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2015 Quarterly Newsletter – Third Quarter

ICD-10: ARE YOU REALLY READY THIS TIME?

ICD-10, the next generation of coding, is set to be implemented effective October 1st, 2015. Originally scheduled for October 2014, CMS pushed the deadline back one year to allow entities more time to adjust to the pending changes. With no further delays expected, all providers, insurance companies, etc. should expect to be ready when the October deadline approaches. All healthcare professionals (doctors and hospitals) and covered entities (insurance carriers such as Medicare, Medicaid, and commercial plans) must adapt to these changes or claims will not be processed. The only exception to the mandate is workers compensation and no-fault automobile carriers, which are not considered "covered entities" by CMS. While these insurance carriers may continue to use ICD-9 after October 2015, they are greatly being encouraged to adopt the new coding system as well. ICD-10, used in a majority of other countries, greatly expands on the current ICD-9 code set by introducing tens of thousands of new codes to report on healthcare claims.

It is important to understand that these broad changes have many benefits to the American healthcare community as a whole, whether from the provider, insurance, or informatics perspectives. With the increased specificity in diagnosis codes, it will provide the following benefits:

- Ability to report conditions relevant to current medical practice standards
- Reduce modifier use due to the specificity of the diagnosis
- Ease in clinical decision making
- Easier public health surveillance and research
- Decrease the need to submit supporting documentation with claims
- More efficient claims processing
- Diminish the likelihood of fraud and waste

While ICD-10 changes seem like too much to handle, especially for smaller practices, there changes are not exceedingly overwhelming. Even with the dramatic increase in the number of diagnosis codes possible, it is not impossible to learn. Like ICD-9, the new codes follow patterns that are simple to understand with practice.

While these changes seem daunting to the medical community, CMS is anticipating that these changes are realistic for both healthcare providers and insurances. Resources are being utilized to make sure that all covered entities are compliant to accept and process ICD-10 claims by the deadline. Providers of all types must also make sure that they are ready for these changes. Practices should be communicating to the following:

- **Software Vendors**: Can the EHR or practice management used in the practice be able to accommodate ICD-10 codes by the October deadline? Will your software be able to simultaneously work with ICD-9 and ICD-10 codes?
- **Clearinghouses**: When claims are submitted from your office, will your clearinghouse be able to transmit the data successfully to the insurances you participate with? Is the clearinghouse engaged in testing to make sure that they are compliant with the October mandate?
- **Billing & Coding Staff**: Are staff members taking adequate steps to prepare for changes in their workflow to accommodate for the new changes in coding? Are superbills modified so charges can be added with the current diagnosis codes? Is there software or training guides available for staff to learn this information in an adequate amount of time?

ICD-10 structure has some similarities with ICD-9 (such as the decimal after the third digit), breaking down sections based on the type of condition, and the availability of unspecified codes. A very important point to make with the new codes is that it will not place stricter documentation burdens on providers. Coders will be able to interpret ICD-10 diagnosis codes with ease if a provider takes adequate documentation at the time of service, along with using current coding manuals or software. It is a common misconception that dramatically increasing the number of possible diagnosis codes will make it difficult to code claims. Documentation, as with ICD-9, should always be made to the highest degree of specificity based on the information available. CMS has also published GEM (General Equivalent Mapping) to guide coders with ICD-9 to ICD-10 similarities, which will be maintained for three years after October 2015. However, while these mappings act as a guide for conversion, they should not be mistaken for direct correlations between the code sets, or as a substitute from learning ICD-10. Choosing the most appropriate diagnosis code can only come from the documentation available. Medical policies from commercial insurance carriers and Medicare have already been updated to reflect ICD-10 codes. It is fair to say that there are going to be growing pains associated with the new system, but the benefits certainly outweigh the drawbacks, since it is no longer viable to maintain a code set that has been used for more than three decades and cannot be supported with the changes in recent medicine.

MODIFIER - X [EPSU)

Modifier -59 is a staple in everyday coding for a wide variety of providers. This value is used in everyday coding to indicate to insurance companies that payment for one procedure should not be included in another because the services are not related, commonly referred to as a "distinct procedural service". Modifier -59 is unfortunately frequently abused, where providers are using the value to intentionally override NCCI edits established by CMS to reduce overpayment of covered services to describe a separate encounter, site or service. As a way to curb the issues with modifier -59, CMS introduced four new modifiers in August 2014 that may be used as of January 2015. Originally, modifier -59 was no longer supposed to be valid after January 2015, but CMS is allowing providers to use either modifier until a final decision about when –X [EPSU] modifiers will be mandated. For a provider to describe a service that should be reimbursed separately from other procedure codes to a patient, the following modifiers may be used:

- **59:** Distinct procedural service
- **XE**: Separate Encounter (*a service that is distinct because it occurred during a separate encounter*)
- **XP**: Separate Practitioner (*a service that is distinct because it was performed by a different practitioner*)
- **XS**: Separate Structure (*a service that is distinct because it was performed on a separate organ/ structure*)
- **XU**: Unusual Non-Overlapping Service (*the use of a service that is distinct because it does not overlap usual components of the main service*)

Note that a provider may only report one of these modifiers on a claim if the documentation supports the use of the modifier. Adding multiple-X [EPSU] modifiers or using one to the new modifier with modifier -59 will cause a claim to be rejected. In addition, once the new modifiers are implemented, there will be limitations on what particular modifier may be allowed to be used on a particular CPT/ HCPCS code, which should be updated in the near future with phasing out the use of modifier -59.

Fingerprinting Requirements for DME Suppliers

Starting in August 2014, CMS implemented a new requirement for providers who are new DME providers. In addition to submitting a CMS-855S with supporting documentation, each individual provider **who has a 5% or greater stake of ownership as indicated in the CMS -855S will have to be fingerprinted**. If each owner does not submit fingerprints, either as part of the initial enrollment request or at the request of a Medicare carrier within 30 days, it will delay the enrollment process. Providers who are currently enrolled as DME suppliers do not have to submit fingerprints at this time. Like revalidation, this information will be requested from current providers in phases that will be spread out over a period of a few years. Unless re-enrolling as a supplier of if the Medicare contractor requests fingerprints, there is no need to submit them (this does not affect participation in Medicare part B). This security measure was enacted to ensure that providers who are enrolled in the DMEPOS program do not have any adverse legal actions against them that would bar an individual from becoming a Medicare provider. Providers do not have to take any action at this time unless they receive correspondence from CMS, which is only directed to a limited scope of providers at this time.

UPDATE: DME provider enrollment application fee for CY 2015 is $553, up from $542 in 2014.

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PQRS PARTICIPATION

The physician quality reporting system (PQRS) is a mandate where rendering providers report on various components of patient care. These measures were initially introduced with CMS offering an incentive for eligible providers to report measures to patients enrolled in Medicare part B, similar to EHR and eRx. Starting in 2015, providers who were eligible to participate since 2013 but have not done so will be subject to a 1.5% reduction in their Medicare payments. If an eligible provider does not report for 2014 or will not for 2015, it will be a 2% reduction in Medicare payments for 2016 and 2017, respectively. Note that these changes will only affect individual providers. If there is more than one practitioner in your practice, the penalty will only apply to rendering providers who are not successful in reporting PQRS measures, not all providers billing under a particular NPI & EIN. If a provider is subject to a penalty due to non-compliance associated with PQRS reporting measures, covered Medicare charges will be noted with the following codes on the EOB from your local Medicare carrier:

CARC CO-237 (*Legislated/Regulatory Penalty*)
RARC N699 (*Payment adjusted based on the Physician Quality Reporting System (PQRS) Incentive Program*)

In order to avoid the payment adjustment, providers need to review the current PQRS measures that are issued by CMS (the list must be reviewed annually, because certain measures can be retired or have their definitions changed from year to year). From the six NQS domains that are published by CMS, providers must report a minimum of three measures from at least three of the six domains to avoid a reduction in Medicare payment. In addition to reporting at least nine unique measures for Medicare beneficiaries, at least one of the reported measures must be considered a "cost cutting measure", which must be reported on each face to face encounter. Each PQRS code has different requirements where providers must report a particular CPT code (such as an office visit) in order for the measure to be counted (there may also be a diagnosis limitation dependent on the code reported). Be sure to review the documentation published by CMS which outlines the definitions, qualifications that a provider must meet in order to bill the PQRS code, and different scenarios where an alternate CPT-II code has to be reported if a patient does not fully meet the reporting criteria outlined by CMS for the specific PQRS measure. Take precautions to make sure this information can be reported through your EHR and clearinghouse when submitting claims to Medicare- part B; carriers will not allow providers to correct claims if a PQRS measure was not reported due to an error. In addition, if a claim reported with PQRS measures was denied (for coding, invalid beneficiary information, missing data, etc.), be sure to include the appropriate PQRS codes on the resubmitted claim or they will not be counted. To verify if the data was successfully received, PQRS codes outlined on the Medicare EOB should have the following codes:

CARC CO-246 (*This non-payable code is for required reporting only*)
RARC N620 (*This procedure code is for quality reporting/ informational purposes only.*)

Even though each PQRS measure has its own CPT-II code that should be reported on Medicare claims, some measures have to be reported through alternative measures in order for providers to successfully attest to PQRS reporting for the calendar year- based on the codes chosen, codes can be counted towards a practitioner's minimum requirements through:

- *Medicare part B claims*
- *Certified PQRS registry*
- *Direct EHR from CEHRT*
- *Data Submission from the CEHRT*
- *Qualified clinical data registry*

SGR Repeal

On Thursday afternoon, April 16, President Barack Obama signed the Medicare Access and CHIP Reauthorization Act of 2015, or "**MACRA**", a bill passed by the House of Representatives on March 26 and by the Senate on April 14 that now permanently repeals the long-maligned Sustainable Growth Rate (SGR) formula for Medicare physician payment.

Retroactive to April 1st, the bill **averts 21% reduction** in Medicare fee-for-service (FFS) payments to providers. It replaces the SGR with a new payment system that includes automatic payment updates for physician fee schedule payments for five years, transitions Medicare FFS payments towards value-based payment system and incentivizes the development and participation in new, alternative payment models, among other notable provisions. The repeal of the SGR means that the temporary measures to override the growth rate formula will no longer dominate Medicare policy discussions, as they have for the last decade. The replacement of the SGR should also accelerate the movement away from unconstrained fee-for-service payments and toward continued payment reforms.
The current legislation replaces the SGR with an approach focused on rewarding high-performing providers while supporting alternative payment models such as accountable care organizations and patient-centered medical homes.

The volume-based cuts to fees under the SGR will be replaced with the modest annual updates instead. Fees will increase by 0.5 percent in June 2015 and each year from 2016 through 2019, and then remain at the 2019 level through 2025, but high-performing providers and providers participating in alternative payment models will have the opportunity for additional payments.

To accelerate the move from volume-based to value-based payment, a merit-based incentive payment system (MIPS) will be established beginning in 2019. The MIPS will replace three previous incentive programs with a combined value-based payment program that assesses the performance of each eligible provider based on quality, resource use, clinical practice improvement activities, and meaningful use of certified electronic health record technology.

MEANINGFUL USE OF EHR

In the past years, CMS has been attempting to motivate providers to adopt changes in adopting EHR (electronic medical records, also known as EMR). This software allows medical practices to move away from paper documentation in an increasingly electronic and interdependent healthcare system. With the Affordable Care Act, and continuing advances in the ability of how technology is aiding healthcare, more and more emphasis has been put on the importance of this software to be a functional practice in the modern healthcare environment. To help offset the major investment in purchasing the software, changing office protocol, training, etc., providers were given incentives to have this technology in their practice, starting in 2011, where providers could receive incentives from CMS or their state Medicaid program for successful integration of this software in their office. Up until 2014, providers have been given incentives- if a provider has not successfully integrated an EMR into their practice at this time, they will begin to be penalized on their Medicare receivables. Starting in 2015, providers who have not successfully attested to being a meaningful use will be subject to a 1% decrease in Medicare payment. For every year following 2015 that a provider does not become a meaningful user, the reduction will get higher, increasing one percent every year to a cap of 5% in 2020 for providers who are still not successful users of this software. In order to avoid the payment adjustment from CMS, take the following steps to ensure that your practice is compliant:

- Register your CEHRT (certified electronic health records technology) software and make sure it is approved by CMS. Providers using outdated software (if software was implemented in an early stage) not certified by CMS will not be meaningful users
- It is not enough to simply own the CEHRT- your practice must incorporate recording necessary information into the daily workflow to report to CMS in order to be compliant with reporting requirements
- Depending on whether you are a Stage 1 or Stage 2 meaningful user, make sure that you are reporting the appropriate number of core measurements, menu measures, and CQMs
- If you are within your first year of meaningful use, make sure that there is 90 days of data that can be attested to CMS. This rule applies to all providers who are currently recertifying their EHR in 2014 to make sure that the software is compliant according to current CMS standards. For all other users and for future attestation periods, providers must report information for a full calendar year in order to receive an incentive payment or avoid a reduction in payment
- Retain proper documentation of all data submitted to CMS, whether participating in the incentive program or not, in order to ensure that Medicare payments are not reduced in the future as a result of an audit
- Continue reporting data annually as mandated by CMS to ensure that there are no reductions in payment