rolapitant, oral, 1 mg	7/1/16
S0285	Add	cnslt before screen colonoscop	Colonoscopy consultation performed prior to a screening colonoscopy procedure	7/1/16
Q9982	Add	flutemetamol f18 diagnostic	Flutemetamol F18, diagnostic, per study dose, up to 5 millicuries	7/1/16
Q9983	Add	florbetaben f18 diagnostic	Florbetaben f18, diagnostic, per study dose, up to 8.1 millicuries	7/1/16
S0311	Add	Comp mgmt care coord adv ill	Comprehensive management and care coordination for advanced illness, per calendar month	7/1/16

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More 2016 HCPCS

G9678	Oncology Care Model (OCM) Monthly Enhanced Oncology Oncology Services (MEOS) payment for enhanced care management services for OCM beneficiaries. MEOS covers care management services for Medicare beneficiaries in a 6-month OCM Episode of Care triggered by the administration of chemotherapy. Enhanced care management services include services driven by the OCM practice requirements, including: 24/7 clinician access, use of an ONC-certified Electronic Health Record, utilization of data for quality improvement, patient navigation, documentation of care plans, and use of clinical guidelines. (G9678 may only be billed for OCM beneficiaries by OCM practitioners)	Oncology Care Model service

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More 2016 HCPCS

HCPCS	Action	Short Description	Long Description	Effective Date
C1820	No Change	Generator neuro rechg bat sy	Generator, neurostimulator (implantable), with rechargeable battery and charging system	1/1/06
C1822	No Change	Gen, neuro, HF, rechg bat	Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system	1/1/16
C9137	Add	Adynovate Factor VIII recom	Injection, Factor VIII (antihemophilic factor, recombinant) PEGylated, 1 I.U.	4/1/16
C9138	Add	Nuwiq Factor VIII recomb	Injection, Factor VIII (antihemophilic factor, recombinant) (Nuwiq), 1 I.U.	4/1/16
C9461	Add	Choline C 11, diagnostic	Choline C 11, diagnostic, per study dose	4/1/16
C9470	Add	Aripiprazole lauroxil im	Injection, aripiprazole lauroxil, 1 mg	4/1/16
C9471	Add	Hymovis, 1 mg	Hyaluronan or derivative, Hymovis, for intra-articular injection, 1 mg	4/1/16
C9472	Add	Inj talimogene laherparepvec	Injection, talimogene laherparepvec, 1 million plaque forming units (PFU)	4/1/16
C9473	Add	Injection, mepolizumab	Injection, mepolizumab, 1 mg	4/1/16
C9474	Add	Inj, irinotecan liposome	Injection, irinotecan liposome, 1 mg	4/1/16
C9475	Add	Injection, necitumumab	Injection, necitumumab, 1 mg	4/1/16

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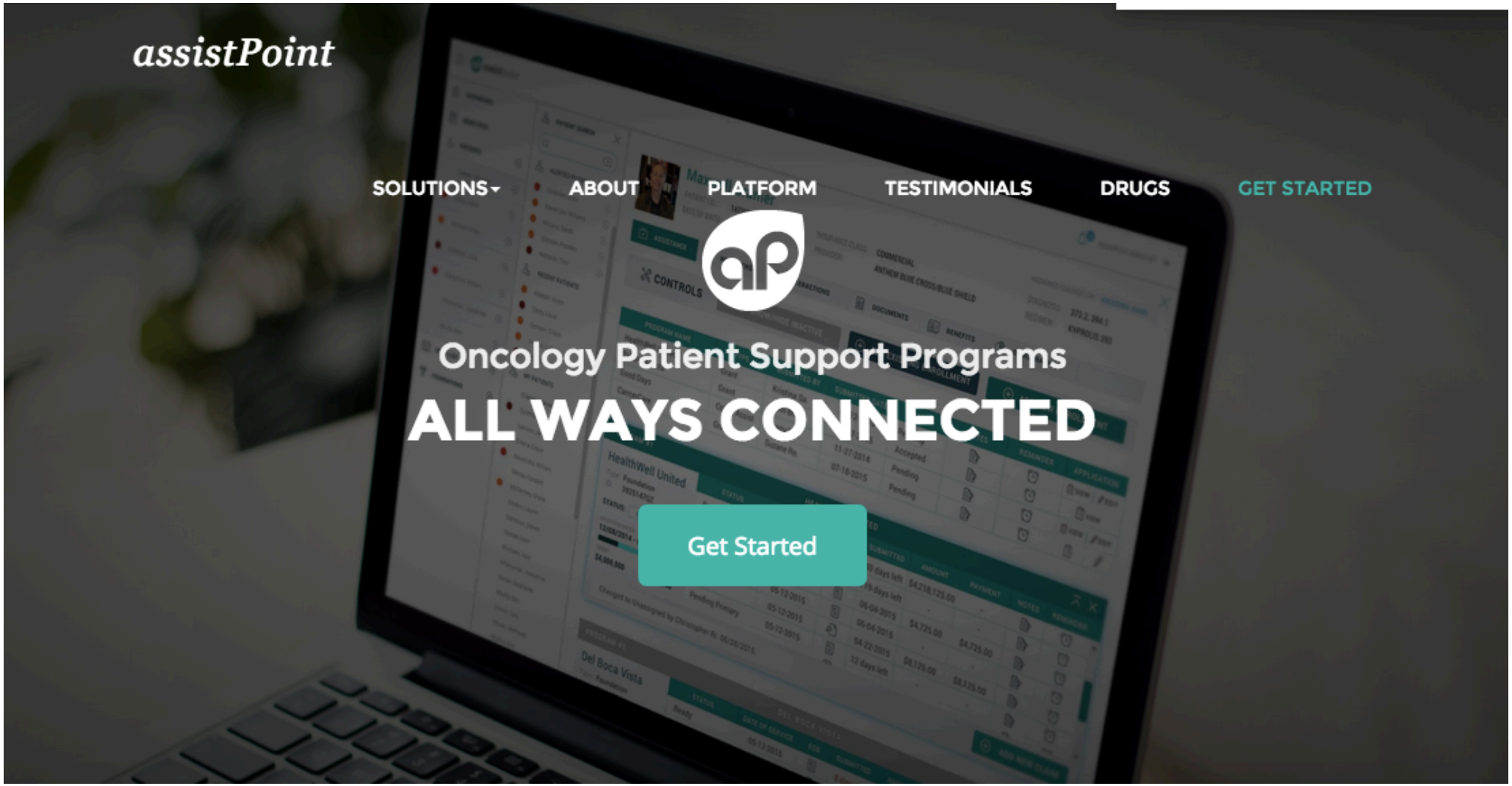

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assistPoint ® Summary

- assistPoint is the solution everyone has been waiting for
- It is free to all facilities
- More features to come next week!

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APPENDICES: PQRS AND VM

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TABLE Q1: Summary of Finalized Requirements for the 2018 PQRS Payment Adjustment: Individual Reporting Criteria for the Satisfactory Reporting of Quality Measures Data via Claims, Qualified Registry, and EHRs and Satisfactory Participation Criterion in QCDRs

Reporting Period	Measure Type	Reporting Mechanism	Satisfactory Reporting/Satisfactory Participation Criteria
12-month (Jan 1– Dec 31, 2016)	Individual Measures	Claims	Report at least 9 measures, covering at least 3 of the NQS domains AND report each measure for at least 50% of the EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Of the measures reported, if the EP sees at least 1 Medicare patient in a face-to-face encounter, the EP will report on at least 1 measure contained in the PQRS cross-cutting measure set. If less than 9 measures apply to the EP, the EP would report on each measure that is applicable , AND report each measure for at least 50% of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted.
12-month (Jan 1– Dec 31, 2016)	Individual Measures	Qualified Registry	Report at least 9 measures, covering at least 3 of the NQS domains AND report each measure for at least 50% of the EP's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Of the measures reported, if the EP sees at least 1 Medicare patient in a face-to-face encounter, the EP will report on at least 1 measure contained in the PQRS cross-cutting measure set. If less than 9 measures apply to the EP, the EP would report on each measure that is applicable, AND report each measure for at least 50% of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted.

Acronyms

TABLE Q1: Summary of Finalized Requirements for the 2018 PQRS Payment Adjustment: Individual Reporting Criteria for the Satisfactory Reporting of Quality Measures Data via Claims, Qualified Registry, and EHRs and Satisfactory Participation Criterion in QCDRs (cont.)

Reporting Period	Measure Type	Reporting Mechanism	Satisfactory Reporting/Satisfactory Participation Criteria
12-month (Jan 1– Dec 31, 2016)	Individual Measures	Direct EHR Product or EHR Data Submission Vendor Product	Report 9 measures covering at least 3 of the NQS domains. If an EP's direct EHR product or EHR data submission vendor product does not contain patient data for at least 9 measures covering at least 3 domains, then the EP would be required to report all of the measures for which there is Medicare patient data. An EP would be required to report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1– Dec 31, 2016)	Measures Groups	Qualified Registry	Report at least 1 measures group AND report each measures group for at least 20 patients, the majority (11 patients) of which are required to be Medicare Part B FFS patients. Measures groups containing a measure with a 0% performance rate will not be counted.
12-month (Jan 1– Dec 31, 2016)	Individual PQRS measures and/or non-PQRS measures reportable via a QCDR	Qualified Clinical Data Registry (QCDR)	Report at least 9 measures available for reporting under a QCDR covering at least 3 of the NQS domains, AND report each measure for at least 50% of the EP's patients. Of these measures, the EP would report on at least 2 outcome measures, OR, if 2 outcomes measures are not available, report on at least 1 outcome measures and at least 1 of the following types of measures – resource use, patient experience of care, efficiency/appropriate use, or patient safety.

Acronyms

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TABLE Q2: Summary of Finalized Requirements for the 2018 PQRS Payment Adjustment: Group Practice Reporting Criteria for Satisfactory Reporting of Quality Measures Data via the GPRO

Reporting Period	Size	Measure Type	Reporting Mechanism	Satisfactory Reporting Criteria
12-month (Jan 1–Dec 31, 2016)	25-99 EPs	Individual GPRO Measures in the GPRO Web Interface	GPRO Web Interface	Report on all measures included in the web interface; AND populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 248, then the group practice must report on 100 % of assigned beneficiaries. In other words, we understand that, in some instances, the sampling methodology we provide will not be able to assign at least 248 patients on which a group practice may report, particularly those group practices on the smaller end of the range of 25–99 EPs. If the group practice is assigned less than 248 Medicare beneficiaries, then the group practice must report on 100% of its assigned beneficiaries. A group practice must report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1–Dec 31, 2016)	100+ EPs (if CAHPS for PQRS applies)	Individual GPRO Measures in the GPRO Web Interface + CAHPS for PQRS	GPRO Web Interface + CMS-Certified Survey Vendor	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor. In addition, the group practice must report on all measures included in the GPRO web interface; AND populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 248, then the group practice must report on 100% of assigned beneficiaries. A group practice will be required to report on at least 1 measure for which there is Medicare patient data. Please note that if the CAHPS for PQRS survey is applicable to a group practice who reports quality measures via the Web Interface, the group practice must administer the CAHPS for PQRS survey in addition to reporting the Web Interface measures.
12-month (Jan 1–Dec 31, 2016)	2-99 EPs	Individual Measures	Qualified Registry	Report at least 9 measures, covering at least 3 of the NQS domains. Of these measures, if a group practice sees at least 1 Medicare patient in a face-to-face encounter, the group practice would report on at least 1 measure in the PQRS cross-cutting measure set. If less than 9 measures covering at least 3 NQS domains apply to the group practice, the group practice would report on each measure that is applicable to the group practice, AND report each measure for at least 50 percent of the group's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.

Acronyms

TABLE Q2: Summary of Finalized Requirements for the 2018 PQRS Payment Adjustment: Group Practice Reporting Criteria for Satisfactory Reporting of Quality Measures Data via the GPRO (cont.)

Reporting Period	Group Practice Size	Measure Type	Reporting Mechanism	Satisfactory Reporting Criteria
12-month (Jan 1–Dec 31, 2016)	2-99 EPs	Individual PQRS measures and/or non-PQRS measures reportable via a QCDR	Qualified Clinical Data Registry (QCDR)	Report at least 9 measures available for reporting under a QCDR covering at least 3 of the NQS domains, AND report each measure for at least 50% of the group practice's patients. Of these measures, the group practice would report on at least 2 outcome measures, OR, if 2 outcomes measures are not available, report on at least 1 outcome measures and at least 1 of the following types of measures – resource use, patient experience of care, efficiency/appropriate use, or patient safety.
12-month (Jan 1–Dec 31, 2016)	2—99 EPs that elect CAHPS for PQRS; 100+ EPs that must report CAHPS for PQRS	Individual PQRS measures and/or non-PQRS measures reportable via a QCDR + CAHPS for PQRS	QCDR + CMS-Certified Survey Vendor	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor, and report at least 6 additional measures covering at least 2 NQS domains using the QCDR. Of the additional measures that must be reported in conjunction with reporting the CAHPS for PQRS survey measures, at least 1 measure must be an outcome measure.

Acronyms

TABLE Q2: Summary of Finalized Requirements for the 2018 PQRS Payment Adjustment: Group Practice Reporting Criteria for Satisfactory Reporting of Quality Measures Data via the GPRO (cont.)

Reporting Period	Group Practice Size	Measure Type	Reporting Mechanism	Satisfactory Reporting Criteria
12-month (Jan 1–Dec 31, 2016)	2-99 EPs	Individual PQRS measures and/or non-PQRS measures reportable via a QCDR	Qualified Clinical Data Registry (QCDR)	Report at least 9 measures available for reporting under a QCDR covering at least 3 of the NQS domains, AND report each measure for at least 50% of the group practice's patients. Of these measures, the group practice would report on at least 2 outcome measures, OR, if 2 outcomes measures are not available, report on at least 1 outcome measures and at least 1 of the following types of measures – resource use, patient experience of care, efficiency/appropriate use, or patient safety.
12-month (Jan 1–Dec 31, 2016)	2—99 EPs that elect CAHPS for PQRS; 100+ EPs that must report CAHPS for PQRS	Individual PQRS measures and/or non-PQRS measures reportable via a QCDR + CAHPS for PQRS	QCDR + CMS-Certified Survey Vendor	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor, and report at least 6 additional measures covering at least 2 NQS domains using the QCDR. Of the additional measures that must be reported in conjunction with reporting the CAHPS for PQRS survey measures, at least 1 measure must be an outcome measure.

Acronyms

VM Policies for 2016, 2017, & 2018

Value Modifier Components	2016 Finalized Policies	2017 Finalized Policies	2018 Finalized Policies
Performance Year	2014	2015	2016
Group Size	Physicians in groups with 10+ EPs	Physicians in groups with 2+ EPs and physician solo practitioners	Physicians, PAs, NPs, CNSs, and CRNAs in groups with 2+ EPs and those who are solo practitioners
Quality-Tiering	**Mandatory:** Groups of physicians with 10-99 EPs receive only the upward or neutral VM adjustment (no downward adjustment). Groups of physicians with 100+ EPs can receive upward, neutral, or downward VM adjustment.	**Mandatory:** Groups of physicians with 2-9 EPs and physician solo practitioners receive only the upward or neutral VM adjustment (no downward adjustment). Groups of physicians with 10+ EPs can receive upward, neutral, or downward VM adjustment.	**Mandatory:** Groups consisting of non-physician EPs and PAs, NPs, CNSs, and CRNAs who are solo practitioners receive only the upward or neutral VM adjustment (no downward adjustment). Groups of physicians with 2+ EPs and physician solo practitioners can receive upward, neutral, or downward VM adjustment.
Peer Group for Categorizing Quality and Cost Composites	Groups with 10+ EPs	Groups with 2+ EPs and solo practitioners	Groups with 2+ EPs and solo practitioners
Available Quality Reporting Mechanisms	GPRO Web Interface, Qualified PQRS Registry, EHR, or 50% of EPs report under the PQRS as individuals	Same as 2016	GPRO Web Interface, Qualified PQRS Registry, EHR, or QCDR, or 50% of EPs report under the PQRS as individuals

Acronyms

VM Policies for 2016, 2017, & 2018 (cont.)

Value Modifier Components	2016 Finalized Policies	2017 Finalized Policies	2018 Finalized Policies
Outcome Measures **NOTE: Performance on the outcome measures and measures reported through one of the PQRS reporting mechanisms will be used to calculate a quality composite score for the TIN for the VM.**	• All-Cause Hospital Readmissions • Composite of Acute Prevention Quality Indicators: (bacterial pneumonia, urinary tract infection, dehydration) • Composite of Chronic Prevention Quality Indicators: (chronic obstructive pulmonary disease (COPD), heart failure, diabetes)	Same as 2016, except the all-cause hospital readmissions measure will not be applied to groups with 2-9 EPs and solo practitioners	Same as 2017
Patient Experience of Care Measures	CAHPS for PQRS: Optional for groups with 25+ EPs; Required for groups with 100+ EPs reporting via Web Interface. Groups may elect to include their 2014 CAHPS results in the calculation of the 2016 VM.	CAHPS for PQRS: Optional for groups with 2-99 EPs; Required for all groups with 100+ EPs. Groups may elect to include their 2015 CAHPS results in the calculation of the 2017 VM.	Groups may elect to include their 2016 CAHPS results in the calculation of the 2018 VM. Include the CAHPS for ACOs Survey in the quality composite of the 2018 VM for TINs participating in ACOs in the Shared Shaving Program in 2016

Acronyms

VM Policies for 2016, 2017, & 2018 (cont.)

Value Modifier Components	2016 Finalized Policies	2017 Finalized Policies	2018 Finalized Policies
Cost Measures	• Total per capita costs measure • Total per capita costs for beneficiaries with four chronic conditions: COPD, Heart Failure, Coronary Artery Disease, Diabetes • Medicare Spending Per Beneficiary measure	Same as 2016	Same as 2016
Benchmarks	No differentiation by group size ("compared to everyone") for both cost and quality measures	No differentiation by group size ("compared to everyone") for both cost and quality measures	No differentiation by group size ("compared to everyone") for both cost and quality measures Create separate eCQM benchmarks, based on the CMS eMeasure ID and exclude eCQM measures from the overall benchmark for a given measure.
Maximum Payment at Risk	-2.0%	-2.0% (Groups of physicians with 2-9 EPs and solo practitioners) -4.0% (Groups of physicians with 10+ EPs)	-2.0% (Groups of physicians with 2-9 EPs and physician solo practitioners) -4.0% (Groups of physicians with 10+ EPs) -2.0% (Groups with non-physician EPs and PAs, NPs, CNSs, and CRNAs who are solo practitioners)

Acronyms

VM Policies for 2016, 2017, & 2018 (cont.)

Value Modifier Components	2015 Finalized Policy	2016, 2017 Finalized Policy	2018 Finalized Policy
Application of the VM to Participants of the Shared Savings Program, Pioneer ACO Model, and the CPC Initiative	Not Applicable	2016: Not Applicable 2017: Shared Savings Program: VM based on the ACO's quality data and average cost; Pioneer ACO Model and the CPC Initiative: average quality/average cost	Shared Savings Program: VM based on the ACO's quality and CAHPS data, and average cost; Pioneer ACO Model and the CPC Initiative: VM waived in 2017 and 2018
VM Informal Review Process: Timeline	• Deadline of February 28, 2015 for a group to request correction of a perceived error made by CMS in the 2015 VM payment adjustment.	Establish a 60 day period that would start after the release of the QRURs for the applicable reporting period for a group or solo practitioner (as applicable) to request correction of a perceived error made by CMS in the determination of the group or solo practitioner's VM for that payment adjustment period.	The Informal Review submission period will occur during the 60 days following the release of the QRURs for the 2016 VM and subsequent years
VM Informal Review Process: If CMS made an error	• Classify a TIN as "average quality" in the event we determine that we have made an error in the calculation of quality composite. • Recompute a TIN's cost composite if CMS made an error in its calculation. • Adjust a TIN's quality tier.	• Recompute a TIN's quality composite in the event we determine that we or a third-party vendor have made an error in the calculation of quality composite. • Otherwise, the same as 2015.	Same as 2016, 2017 and: Reclassify a TIN as Category 1 when PQRS determines on informal review that at least 50 percent of the TIN's EPs meet the criteria for satisfactory reporting of data on PQRS quality measures as individuals for the relevant CY PQRS payment adjustment, or in lieu of satisfactory reporting, satisfactorily participate in a PQRS QCDR for the relevant CY PQRS payment adjustment.

Acronyms