2016 Trends To Watch

- ICD-10-CM “Mess” and Clean-up
- More Penalties for Poor Reporting
- Continued Consolidation Into Mega-Groups
- Bundling and Other Alternative Models
- More $$ for Coordination of Care
- Telemedicine for Non-Medicare Patients
- Pathways Still Spread
- But, Episodes of Care May Win
- More Information To The Public
Agenda

- Medicare PFS Rule 2016
- HOPPS Rule 2016
- Budget Deal
- PQRS
- The Value-Based Modifier
- Pathways
- Coding 2016

Disclaimer

- The information described herein is gathered from third-party sources and is subject to continual change and interpretation. It is provided for informational purposes only and does not guarantee coverage or payment. It is always the provider's responsibility to determine and submit appropriate codes and modifiers based on the services rendered and the provider's medical judgment. Providers should contact the payer for coding and billing guidance.
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Web Sites for 2016 Regulations

• This presentation is based on published rules
  – HOPPS: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.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. Set to expire after CY 2013 (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
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

*"Medicare Access and CHIP Reauthorization Act of 2015"

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
  – Will come out of EHR incentives and probably out of other incentives paid during the sequestration period.
• Murray-Ryan Budget Deal extended the Sequester until 2023; PAMA extended it to 2024, and the latest budget deal extends it to 2025
SGR “Fixed”

- The SGR is permanently “fixed” or at least the updates are stabilized by the SGR Repeal and Medicare Provider Payment Act
  - Providers will receive a 0.5% update from 7/1/2015 until 2019
  - The rates in 2019-2025 will be maintained, but providers will be eligible for a bonus based on MIPs*
  - From 2026 on, providers will receive a 0.75% update if they are in an Alternative Payment Mechanism, while all others will get a 0.25%

*-- The Merit-Based Incentive Payment System (MIPS)

SGR Fix: Consolidation of Quality Programs

- Payments to professionals will be adjusted based on performance in a unified Merit-based Incentive Program (MIPs), which consolidates
  - PQRS
  - Value-Based Modifier
  - EHR MU
- Payment provisions associated with these programs will sunset at the end of 2018, including
  - 2% penalty for PQRS
  - 3-5% penalty for MU
  - Will remain in the physician fee schedule
SGR Fix: MIPs

• MIPs will assess a provider's performance in these four ("4") areas:
  1. Quality measures
  2. Resource use, similar to VBM
  3. Meaningful Use
  4. Clinical practice improvements

• Providers will receive a composite score of 100 based on their performance in these categories. There will also be ‘credit’ for year-over-year performance

SGR Fix: MIPs

• Each MIPs score will be compared to a performance threshold based on averaging (median or mean) of all professionals within the time period:
  – **Negative adjustments**: will be capped at 4% in 2019; 5% in 2020; 7% in 2021; and 9% in 2022
  – **Zero adjustments**: Self explanatory
  – **Positive adjustments**: Eligible professionals with higher performance scores will receive proportionately larger payments up to a maximum of three times the annual cap for negative payment adjustments
SGR FIX: APMs

- Professionals who receive a significant share of their revenues through an Alternative Payment Mechanism will receive a 5% bonus 2019-2024 (e.g. Medical Home, ACO, OCM) under 2 options:
  - A significant part of Medicare revenue comes from APMs
  - Or, receiving a significant percent of APM revenue from Medicare and other payers

SGR Fix: Access to Physician Information

- This is to expand the info for Beneficiary choice
  - Utilization and payment data to be published
  - Will be searchable by
    - Name
    - Location
    - Services
  - Qualified Entities may re-sell data. QEs include professionals, medical societies, hospitals
SGR Fix: Other Provisions

- Allows ‘opt-out’ physicians to automatically renew at the end of 2 years
- Requires regular reporting of ‘opt-out’ physicians characteristics
- Requires EHRs to be interoperable by 2018 and no physician can block these
- Requires CMS to come up with a permanent hospital gain-sharing method
- Requires GAO to report on barriers to expanded use of telemedicine

SGR Fix: Other Provisions

- MACs and RACs will have to interact and consolidate efforts
  - One area of potential future enforcement action with this "misinterpretation of Medicare policies" authority is further scrutiny of payments for those off-label uses of drugs and biologics that are not covered.
  - Further, the MolDx program, which makes coverage decisions for Medicare on molecular diagnostic tests, recently finalized a local coverage determination that identifies several uses of immunohistochemistry testing that are not reasonable and necessary for use as companion diagnostics in the selection of oncology drugs and biologics
SGR Fix: Other Provisions

• The Act also reverses CMS’ decision to eliminate global 10- and 90-day surgical packages (under which only same-day, related services would have been be bundled.)
• Title III of H.R. 2 funds CHIP for another two years
• Consistent with PAMA and other prior SGR legislation, H.R. 2 temporarily extends (until 2017 or 2018) the following programs: the geographic practice cost index (GPCI) floor; the therapy cap exceptions process; the ambulance add-on payment; the payment adjustment for low-volume hospitals; the Medicare dependent hospital program; the authority for Special Needs Plans (SNPs) in Medicare Advantage; funding for the National Quality Forum to develop quality measures; add-on payments for home health services provided in rural areas; and special programs that provide services to individuals with Type I diabetes, Native Americans, and families of children with disabilities

SGR Fix: Offsets

• Spending decreases (affecting primarily hospitals and post-acute care providers) and increases in premiums paid by high-income Medicare beneficiaries that are estimated to total $73 billion over 10 years
• Beginning in 2020, Sec. 401 limits Medigap plan coverage of beneficiary cost-sharing for newly eligible Medicare beneficiaries to amounts above the Part B deductible (currently $147/month)
Mis-Valued Services

- Medicare will look at codes that ‘cost too much per year’, e.g. over $10 million. Codes impacting you are
  - 96360
  - 96372
  - 96374
  - 96375
  - 96401
  - 96409
  - 96411

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 areas
- 2016 Medicare telehealth originating site fee is $25.10, compared to $24.83 in 2015
“Incident To”: Final Rule

- There is a provision that states that the supervising physician must supervise the ‘incident to’ 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

Biosimilars

- 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. The 6%, when WAC is used will be 6% of WAC

*WAC = Wholesale Acquisition Cost
Biosimilars 2016

- Billing and coding of similar products
  - Reference product will have its own code
  - Biosimilars will have another
  - Distinguishing biosimilars will be by modifier
    - Modifier –ZA will be used for ZARXIO? Waiting for guidance

Advance Care Planning
99497-99498

- 99497: "Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate"
- 99498: "Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (list separately in addition to code for primary procedure)"
- Was not paid by Medicare in 2015; want to pay for it in 2016
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
  – Use -25 with another visit
  – Must be face-to-face and must be ‘incident to’ a physician service

Advance Care Planning

• Recognize and provide 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

• Adopt RUC-recommended values
  – CPT code 99497 – approximately $80 (facility) and $86 (nonfacility))
  – CPT code 99498 – approximately $75 (facility and nonfacility))
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

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
“Collaborative Care” (Proposed 2016)

- CMS wants to pay for Primary Care Physicians coordinating care with specialists
- May include e-mail and telephone calls
- Asks for comments regarding this, was put off until next year

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
HOPPS Final Rule 2016

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
• Decrease of $133 million compared to CY 2015
Bundling of Services 2016

- **Comprehensive APCs**: Adopted in the CY 2014 outpatient PPS final rule but delayed until CY 2015 for implementation, Comprehensive APCs (C-APCs) pay for high cost device dependent services using a single payment for the hospital stay, but unlike the existing device-dependent APCs, these payments will include room and board as well as nursing costs.
  - There are currently 25 C-APCs, which mostly include procedures for the implantation of costly medical devices.
  - For CY 2016, CMS will add ten new C-APCs, including some surgical APCs and a new C-APC for comprehensive observation services that will include all primary procedures found on the observation claim.

Bundling of Services 2016

- 35 C-APCs total
  - 25 existing C-APCs organized into 14 clinical families
  - 10 new C-APCs finalized – 8 fit into clinical family structure and 2 do not (observation and ancillary OP services when patient expires)
- Comprehensive Observation Services
  - Modifying existing observation composite APC criteria: 8 hrs or more of observation services, no surgical procedure on ANY day, and
  - includes observation referral or any level ER visit
  - If claims contains a primary procedure paid by another C-APC, the payment for that C-APC trumps observation C-APC
- Ancillary OP Services when Patient Expires – replaces existing composite APC
- Will only require HCPCS modifier to collect data on adjunctive services associated with SRS procedure but billed on a different claim, not ALL C-APCs as proposed
Stereotactic Radiosurgery (SRS)

- CMS will require modifier -CP (adjunctive service related to a procedure assigned to a C-APC procedure, but reported on a different claim) for adjunctive services related to SRS services described by HCPCS codes 77371 and 77372 but reported on a separate claim. CMS expects the new modifier to be used with adjunctive services provided within 30 days prior to SRS treatment. Providers can expect more details on the use of this modifier and responses to commenters’ technical questions through regulatory guidance that CMS intends to release before January 1, 2016.

Reduction Due to Labs

- Rationale behind 2.0% decrease for packaged labs
- Inflation adjustment:
  - CMS noticed double-digit growth in CY 2014 due to new lab packaging policy; this occurred without a similar drop in the Clinical Lab Fee Schedule spending
  - $1 billion in overspending for non-packaged lab tests – essentially paying twice: once separately under the fee schedule and once by inflated APC rates
  - No real change in lab billing patterns or case mix was observed, purely a function of payment policy change
- $1 billion represents 2.0% of total spending in CY 2014 ($50 billion)
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...

Biosimilars

• Under the OPPS, CMS packages drugs and biologicals into the OPPS payment below a specified threshold cost per day. Above that amount, CMS pays separately at ASP plus six percent.
• Accordingly, CMS is adopting a policy to pay biosimilars based on ASP, using six percent of the reference biological product as the add-on percentage and to allow drug pass-through payment for biosimilars using the same amount.
• They finalized the proposal that coding and modifiers for biosimilar biological products will be based on the policy established under the CY 2016 Medicare Physician Fee Schedule final rule.
Blood Products

• For CY 2016, the Healthcare Common Procedure Coding System (HCPCS) Workgroup created three new codes for pathogen-reduced blood products.
  – P9070, Plasma, pooled multiple donor, pathogen reduced, frozen, each unit
  – P9071, Plasma (single donor), pathogen reduced, frozen, each unit
  – P9072, Platelets, pheresis pathogen reduced
• CMS has created interim payment amounts for these three codes via crosswalks to existing blood products while claims data accumulates.

Changes To The 2-Midnight Rule

• CMS finalized its proposed rule regarding the 2-midnight rule, including moving responsibility for rule enforcement and education from Recovery Auditors to Quality Improvement Organizations (QIO). This latter change occurred October 1, 2015.

• For stays in which the physician expects the patient will need less than two midnights of hospital care, inpatient admission may be allowed on a case-by-case basis determined by the judgment of the admitting physician. The documentation must support the admission and will be subject to review by a QIO. CMS expects inpatient admission for minor surgical procedures to be unlikely and will prioritize those cases for medical review. For hospital stays expected to last two midnights or longer, CMS policy remains unchanged.
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. CMS will monitor the number of these types of admissions and plans to prioritize these types of cases for medical review.
- No change for stays over the two-midnight benchmark:
  - For hospital stays that are expected to be two midnights or longer, our policy is unchanged; 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. This includes stays in which the physician’s expectation is supported, but the length of the actual stay was less than two midnights due to unforeseen circumstances such as unexpected patient death, transfer, clinical improvement or departure against medical advice.

Outlier Threshold

- For CY 2016, CMS will make outlier payments when the cost of furnishing a service by a hospital:
  - 1. Exceeds 1.75 times the APC payment amount; AND
  - 2. Exceeds the APC payment rate by at least $3,250.
- CY 2016 outlier criteria are similar to the current criteria for 2015, except that the fixed-dollar threshold for 2015 is $475 higher than it is in 2015 ($2,775). Consistent with current policy, the outlier payment for a particular service would then equal 50% of the amount by which the cost to the hospital exceeds 1.75 times the APC payment rate.
## Drug Administration By Setting

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

Source—National Rates for Appendix B of Both Rules

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## Physician Compare, PQRS and Other Quality Programs

**MEDICARE PHYSICIAN FEE SCHEDULE 2016**
Physician Compare Website

- CMS required to create the Physician Compare website
  - Section 10331 of the Patient Protection and Affordable Care Act

- Purpose
  - Allow consumers to make more informed healthcare decisions by providing useful information
  - Incentivize physicians to optimize performance
  - Eventually, to reward patients for quality physician choices

2016 Physician Fee Schedule Final Rule

- We are continuing existing policies for Physician Compare

- The following 2016 measures are available for public reporting:
  - All PQRS measures for individual EPs and group practices
  - All CAHPS for PQRS measures for groups of 2 or more EPs who meet the specified sample size requirements and collect data via a CMS-specified certified CAHPS vendor
  - All ACO measures, including CAHPS for ACOs
2016 Physician Fee Schedule Final Rule

We are finalizing the following proposals:
- Include Certifying Board, and specifically add American Board of Optometry (ABO) Board Certification and American Osteopathic Association (AOA) Board Certification
- Include an indicator on profile pages for individual EPs who satisfactorily report the new PQRS Cardiovascular Prevention measures group in support of Million Hearts

As required by MACRA, we are finalizing the following proposals:
- All individual and group-level QCDR measures are available for public reporting
- Adding utilization data to the public downloadable database

MLN Connects

2016 Physician Fee Schedule Final Rule

We are finalizing to publicly report an item-level benchmark for group practice and individual EP PQRS measures using the Achievable Benchmark of Care (ABC) methodology
- We will stratify the benchmark by reporting mechanism to ensure comparability and reduce the interpretation burden for consumers
- We will use this methodology to systematically assign stars for the Physician Compare 5 star rating

MLN Connects
2016 Physician Fee Schedule Final Rule

We are finalizing to add VM information to the downloadable database:

- Quality tiers for cost and quality noting if the group practice or EP is high, low, or neutral on cost and quality per the VM
- A notation of the payment adjustment received based on the cost and quality tiers
- An indication if the individual EP or group practice was eligible to but did not report quality measures to CMS

We are not finalizing to include a visual indicator on profile pages for group practices and individual EPs who receive an upward adjustment for the VM.

PQRS Overview

- CY2018 payment adjustments, based on PY2016 reporting: -2.0% MPFS

- Changes to PQRS
  - Definition of eligible professional (EP) for purposes of participating in PQRS
  - Changes to the requirements for the qualified clinical data registry (QCDR) and qualified registries
  - QCDRs and qualified registries have more time in which to self-nominate
  - Revised auditing requirements for entities submitting PQRS quality measures data (qualified registries, QCDR, direct EHR, or direct Data Submission Vendor [DSV] product)
Changes to PQRS Reporting Criteria

- Changes to group practice reporting option (GPRO):
  - New QCDR reporting option
  - Required CAHPS reporting for groups of 100 or more EPs regardless of reporting mechanism

- Changes for QCDR Vendors
  - Support tax identification number (TIN)-level reporting
  - New process for self-nomination and attestation
  - Revised auditing requirements

- Changes Registry Vendors
  - New process for self-nomination and attestation
  - Revised auditing requirements

- EHR
  - Revised auditing requirements

### 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

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>Measure Type</th>
<th>Reporting Mechanism</th>
<th>Satisfactory Reporting/Satisfactory Participation Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-month (Jan 1–Dec 31, 2016)</td>
<td>Individual Measures</td>
<td>Claims</td>
<td>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 FFIs 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 FFIs patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted.</td>
</tr>
<tr>
<td>12-month (Jan 1–Dec 31, 2016)</td>
<td>Individual Measures</td>
<td>Qualified Registry</td>
<td>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 FFIs 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 FFIs patients seen during the reporting period to which the measure applies. Measures with a 0% performance rate would not be counted.</td>
</tr>
</tbody>
</table>
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.)

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>Measure Type</th>
<th>Reporting Mechanism</th>
<th>Satisfactory Reporting/Satisfactory Participation Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-month (Jan 1–Dec 31, 2016)</td>
<td>Individual Measures</td>
<td>Direct EHR Product or EHR Data Submission Vendor Product</td>
<td>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.</td>
</tr>
<tr>
<td>12-month (Jan 1–Dec 31, 2016)</td>
<td>Measures Groups</td>
<td>Qualified Registry</td>
<td>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.</td>
</tr>
<tr>
<td>12-month (Jan 1–Dec 31, 2016)</td>
<td>Individual PQRS measures and/or non-PQRS measures reportable via a QCDR</td>
<td>Qualified Clinical Data Registry (QCDR)</td>
<td>Report at least 9 measures available for reporting under a QCDR covering at least 3 of the NQS domains. AND report on at least 2 outcome measures, OR, if 2 outcomes measures are not available, report on at least 1 outcome measure and at least 1 of the following types of measures – resource use, patient experience of care, efficiency/appropriate use, or patient safety.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>Size</th>
<th>Measures Type</th>
<th>Reporting Mechanism</th>
<th>Satisfactory Reporting Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-month (Jan 1–Dec 31, 2016)</td>
<td>25-99 EPs</td>
<td>Individual GPRO Measures in the GPRO Web Interface</td>
<td>GPRO Web Interface</td>
<td>Report on all measures included in the web interface, AND populate data fields for the first 246 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 246, then the group 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 246 patients on which a group practice may report, particularly those group practices on the smaller end of the range of 25-49 EPs. If the group practice is assigned less than 246 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.</td>
</tr>
<tr>
<td>12-month (Jan 1–Dec 31, 2016)</td>
<td>100+ EPs (CMS PQRs for GPRO software)</td>
<td>Individual GPRO Measures in the GPRO Web Interface and CMS Certified Survey Vendor</td>
<td>GPRO Web Interface + CMS Certified Survey Vendor</td>
<td>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 website interface, AND populate data fields for the first 246 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 246, 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.</td>
</tr>
<tr>
<td>12-month (Jan 1–Dec 31, 2016)</td>
<td>2-99 EPs</td>
<td>Individual Measure</td>
<td>Qualified Registry</td>
<td>Report at least 9 measures covering at least 3 of the NQS domains. If 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 96 percent of the group’s Medicare Part B FFS patients seen during the reporting period for which the measure applies. Measures with a 0 percent performance rate would not be counted.</td>
</tr>
</tbody>
</table>
### 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.)

<table>
<thead>
<tr>
<th>Reporting Period</th>
<th>Group Practice Size</th>
<th>Measure Type</th>
<th>Reporting Mechanism</th>
<th>Satisfactory Reporting Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-month (Jan 1–Dec 31, 2016)</td>
<td>2–59 EPs</td>
<td>Individual PQRS measures and non-PQRS measures reportable via a QCDR</td>
<td>Qualified Clinical Data Registry (QCDR)</td>
<td>Report at least 9 measures available for reporting under a QCDR covering at least 3 of the NGS 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, efficiently/appropriate use, or patient safety.</td>
</tr>
<tr>
<td></td>
<td>2–99 EPs that elect CAF/FS for PQRS; 100+ EPs that must report CAF/FS for PQRS</td>
<td>Individual PQRS measures and non-PQRS measures reportable via a QCDR + CAHPS for PQRS</td>
<td>QCDR + CMS-Certified Survey Vendor</td>
<td>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 8 additional measures covering at least 2 NGS 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.</td>
</tr>
</tbody>
</table>

**Acronyms**

- CAHPS: Consumer Assessment of Healthcare Providers and Systems
- QCDR: Qualified Clinical Data Registry
- NGS: National Greenbook System
- CMS: Centers for Medicare & Medicaid Services
### Final Policies for the 2018 VM

**POQ5 Reporters – 3 types – Category 1**
1. Group Reporters: Report as a group via a POQ5 GPRC and meet the criteria to avoid the 2018 POQ5 payment adjustment.
2. Individual Reporters: Report POQ5 measures as individuals and meet the criteria to avoid the 2018 POQ5 payment adjustment.
3. A group’s POQ5 measures as individuals

**Non-POQ5 Reporters – Category 2**
1. Groups: Do not avoid the 2018 POQ5 payment adjustment as a group.
2. Solo practitioners: Do not avoid the 2018 POQ5 payment adjustment as individuals.

#### Acronyms
- MLN Connects

### VM Policies for 2016, 2017, & 2018

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Performance Year</strong></td>
<td>2014</td>
<td>2015</td>
<td>2016</td>
</tr>
<tr>
<td>Group Size</td>
<td>Physicians in groups of 10+ EPs</td>
<td>Physicians in groups of 2+ EPs and physician solo practitioners</td>
<td>Physicians, PA, NPs, CNSs, CRNAs, and OCMs in groups of 2+ EPs and those who are solo practitioners</td>
</tr>
<tr>
<td>Quality-Tiering</td>
<td>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.</td>
<td>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.</td>
<td>Mandatory: Groups consisting of non-physician EPs and PA, NPs, CNS, CRNAs, and OCMs 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.</td>
</tr>
<tr>
<td>Peer Group for Categorizing Quality and Cost Composites</td>
<td>Groups with 10+ EPs</td>
<td>Groups with 2+ EPs and solo practitioners</td>
<td>Groups with 2+ EPs and solo practitioners</td>
</tr>
<tr>
<td>Available Quality Reporting Mechanisms</td>
<td>GPRO Web Interface, Qualified PQR5 Registry, EHR, or 50% of EPs report under the PQR5 as individuals</td>
<td>Same as 2016</td>
<td>GPRO Web Interface, Qualified PQR5 Registry, EHR, or OCR, or 50% of EPs report under the PQR5 as individuals</td>
</tr>
</tbody>
</table>
### VM Policies for 2016, 2017, & 2018 (cont.)

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Outcome Measures:</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>- All-Cause Hospital</td>
<td></td>
<td>Same as 2016, except</td>
<td>Same as 2017</td>
</tr>
<tr>
<td>Readmissions</td>
<td></td>
<td>the all-cause hospital</td>
<td></td>
</tr>
<tr>
<td>- Composite of Acute</td>
<td></td>
<td>readmissions measure</td>
<td></td>
</tr>
<tr>
<td>Prevention Quality</td>
<td></td>
<td>will not be applied</td>
<td></td>
</tr>
<tr>
<td>Indicators:</td>
<td></td>
<td>to groups with</td>
<td></td>
</tr>
<tr>
<td>(bacterial pneumonia,</td>
<td></td>
<td>2-9 EPs and solo</td>
<td></td>
</tr>
<tr>
<td>urinary tract infection,</td>
<td></td>
<td>practitioners</td>
<td></td>
</tr>
<tr>
<td>dehydration)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Composite of Chronic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention Quality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicators:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(chronic obstructive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>pulmonary disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(COPD), heart failure,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>diabetes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Experience of</td>
<td>CAHPS for PQRS:</td>
<td>CAHPS for PQRS:</td>
<td>Groups may elect to</td>
</tr>
<tr>
<td>Care Measures</td>
<td>Optional for groups</td>
<td>Optional for groups</td>
<td>include their 2016</td>
</tr>
<tr>
<td></td>
<td>with 25+ EPs; Required</td>
<td>with 25+ EPs; Required</td>
<td>CAHPS results in the</td>
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<td>for groups with 100+ EPs</td>
<td>for all groups with</td>
<td>calculation of the 2016</td>
</tr>
<tr>
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<td>reporting via Web</td>
<td>100+ EPs.</td>
<td>VM.</td>
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<tr>
<td></td>
<td>Interface.</td>
<td>Groups may elect to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Groups may elect to</td>
<td>include their 2015</td>
<td></td>
</tr>
<tr>
<td></td>
<td>include their 2014</td>
<td>CAHPS results in the</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CAHPS results in the</td>
<td>calculation of the 2017 VM.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>calculation of the 2016 VM.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Acronyms

- VM: Value Modifier
- PQRS: Program for Medicare Improvement and= Assurance Contract Participants
- CAHPS: Consumer Assessment of Healthcare Providers and Systems
- ACO: Accountable Care Organization

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

<table>
<thead>
<tr>
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<tr>
<td>Cost Measures</td>
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<td>Same as 2016</td>
<td>Same as 2016</td>
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<tr>
<td>- Total per capita costs</td>
<td>Total per capita costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>measure for beneficiaries with four chronic conditions: COPD, Heart Failure, Coronary Artery Disease, Diabetes</td>
<td>for both cost and quality measures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Total per capita costs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>for beneficiaries with</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>four chronic conditions:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COPD, Heart Failure,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coronary Artery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disease, Diabetes,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Spending Per</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Beneficiary measure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benchmark</td>
<td></td>
<td>No differentiation by</td>
<td>No differentiation by</td>
</tr>
<tr>
<td></td>
<td></td>
<td>group size (&quot;compared to everyone&quot;) for both</td>
<td>group size (&quot;compared to everyone&quot;) for both</td>
</tr>
<tr>
<td></td>
<td></td>
<td>cost and quality measures</td>
<td>cost and quality measures</td>
</tr>
<tr>
<td>Maximum Payment at Risk</td>
<td>-3.0%</td>
<td>-2.0% (Groups of physicians with</td>
<td>-2.0% (Groups of physicians with</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2-9 EPs and solo</td>
<td>2-9 EPs and physician solo</td>
</tr>
<tr>
<td></td>
<td></td>
<td>practitioners)</td>
<td>practitioners)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-4.0% (Groups of physicians</td>
<td>-4.0% (Groups of physicians</td>
</tr>
<tr>
<td></td>
<td></td>
<td>with 10+ EPs)</td>
<td>with 10+ EPs)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>-2.5% (Groups with non-</td>
<td>-2.5% (Groups with non-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>physician EPs and PA, RN,</td>
<td>physician EPs and PA, RN,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CRNA, and CRNAs who are solo</td>
<td>CRNA, and CRNAs who are solo</td>
</tr>
<tr>
<td></td>
<td></td>
<td>practitioners)</td>
<td>practitioners)</td>
</tr>
</tbody>
</table>

### Acronyms

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

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Application of the VM to Participants of the Shared Savings Program, Pioneer ACO Model, and the CPC Initiative</td>
<td>Not Applicable</td>
<td>2016: Not Applicable</td>
<td>Shared Savings Program: VM based on the ACO’s quality and CAHPS data and average cost; Pioneer ACO Model and the CPC Initiative: average quality/average cost.</td>
</tr>
<tr>
<td>VM Review Process: Timeline</td>
<td>Deadline of February 28, 2015 for a group to request correction of a perceived error made by CMS in the 2015 VM payment adjustment.</td>
<td>Establish a 60 day period that would start after the release of the QRIs 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.</td>
<td>The informal review submission period will occur during the 60 days following the release of the QRIs for the 2016 VM and subsequent years.</td>
</tr>
<tr>
<td>VM Informal Review Process: If CMS made an error</td>
<td>Classify a TIN as “average quality” in the event we determine that we have made an error in the calculation of quality composite.</td>
<td>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.</td>
<td>Same as 2016, 2017 and. Reclassify a TIN as Category 1 when CMS determines 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 GQDR for the relevant CY PQRS payment adjustment.</td>
</tr>
</tbody>
</table>

### Acronyms

- MLN Connects

### MORE CODING
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 recently announced flexibilities.
• REMEMBER this only applies to Medicare claims

Medicare ‘Flexibility’ Period

• But, read the fine print in the clarification to the guidance:
  – “In certain circumstances, a claim may be denied because the ICD-10 code is not consistent with an applicable policy, such as Local Coverage Determinations or National Coverage Determinations. (See Question 7 for more information about this). This reflects the fact that current automated claims processing edits are not being modified as a result of the guidance.”
  – So, if a policy requires specific codes, you had better have them on there
### Worst Plans ICD-10-CM

<table>
<thead>
<tr>
<th>Name</th>
<th>ICD 9 Paid Claims</th>
<th>ICD 10 Paid Claims</th>
<th>ICD 9 DTF</th>
<th>ICD 10 DTF</th>
<th>ICD 9 Denial %</th>
<th>ICD 10 Denial %</th>
</tr>
</thead>
<tbody>
<tr>
<td>BASIC HEALTH</td>
<td>235</td>
<td>27</td>
<td>35</td>
<td>30</td>
<td>23</td>
<td>1.32%</td>
</tr>
<tr>
<td>OREGON MEDICAID</td>
<td>137</td>
<td>6</td>
<td>12</td>
<td>19</td>
<td>27</td>
<td>5.12%</td>
</tr>
<tr>
<td>SUPERIOR HEALTH PLAN - TEXAS</td>
<td>26</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>14</td>
<td>9.03%</td>
</tr>
<tr>
<td>MOLINA HEALTHCARE OF TEXAS</td>
<td>41</td>
<td>5</td>
<td>7</td>
<td>3</td>
<td>42</td>
<td>39.36%</td>
</tr>
<tr>
<td>LOUISIANA BLUE SHIELD</td>
<td>273</td>
<td>26</td>
<td>12</td>
<td>7</td>
<td>30</td>
<td>33.77%</td>
</tr>
<tr>
<td>MDWISE SELECT HEALTH NETWORK</td>
<td>233</td>
<td>13</td>
<td>8</td>
<td>5</td>
<td>45</td>
<td>14.77%</td>
</tr>
<tr>
<td>IOWA MEDICAID</td>
<td>520</td>
<td>89</td>
<td>16</td>
<td>6</td>
<td>43</td>
<td>28.80%</td>
</tr>
<tr>
<td>MERCY CARE PLAN OF ARIZONA</td>
<td>1,309</td>
<td>277</td>
<td>5</td>
<td>4</td>
<td>51</td>
<td>22</td>
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<tr>
<td>WASHINGTON DC MEDICARE</td>
<td>118</td>
<td>8</td>
<td>20</td>
<td>8</td>
<td>34</td>
<td>17.61%</td>
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<td>WYOMING MEDICAID</td>
<td>338</td>
<td>20</td>
<td>19</td>
<td>6</td>
<td>31</td>
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<td>BLUECHOICE HEALTH PLAN OF SOUT</td>
<td>646</td>
<td>171</td>
<td>19</td>
<td>2</td>
<td>20</td>
<td>47.73%</td>
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<td>NORTH CAROLINA MEDICAID</td>
<td>2,341</td>
<td>274</td>
<td>22</td>
<td>9</td>
<td>43</td>
<td>30.10%</td>
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<tr>
<td>TEXAS MEDICAID</td>
<td>2,269</td>
<td>299</td>
<td>13</td>
<td>10</td>
<td>41</td>
<td>24.31%</td>
</tr>
<tr>
<td>CAROLINA BENEFIT ADMINISTRATOR</td>
<td>5,063</td>
<td>957</td>
<td>7</td>
<td>3</td>
<td>18</td>
<td>31.00%</td>
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<tr>
<td>VIRGINIA MEDICAID</td>
<td>145</td>
<td>32</td>
<td>12</td>
<td>8</td>
<td>21</td>
<td>24.82%</td>
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<tr>
<td>GEORGIA MEDICAID</td>
<td>1,049</td>
<td>62</td>
<td>26</td>
<td>8</td>
<td>34</td>
<td>36.28%</td>
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<tr>
<td>PRESBYTERIAN - NEW MEXICO</td>
<td>41</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>65</td>
<td>11.72%</td>
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<td>FLORIDA HEALTH OPTIONS HMO</td>
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<td>24</td>
<td>18</td>
<td>5</td>
<td>20</td>
<td>31.65%</td>
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<tr>
<td>NEW YORK MEDICAID - PHASE II</td>
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<td>101</td>
<td>18</td>
<td>11</td>
<td>41</td>
<td>25.76%</td>
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<tr>
<td>BROWN AND TOLAND MEDICAL GRP</td>
<td>639</td>
<td>100</td>
<td>9</td>
<td>7</td>
<td>40</td>
<td>17.20%</td>
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<td>VISITING NURSE SERVICE OF NEW</td>
<td>89</td>
<td>11</td>
<td>9</td>
<td>4</td>
<td>24</td>
<td>20.17%</td>
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<tr>
<td>MOLINA HEALTHCARE OF NEW MEX</td>
<td>310</td>
<td>36</td>
<td>6</td>
<td>6</td>
<td>24</td>
<td>17.57%</td>
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### Worst Drugs Under ICD-10-CM

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>ICD 9 Paid Claims</th>
<th>ICD 10 Paid Claims</th>
<th>ICD 9 DTF</th>
<th>ICD 10 DTF</th>
<th>ICD 9 Denial %</th>
<th>ICD 10 Denial %</th>
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<td>Zarko</td>
<td>40</td>
<td>60</td>
<td>21</td>
<td>7</td>
<td>64</td>
<td>23</td>
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<tr>
<td>Cyramza</td>
<td>1,581</td>
<td>138</td>
<td>17</td>
<td>7</td>
<td>57</td>
<td>32</td>
</tr>
<tr>
<td>Provenge</td>
<td>355</td>
<td>40</td>
<td>19</td>
<td>8</td>
<td>49</td>
<td>29</td>
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<tr>
<td>Optvue</td>
<td>2,514</td>
<td>605</td>
<td>14</td>
<td>7</td>
<td>54</td>
<td>31</td>
</tr>
<tr>
<td>Keytruda</td>
<td>443</td>
<td>26</td>
<td>12</td>
<td>7</td>
<td>58</td>
<td>30</td>
</tr>
<tr>
<td>Adoctris</td>
<td>415</td>
<td>42</td>
<td>12</td>
<td>5</td>
<td>33</td>
<td>23</td>
</tr>
<tr>
<td>Precit</td>
<td>108,925</td>
<td>10,534</td>
<td>10</td>
<td>6</td>
<td>29</td>
<td>24</td>
</tr>
<tr>
<td>Inempra</td>
<td>542</td>
<td>46</td>
<td>10</td>
<td>7</td>
<td>32</td>
<td>26</td>
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<tr>
<td>Actemra</td>
<td>110</td>
<td>11</td>
<td>5</td>
<td>7</td>
<td>24</td>
<td>25</td>
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<tr>
<td>Aranesp</td>
<td>33,449</td>
<td>3,536</td>
<td>10</td>
<td>7</td>
<td>29</td>
<td>25</td>
</tr>
</tbody>
</table>
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

Billing for Chronic Care Management (2015)

- Use of CPT code 99490 for a 30-day period for a minimum of 20 minutes
  - 99490: Chronic care management services furnished to patients with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; 20 minutes or more; per 30 days
- Can be billed by specialists as specifically stated by CMS as long as requirements are met
- Must fulfill ‘incident to’ requirements, except direct supervision for off-hours care
More Chronic Care Management

- Payment requirements include:
  - It will pay approximately $40 per 20 minutes per month
  - There is cost-sharing
  - You must use an EMR
  - Only one physician may bill per month
CPT Update

• 2016 CPT Code Changes
  – 140 New Codes
  – 132 Revised Codes
  – 91 Deleted Codes

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
**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 $8.14

- **99416**: each additional 30 minutes (List separately in addition to code for prolonged service) (Use 99416 in conjunction with 99415) — Medicare $.55

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**Instructions on reporting prolonged services**

- Codes 99415, 99416 are used to report the total duration of face-to-face time spent by clinical staff on a given date providing prolonged service in the office or other outpatient setting, even if the time spent by the clinical staff on that date is not continuous.

- **Time spent performing separately reported services other than the E/M service is not counted toward the prolonged services time.**

- Code 99415 is used to report the first hour of prolonged clinical staff service on a given date. Code 99415 should be used only once per date, even if the time spent by the clinical staff is not continuous on that date.
99415-99416

• Instructions on reporting prolonged services
  – Prolonged service 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.

99415-99416

• Instructions on reporting prolonged services
  – Code 99416 is used to report each additional 30 minutes of prolonged clinical staff service beyond the first hour.
  – Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.
  – Codes 99415, 99416 may be reported for no more than two simultaneous patients
  – Facilities may not report 99415, 99416.
Immunizations

Beginning 2016, CPT abbreviations are based on the Advisory Committee on Immunization Practices (ACIP)

• 45 immunization codes were revised to reflect the ACIP’s abbreviations
  – Example 2015 description of 90632, Hepatitis A vaccine, adult dosage, for intramuscular use
  – Example 2016 description for 90632, Hepatitis A vaccine (HepA), adult dosage, for intramuscular use

• Deleted 17 codes
  – Obsolete vaccines – no longer available in the US

• New Immunization Codes
  – 90625, Used to report adult oral dosage of live cholera vaccine
  – 90697, Used to report the hexavalent vaccine including diphtheria; tetanus;acellular pertussis (DTaP); poliomyelitis (IPV); Haemophilus influenza type b (Hib); and hepatitis B (HepB)
Immunizations

- 90620 and 90621--Used to report serogroup B meningococcal vaccines
- As appropriate, the AMA will assign updated/expedited codes for vaccines throughout the year
  - List will be updated every 3 months as needed

Chronic Care Management (2015)

- Billing requirements
  - 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
Transitional Care Management

- Billing date is no longer the last day of the month—it is the date of the face-to-face visit

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%20Coding.pdf
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
- G9500 Radiation exposure indices, exposure time or number of fluorographic images in final report for procedures using fluoroscopy documented
- G9501 Radiation exposure indices, exposure time or number of fluorographic images not documented in final report for procedure using fluoroscopy, reason not given
- J0202 Injection, alemtuzumab, 1 mg
- J0596 Injection, cl esterase inhibitor (recombinant), ruconest, 10 units
- J0695 Injection, ceftolozane 50 mg and tazobactam 25 mg
- J0714 Injection, ofloxazidime and azibactam, 0.5 g/0.125 g
- J0875 Injection, dalbavancin, 5 mg
- 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 immunoglobulin
- J1833 Injection, leucovorin, 1 mg
- J2047 Injection, ibravaxin, 10 mg
- J2502 Injection, pasineotide 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

HCPCS Added

- J7121 5% dextrose in lactated ringers infusion, up to 1000 cc
- J7188 Injection, factor viiii (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
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

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
assistPoint® Summary

• assistPoint is the solution everyone has been waiting for
• It is free or inexpensive for all facilities
• Major manufacturers are coming on board in November
• The comprehensive dashboard helps you compile the financial impact of these programs and supports A/R tracking

To See A Video About aP

• Go to https://www.youtube.com/watch?v=PbgH5phv3Ac