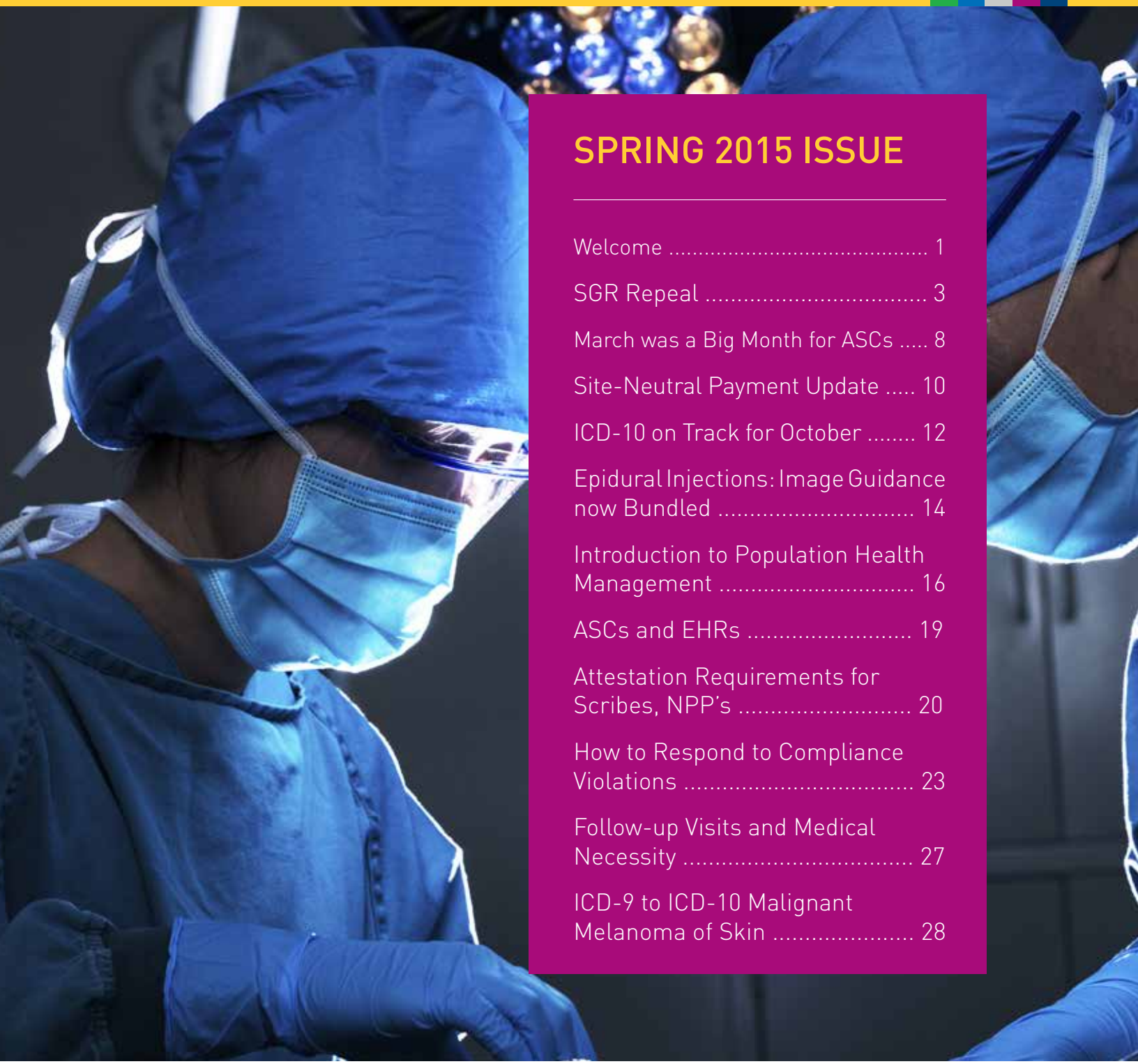
THE LEADING EDGE



SPRING 2015 ISSUE

THE LEADING EDGE

Welcome!

Welcome to the Spring 2015 edition of the Leading Edge. SGR Reform is at the top of everyone's list with the "Medicare Access and CHIP Reauthorization Act, H.R. 2" in the news for the past several weeks. Our SGR feature describes the key elements—which start with no future SGR reductions and include a number of other important provisions, including a 0.5% increase for each of the next 5 years. Of course, we are waiting for the Senate to make it official, which is highly likely.

Our next feature updates ICD-10 because some observers expected that the SGR debate would lead to another ICD-10 postponement, as happened last year. That likelihood seemed more remote after Congressional hearings in February had only one witness of seven arguing for a delay, and the SGR debates have not raised ICD-10 as an issue. As a result, everyone in healthcare needs to renew focus on their ICD-10 implementation plan! As we have for the past 8 issues, we provide an example of ICD-9 vs. ICD-10 (in this issue: malignant melanoma of the skin).

"March was a big month for ASC's" describes a number of important emerging pieces of legislation and regulation that could eventually have a big impact on ASC reimbursement and volume. In a related article on ASC's and EHRs, we outline the House Ways and Means Committee-approved legislation to exempt encounters in an ASC from EHR Meaningful Use until ASC EHR certification standards are in place.

If you perform epidural injections, you probably know that four codes have increased rates for 2015, but with image guidance now bundled, meaning it cannot be billed separately. There has been some confusion but CMS language "prohibiting separate billing of image guidance in 2015" is the definitive rule.

Moving on to broader industry trends, our third feature discusses "Population Health Management," one of the so-called "triple aims" of healthcare reform. With more reimbursement moving to value-based, understanding and managing the health of a group of patients will become critical for all provider organizations.

Our last feature provides an update on "site neutral" payments. This umbrella term encompasses several (sometimes competing) initiatives aimed at reducing disparities between payments for similar services in different settings. While the SGR Reform bill did not include site neutral provisions (despite many thinking it would), CMS is moving ahead to gather data that most think will lead to significant future rate adjustments.

In the Compliance Corner, we have several important reminders plus an outline of how a Compliance Program should deal with violations when they occur.

THE LEADING EDGE

A reminder: any article in this newsletter can be printed as a nicely formatted PDF. And the "Download Current Issue" provides the entire newsletter in one PDF for email or printing.

As always, we appreciate your feedback and suggestions. Please call or email me with comments, questions and suggested topics for the next issue: bgilbert@ahsrcm.com and (908) 279-8120.

Bill Gilbert

SGR Repeal

On March 26, the House overwhelmingly voted (392-37) to repeal the Medicare SGR formula by passing H.R. 2 – the "Medicare Access and CHIP Reauthorization Act of 2015," or the "doc fix" as it is also called. However, the Senate went on "spring break" without addressing the bill but promising to take it up immediately upon their return on April 13 (H.R. 2 adds to provisions included in H.R. 1470, the *SGR Repeal and Medicare Provider Payment Modernization Act of 2015, passed by the House a week earlier)*

As a result, the threat to reduce physicians' Medicare payments by 21.2 percent is still on the table, though no one really expects such a reduction will happen. But, the "law of the land" says that the reduction is scheduled for service dates beginning April 1, 2015.

The SGR formula was created in 1997 when the Balanced Budget Act amended the Social Security Act to control growth in Medicare spending for physicians' services by establishing targets for expenditures – limiting the annual increase in cost per Medicare beneficiary to the growth in the national economy. In the first years, while economic growth was high and medical cost growth was low, the system produced increases in physician payments and no cuts were necessary. In 2001, however, the combination of a recession (declining GDP) and increasing medical costs[1] led to an automatic cut of 4.8 percent in 2002, and cuts each year thereafter. Congress has postponed SGR-triggered pay cuts for physicians 17 times since 2003, causing the potential SGR reduction to increase every year.

Medicare claims for service dates, beginning April 1, will be paid with a 21.2% Medicare payment reduction unless the bill passes or another patch is put in place before Medicare begins to process those claims. As in other years when Congress has gone down to the wire in determining whether or not to repeal or delay the SGR patch, the Centers for Medicare and Medicaid Services (CMS) has informed providers that it *must take steps to implement the negative update. Fortunately, under current law, electronic claims are not paid sooner than 14 calendar days (29 days for paper claims) after the date of receipt.* This leaves a small window for the Senate to act upon, and the President to sign, legislation averting the payment cut.

CMS has stated they will notify providers on or before April 11, 2015, with more information about the status of Congressional action to avert the negative update and next steps.

In the meantime, AdvantEdge will evaluate whether physicians or AdvantEdge should hold April claims until Senate action on April 13th.

What's the Possibility of Passing?

When the Senate returns to the Capitol (it is currently scheduled to reconvene at 2pm on April 13), it expects to consider several amendments to the House bill. Democrats will push to extend authorization of the Children's Health Insurance Program (CHIP) for four years instead of the two year extension included in the bill. They will also take up other areas of disagreement such as the House provisions that limit abortions in community health centers and offsets that impact Medicare beneficiaries.

Conservative Republicans complain that payment offsets in the bill only contribute $70 billion of the 10-year, $200 billion package. While the measure has strong support in the Senate, the delay could give opponents time to sway other senators against the bill. However, Senate Majority Leader Mitch McConnell told reporters before leaving for break that " there is every reason to believe it's going to pass the Senate by a very large majority."

The Current Bill

Most observers expect that the House bill will pass the Senate with relatively few changes. As a result, here we outline the key components of the House bill that affect physicians directly (note that there are 5 Titles). A more comprehensive list of all the provisions of the bill, including all the offsets, can be found in the House ***Energy and Commerce*** and Ways and Means Committee's Section-by-Section Summary.

TITLE 1 – SGR REPEAL AND MEDICARE PROVIDER PAYMENT MODERNIZATION

A 5-year transition to Alternative Payment Models (APMs) will replace the SGR as follows:

- No change to the current conversion factor thru June 31, 2015.
- For July 1, 2015 thru December 31, 2015, a 0.5% update to the current conversion factor.
- Professionals (i.e. those reimbursed through the Medicare Professional Fee Schedule) will receive an annual update of 0.5 % in each of the calendar years 2015 through 2019. (The year 2015 will begin with July 1, 2015 as noted above.)
- The 2019 rates will be maintained through 2025, while providing professionals with the opportunity to receive additional payment adjustments through the MIPS. (See below)
- In 2026 and subsequent years, professionals participating in APMs (Alternative Payment Models) that meet certain criteria will receive annual updates of .75 %, while all other professionals will receive annual updates of .25%.

Consolidate Incentive Payment Programs into one Merit-Based Incentive Payment System (MIPS)

Payments to professionals will be adjusted based on performance in the unified MIPS starting in 2019. The payment penalties associated with current incentive programs are sunseted at the end of 2018, including the 2 percent penalty for failure to report PQRS measures and the 3-5percent penalty for failure to meet EHR MU (meaningful use) requirements.

The money from penalties that would have been assessed will remain in the physician fee schedule, significantly increasing total payments compared to the current law's baseline.

MIPS will consist of consolidating three existing incentive programs as well as participation in the APM programs:

- Physician Quality Reporting System (PQRS: incentivizes professionals to report on quality of care measures).
- The Value-Based Modifier (VBM: adjusts payment based on quality and resources-in a budget-neutral manner).
- Meaningful Use of EHRs (entails meeting certain requirements in the use of certified EHR systems).

A complete description of the MIPS program can be found in the Energy and Commerce Committee's summary of the SGR Repeal and Medicare Provider Payment Modernization Act. (Pages 1-5)

Other Provisions

Encouraging care management for individuals with chronic care needs – In order to encourage the management of care for individuals with chronic care needs, payment will be made for chronic care management services furnished on or after January 1, 2015, by a physician, physician assistant or nurse practitioner, clinical nurse specialist, or certified nurse midwife.

- At least one payment code for care management services will be established for professionals treating such individuals.
- In order to prevent duplicative payments, only one professional or group practice will receive payment for these services provided to an individual during a specified period.
- Payments for chronic care management would not require an annual wellness visit or an initial preventive physician examination be furnished as a condition of payment.
- Payment for care management code(s) will be budget-neutral within the physician fee schedule.

Empowering beneficiary choices through continued access to information on physicians' services Beginning with 2015, utilization and payment data will be published for physicians and professionals including the number of services furnished, charges submitted and payments. This information will be searchable by the eligible professional's name, location, and furnished services. This information will be placed on the Physician Compare website starting in 2016.

Expanding Availability of Medicare Data – Entities that currently receive Medicare data for public reporting purposes (qualified entities, "QEs");

- Will be permitted to provide or sell non-public analyses and claims data to physicians, other professionals, providers, medical societies, and hospital associations to assist them in their quality improvement activities or in developing APMs.
- Will be permitted to provide or sell non-public analyses to health insurers (who provide claims data to the QE) and self-insured employers (only for purposes of providing health insurance to their employees or retirees)

Providers identified in such analyses will have an opportunity to review and submit corrections before the QE provides or sells the analysis to other entities.

Reducing Administrative Burden and Other Provisions

Rule of Construction – Provides that the development, recognition, or implementation of any guideline or other standard under any Federal health care provision, including Medicare, cannot be construed to establish the standard of care or duty of care owed by a health care professional to a patient in any medical malpractice or medical product liability action or claim. This ensures that MIPS participation cannot be used in liability cases.

Other Provisions

- Allows professionals who opt-out of Medicare to automatically renew at the end of each two-year cycle
- Requires regular reporting of opt-out physician characteristics
- Requires that Electronic Health Records (EHR) be interoperable by 2018 and prohibits providers from deliberately blocking information sharing with other EHR vendor products.
- Requires the Secretary to issue a report recommending how a permanent physician-hospital gainsharing program can best be established.
- Requires GAO to report on barriers to expanded use of telemedicine and remote patient monitoring.

TITLE 2 – MEDICARE AND OTHER HEALTH EXTENDERS

- **Extension of work GPCI floor** – Boost payments for the work component of physician fees in areas where labor cost is lower than the national average. The provision extends the existing 1.0 floor on the "physician work" cost index until January 1, 2018.
- **Extension of therapy cap exceptions process** – The Medicare program currently limits ("caps") the amount of annual per-patient therapy expenditures. Congress created an exception process in 2006 that allows patients to exceed the cap based on medical necessity. This provision extends the therapy cap exceptions process until January 1, 2018 and reforms the process of medical manual review to help support the integrity of the Medicare Program.
- **Extension of ambulance add-ons** – Extends the add-on payment for ground ambulance services, including in super-rural areas until January 1, 2018.
- **Extension of increased inpatient hospital payment adjustment for certain low-volume hospitals**. – Extends additional payments to hospitals for the higher costs associated with operating a hospital with a low volume of discharges until October 1, 2017.
- **Extension of the Medicare-dependent hospital (MDH) program**. – Extends special payments to MDHs until October 1, 2017.

TITLE 3 – THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

- **2-Year Extension of the CHIP** – Extends funding of the CHIP through fiscal year 2017.
- **Extension of Certain Programs and Demonstration Projects** – Extends and funds the Pediatric Quality Measures Program and Childhood Obesity Demonstration project.

TITLE 4 – OFFSETS

- **Medigap**. Some Medigap plans on the market today provide first-dollar coverage for beneficiaries – which means the plan pays the deductibles and co-payments so that the beneficiary pays no out-of-pocket costs. Beginning in 2020, new plans sold would limit coverage to costs above the amount of the Part B deductible (currently $147 a year).
- **Income-related premium adjustment for Parts B and D** – The portion of the Medicare Part B and Part D premium that a beneficiary pays is based on the beneficiary's income. Beginning in 2018, the percentage paid by Medicare beneficiaries with modified adjusted gross income (MAGI) between $133,501 and $160,000 ($267,001-$320,000 for a couple) increases from 50 percent to 65 percent. Beneficiaries that earn $160,001 and above ($320,001 and above for a couple) would pay 80 percent. Additionally, current law freezes the income thresholds

through 2019, at which point the income thresholds would be indexed to inflation as if they had not been frozen.

Starting in 2020, the threshold for inflation will be based on where they were in 2019. This provision would also apply to Part D premiums, meaning that beneficiaries who have income above the thresholds are assessed an income-related monthly adjustment amount in addition to the base Part D monthly premium.

- **Levy on Medicare providers for nonpayment of taxes** – for Medicare service providers with tax delinquencies, increases the levy from up to 30 percent to 100 percent.

TITLE 5 – MISCELLANEOUS

- **Protecting the Integrity of Medicare Act of 2015** by reducing wrongful or improper Medicare payments, removing duplicative Medicare Secondary Payer reporting requirements, and eliminating civil money penalties for inducements to physicians to limit services that are not medically necessary.

- **Delay of Two-Midnights** – Per CMS regulation, the two-midnight policy requires a patient stayof two-midnights in a hospital to qualify for inpatient status in most instances; stays less than that will be paid as an outpatient visit. This provision extends the CMS deadline from March 31, 2015 to September 30, 2015 to use the MAC "probe and educate" program to assess provider compliance with the "two-midnight rule."

- **Payment for global surgical packages** – Reverses the CMS decision in the 2015 Medicare Physician Fee Schedule that required the transition of all 10-day and 90-day global surgery packages to 0-day global periods. It requires CMS to periodically collect information on the services that surgeons furnish during these global periods beginning not later than 2017 and use that information to ensure that the bundled payment amounts for surgical services are accurate.

The Secretary has the authority to delay a portion of payment for services with a 10 and 90-day global period to incentivize reporting of information. The Secretary can cease the collection of information from surgeons once the needed information can be obtained through other mechanisms, such as clinical data registries and electronic medical records.

[1] Fontenot, Keith et al, "A Primer in Medicare Physician Payment Reform and the SGR ," Health 360, February 2, 2015.

March was a Big Month for ASCs

In the last several weeks, one piece of proposed legislation and two government reports were issued that could influence the future of Ambulatory Surgical Centers (ASCs).

- The ASC Access Act of 2015 (introduced in the House),
- The March 2015 MedPAC report, and
- The OIG's Compendium of Unimplemented Recommendations.

ASC Access Act of 2015 Introduced in US House of Representatives

In mid- March, US Representatives Devin Nunes (R-CA) and John Larson (D-CT) introduced the *Ambulatory Surgical Center Quality and Access Act of 2015 (H.R. 1453)*. The bill addresses several issues but most important is neutralizing the disparity in reimbursement caused by the different inflation factors CMS uses for ASCs and HOPDs (Hospital Outpatient Departments). ASCs are updated based on the Consumer Price Index for All Urban Consumers (CPI-U), which measures the rising cost of goods like food; HOPDs are updated based on the Hospital Market basket, which measures the rising cost of providing medical services.

Some of the major proposed provisions of the Act are:

- Changing the ASC reimbursement update from the Consumer Price Index for All Urban Consumers (CPI-U) to the hospital market basket update, which better measures the cost of practicing medicine;
- Requires CMS to post similar quality metrics for ASCs and HODPs online in a "side-by-side comparison." The publicly available data would include quality measures and copay amounts for both sites of service in the same geographic area;
- Currently, ASCs do not have a voice on the Advisory Panel on Hospital Outpatient Payment, which controls various aspects of physician payment rates. This legislation would add an ASC industry leader to that panel;
- Adding transparency to the health care industry by requiring the Centers for Medicare and Medicaid Services (CMS) to disclose which criteria they use to deny certain procedures from being performed in an ASC and by requiring them to make publically available the results of quality reporting measures that apply to both ASCs and HOPDs.

The legislation is different than the 2013 version of the bill, which included a value-based purchasing (VBP) program. Instead of including the VBP, this legislation improves patient access to quality reporting data reported by both ASCs and HOPDs.

The MedPAC Report

Recently, MedPAC released its March 2015 report concerning Medicare payment policies. The report recommended a zero percent update for most providers, including ASCs. Of interest to ASCs, is that contrary to the zero percent update for ASCs, MedPAC recommended a 3.25 percent increase for hospital outpatient departments and inpatient services.

MedPAC also reiterated its recommendation for an ASC value-based purchasing program as

well as its recommendation that ASCs submit cost reporting data to the Centers for Medicare and Medicaid Services (CMS). Here is the ASC section of the MedPAC report.

As a follow-up to the release of the MedPAC report, Becker's ASC Review published an article, 9 things to know about MedPAC's 2015 ASC report, a quick summary of the major points of the report.

1. MedPAC recommends that Congress should eliminate payment updates for ASCs in 2016. MedPAC also recommends that ASCs be required to submit cost data.
2. In 2013, 5,364 ASCs provided care to 3.4 million fee-for-service Medicare beneficiaries. The Medicare program and beneficiaries spend $3.7 billion on ASC services.
3. This year, Medicare rates for hospital outpatient departments are 82 percent higher than ASC rates.
4. MedPAC concluded that 2015 payments to ASCs are adequate and Medicare beneficiaries have adequate access to care in ASCs. The organization also noted that Medicare payments to ASCs have steadily grown.
5. The growth rates of ASCs slowed from 4.2 percent in 2008 to 1.1 percent in 2013.
6. MedPAC noted that outpatient volume is growing at a faster rate in HOPDs than in ASCs. From 2012 to 2013, volume per fee-for-service beneficiary increased 0.5 percent in ASCs, but rose 3.1 percent in HOPDs.
7. MedPAC reported Medicare beneficiary access to ASCs should be maintained due to disparity in spending between ASCs and HOPDs.
8. The organization urges Congress to implement a value-based purchasing program for ASCs no later than 2016. Recommended measures to include in the program: patient falls, patient burns, wrong site surgery, hospital transfer and surgical site infections.
9. MedPAC suggests revisiting the consumer price index for all urban consumers as the market basket to update ASC payments, as the CPI-U may not reflect an ASC cost structure.

The OIG Report

At around the same time the MedPAC report was released, the Office of the Inspector General (OIG) published its Compendium of Unimplemented Recommendations, a report of the top 25 unimplemented recommendations that, "on the basis of OIG's professional opinion, would most positively impact HHS programs in terms of cost savings and/or quality improvements." The recommendations come from OIG audits and evaluations.

The recommendation that directly affects ASCs is for Medicare to reduce outpatient department payment (HOPD) rates for ambulatory surgical center-approved procedures:

- "On the basis of current payment differentials and 2011 utilization data, Medicare saved almost $7 billion during CYs 2007 through 2011 and could potentially save $12 billion from CYs 2012 through 2017 because ASC rates are frequently lower than outpatient department rates for surgical procedures."
- The report goes on to say that beneficiaries would save approximately $2 billion during CYs 2001-2011 and potentially save an additional $3 billion for the next 6 years through reduced cost sharing.
- If legislation passes allowing the OPPS rates for ASC-approved procedures to be determined in a non-budget-neutral manner, Medicare could generate potential savings of as much as $15 billion for CYs 2012 through 2017.

Site-Neutral Payment Update

In the Fall edition of the Leading Edge, we published an article, Site-Neutral Payments are still on the Table, reviewing the controversy around site-neutral payments stemming from recent shifts of services from the physician's office to the hospital out-patient department, where payment for the same services are generally higher. This trend increases Medicare spending with no proof that the quality of care is better. No changes in billing requirements or reimbursement have taken place yet, but the trend to equalize the payments is still alive and well, with a projected date for some site-neutral payment changes to occur by January 2015.

Here are updates on some of the site-neutral payment discussions.

2015 Medicare Physician Fee Schedule

In the 2015 Medicare Physician Fee Schedule(MPFS), recognizing the growing trend toward hospital acquisition of physician offices and subsequent treatment of those locations as off-campus provider-based outpatient departments, CMS sought comment regarding the best method for collecting information that would allow them to analyze the frequency, type, and payment for services furnished in off-campus provider-based hospital departments. Their hope was to see how this trend affects payments under the MPFS and beneficiary cost-sharing.

As a result of their study, CMS finalized their proposal to require a change in place of service codes for physician/professional billing and a new modifier to be used for hospital billing. For physician billing, CMS will delete the current Place of Service (POS) code 22 (outpatient hospital location) and replace it with two new POS codes, one to identify outpatient services furnished in on-campus, remote or satellite locations of a hospital and the second, to identify services furnished in an off-campus hospital Provider Based Out-patient Department setting. CMS will maintain the separate POS code 23 (emergency department).

The new place of service code will be required for professional claims as soon as it is available, but not before January 1, 2016. Data collection will be voluntary for hospitals in 2015 and required beginning on January 1, 2016.

The Alliance for Site-Neutral Payment Reform (ASNPR)

In January 2015, shortly before the President's 2016 budget was announced, a newly formed group called the Alliance for Site-Neutral Payment Reform (ASNPR) wrote a letter to Congressional Leaders to call attention to the "disparities in payments between the same clinical patient services provided in different healthcare settings," and that these "disparities are far reaching – from lab work, to radiology imaging exams, to cancer care – and are driving up healthcare costs to the tune of billions annually." The Alliance is made up of physicians, health insurers and other health care organizations that are promoting reimbursement parity across site of service but encouraging a parity policy that does not reduce patient access or quality of care.

MedPAC Update

Also in January, the Medicare Payment Advisory Commission unanimously voted to recommend

site-neutral payments for certain post-acute services, eliminating differences in payments between inpatient rehabilitation facilities and skilled nursing facilities for selected conditions, a continuation of their long-held belief that payments should be equalized among locations of services.

The President's 2016 Fiscal Year Budget

In February, President Obama's 2016 fiscal year budget contained a provision agreeing with the MedPAC proposals, to lower payments provided in off-campus hospital outpatient departments to either the applicable physician fee schedule rate or the ambulatory surgical center (ASC) rate.

The administration's proposal would essentially end the system of different prices for similar services. Medicare would pay the same for any visit, test or procedure offered by doctors who work in private practice and by those who work in off-campus practices that are owned by hospitals. Doctors who work in the hospital building could still be paid the higher hospital rate. But the free-standing practice that suddenly changes hands would not continue to be paid more.[1]

The budget proposed changes would be phased in, beginning in 2017. It is estimated that Medicare would save an estimated $29.5 billion for the years FY2017-2025.

The two main entities involved in Medicare rate setting are the Centers for Medicare and Medicaid Services (CMS) and the Medicare Payment Advisory Committee (MedPAC). Although both CMS and MedPAC agree on price parity, they have butted heads on how to equalize payments. CMS had proposed to limit the amount paid for a service in the physician office setting to the amount paid for the same service when provided in a hospital outpatient department or ambulatory surgical center. MedPAC, on the other hand, promotes paying outpatient services at the rate of the physician fee schedule. The outcome of either decision could pit physicians against hospitals.

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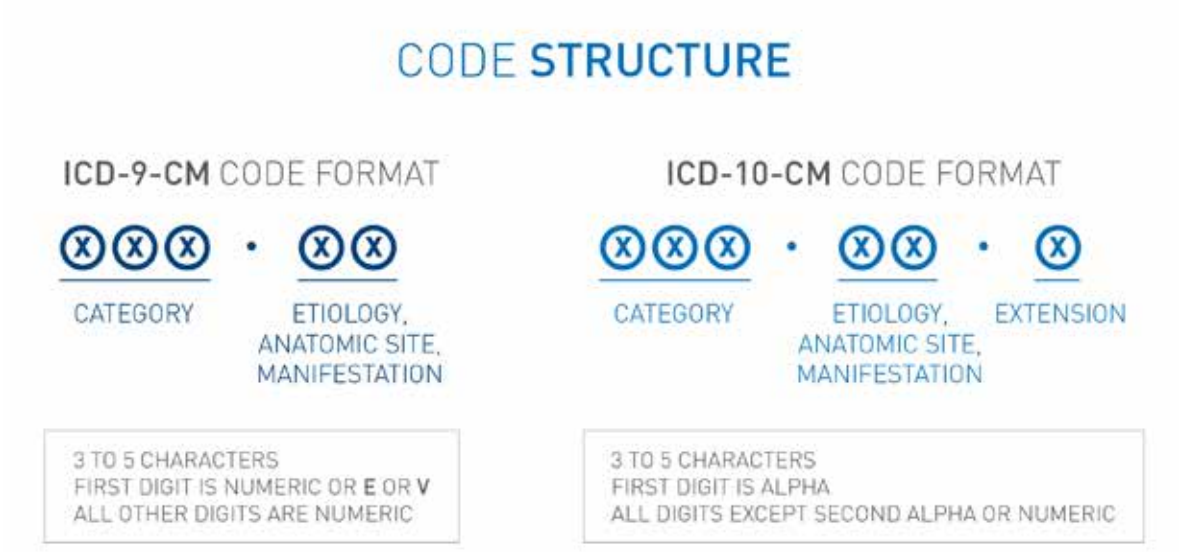
[1] Sanger-Katz, Margot, "When Hospitals Buy Doctors' Offices, and Patient Fees Soar," The New York Times, February 6, 2015.

ICD-10 on Track for October

ICD-10 appears to be firmly on track for implementation October 1 of this year, just a few months from now. Proponents for further delay have not been persuasive with Congress to date and, as of this article, do not appear to have support for Congressional intervention.

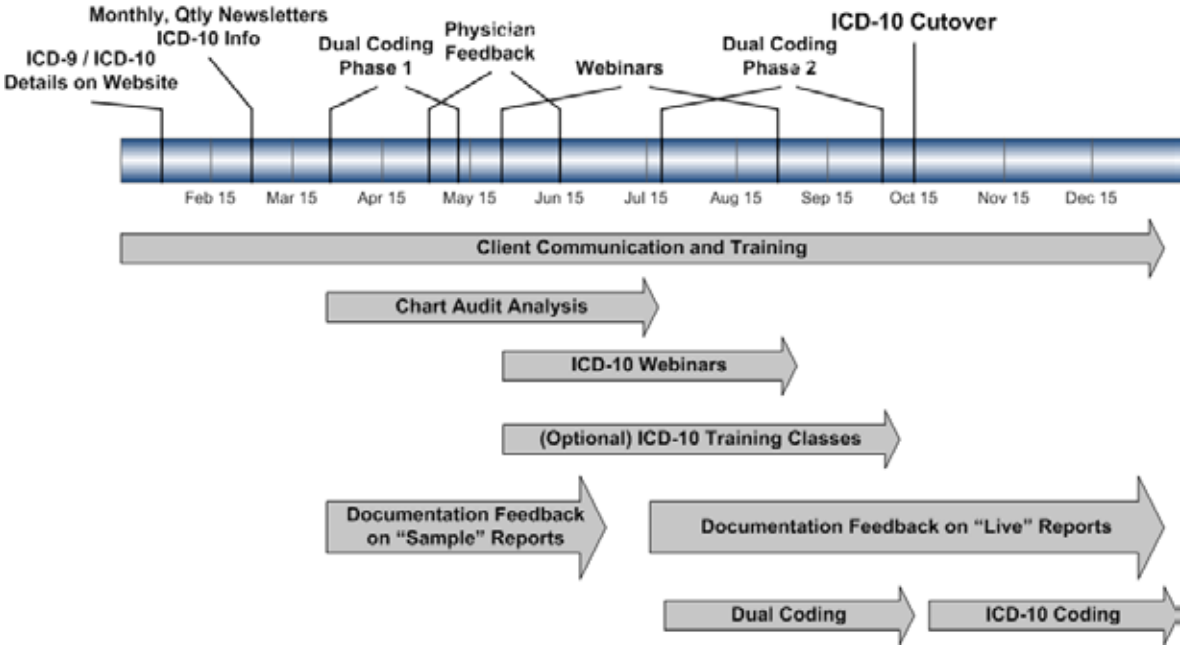
Most of us know that ICD-10 represents a larger set of diagnosis codes (69,000 vs. 14,000) that provide much more specificity including designations for anatomic site, visit specific information, technology, etc.



At this point, every physician, group and department needs to be getting ready for ICD-10. AdvantEdge is fully prepared to implement ICD-10 on October 1, 2015 including numerous steps to assist clients with the needed clinical documentation updates. The company has been working on ICD-10 implementation since 2011 and our ICD-10 taskforce is coordinating all of the components of ICD-10 that must come together for a successful transition.

For physicians and other providers, ICD-10's largest impact is on documentation (for providers where AdvantEdge does the diagnosis coding) and on understanding the new codes themselves (for providers who do their own diagnosis coding). To assist with the transition, this newsletter (The Leading Edge) has been publishing ICD-9 / ICD-10 comparisons for the past two years. Those comparisons are now available on the AdvantEdge website. In addition, several AdvantEdge whitepapers provide additional details to help with ICD-10 planning. Contact your client manager for a copy or email info@ahsrcm.com.

For the timeframe between now and October, AdvantEdge has a number of initiatives under way to assist clients with the transition as shown here:



For more information about the ICD-10 transition, please contact your Client Manager.

Epidural Injections: Image Guidance now Bundled

Medicare Rate is Increased but Guidance is Bundled.

Over the past few years, radiologic guidance imaging services have been bundled into surgical procedures, decreasing reimbursement for radiologists and other specialists who perform guidance imaging. In 2015, *fluoroscopic guidance for epidural injections* (CPT® codes 77001 – 77003) *will be included in the reimbursement for the epidural injection codes*, 62310, 62311, 62318 and 62319 (see end of article for complete code descriptions). However, CMS has increased the reimbursement rates for these codes by reverting back to the 2013 Medicare rates until these codes are fully re-evaluated.

Under the 2014 Medicare Physician Fee Schedule (MPFS), CMS significantly reduced payment for CPT Codes 62310, 62311, 62318 and 62319 under the misvalued code initiative. CMS justified the reduction because they did not believe the RUC (AMA's Relative Value Scale Update Committee) recommended work RVUs accounted for the substantial decrease in time it takes to furnish these services, as reflected in the RUC survey data for these codes, and since the RUC did not indicate that the intensity of the procedures had changed, CMS believed the work RVUs should reflect the reduction in time.

In addition, CMS had also established interim final direct PE (practice expense) inputs for these codes based on the RUC-recommended inputs which included the removal of the radiographic-fluoroscopy room for the epidural CPT codes. The result of these two provisions was a reduction of approximately 54.9% for code 62310 (the injection of spine; cervical or thoracic) and 51.8% for 62311 (injection of spine; lumbar or sacral.) [1] However, the fluoroscopic imaging guidance continued to be reimbursed separately from the surgical codes.

In response to concerns from physicians regarding the accuracy of the valuation of the codes in 2014, CMS agreed to re-evaluated these codes, and under the 2015 MPFS, reverted reimbursement for 2015 back to the 2013 reimbursement rate until they finalize the valuation of these codes. At the same time, CMS reviewed other injection codes to see how they were valued, as recommended by some of the commenters, and in most cases, these injection codes were valued with the inclusion of fluoroscopic guidance.

The following is an excerpt from the 2015 MPFS final rule for "Epidural Injection and Fluoroscopic Guidance CPT® Codes 62310, 62311, 62318, 62319,

"Because it was clear that inputs that are specifically related to image guidance, such as the radiographic fluoroscopic room, are included in these proposed direct PE inputs for the epidural injection codes, we believed allowing separate reporting of the image guidance codes would overestimate the resources used in furnishing the overall service. To avoid this situation, we also proposed to prohibit the billing of image guidance codes in conjunction with these four epidural injection codes. ... After considering comments received, we are finalizing CPT® codes 62310, 62311, 62318, and 62319 as potentially misvalued, finalizing the proposed RVUs for these services, and ***prohibiting separate billing of image guidance in conjunction with these services****."* (emphasis added)

So for 2015 CMS will:

- Include CPT codes 62310 – 62319 on the potentially misvalued code list. CMS has asked the

RUC to further review this issue and make recommendations on how to value epidural pain injections with imaging guidance in the future.
- Pay the epidural codes at the 2013 Medicare reimbursement rate, which is higher than last year
- Bundle the fluoroscopic guidance service in the epidural codes. Any guidance imaging codes billed with the epidural codes will be denied by CMS.

Interestingly, perhaps because of timing, the 2015 CPT manual did not bundle fluoroscopic guidance into these epidural codes, nor did the latest Correct Coding Initiative (CCI) edits. However, with CMS' strong wording of "prohibiting separate billing of image guidance in 2015", all AdvantEdge coders have been instructed to no longer add the fluoroscopic guidance code to the epidural codes.

It is expected that all other insurance carriers will follow the CMS final ruling.

Description of CPT Codes 62310 – 62319

- **62310** (Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical orthoracic)
- **62311** (Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal))
- **62318** (Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic)
- **62319** (Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)).

Description of Fluoroscopic Guidance Codes

- **77001** – Fluoroscopic guidance for central venous access device placement, replacement (catheter only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography radiologic supervision and interpretation, and radiographic documentation of final catheter position.
- **77002** - Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device)
- **77003** – Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)

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[1] AANEM – "2015 Fee Schedule – What does this mean for Reimbursement?" November 18, 2014

Introduction to Population Health Management

Improving population health is one of the "Triple Aims" of the Affordable Care Act and is the key to attaining the other two requirements: improving the patient experience (quality and satisfaction) and lowering the per-capita cost. Population health management (PHM) is defined as the use of clinical, social and personal information to manage the health outcomes of a group of individuals.

The goal of PHM is to keep a patient population as healthy as possible and minimize the need for expensive interventions such as emergency department visits, hospitalizations, imaging tests, and procedures[1]. PHM also redefines healthcare as an activity that encompasses far more than sick care. Instead of episodic care where providers treat ill patients, care would be defined as that which addresses the preventive and chronic needs of every patient, modifying the factors that make people sick or worsen their illnesses.

While not a part of the definition itself, it is understood that population health outcomes are determined by many factors beyond medical care, such as public health, genetics, behaviors, social factors, and environmental factors. In fact, according to a study done by the University of Wisconsin Population Health Institute in 2010, medical care accounts for only 20% of a patient's health. The remaining 80% is made up of social economic factors, health behaviors and environmental factors.

Many see attention to population health as a great opportunity for health care delivery systems, public health agencies, community-based organizations and others to work together to improve health outcomes in the communities they serve.[2]

The Road to Improve Population Health

Over the last few years many health care practices and organizations have spent time and money participating in numerous government health care initiatives (PQRS, eRX, EHR Incentive programs, etc.), private insurer initiatives, ACOs and patient-centric homes. These externally-driven programs represent initial steps toward improving the population's health at a reduced cost.

The next steps are up to the care givers. The MGMA (Medical Group Management Association) believes that population health management success depends on a provider organization's ability to understand its processes and patient base to deliver the best care and adapt to the changing healthcare environment.[3] The need to keep patient populations healthy is part of the new care models being implemented as part of payment models that incorporate financial risk-taking and incentive management. What these changing models share is the move to coordinate consumer care not by the type of clinical problem, but by the type of specific consumers and consumer needs – the transformation of a horizontal care management system to a vertical care management model.[4]

Understanding and managing your patient population is, or soon will be, critical to managing your organization's finances while improving patient outcomes. In the beginning, the potential benefits, along with the capabilities the organization has to reach those benefits, must be assessed. The organization must understand the PHM process, risk-based contracting with insurers and what risk-taking means at all levels. The organization must know what a population

of healthy people looks like, how clinical risk is defined, how financial risk is measured, and the metrics used to analyze how patients with chronic disease get sicker or improve their illness.[5]

As one can see, instituting mechanisms to improve population health is very complex. But there are two basic components where even small practices and hospitals can begin to make improvements and participate in the new care models: (1) changing how you manage your patient population and (2) understanding your patient population.

Care Management – Changing how you Manage your Patient's Care

Care management is foreign to many aspects of our current health care system but it is where the "new world" of healthcare is headed. Providers, once they begin tracking their patient population, are surprised by the number of patients who have uncontrolled chronic conditions, or how many patients have not had timely colonoscopies, mammograms, flu shots or vaccinations. These are called gaps in care and they are bred by our episodic delivery of care. Monitoring patients who receive and do not receive these preventive services can go a long way toward keeping patients healthier.

Much of this monitoring will include managing social factors. Why do patients not see their physicians or why do they not follow their physician's orders? Factors such as difficulty with understanding the English language, not understanding a provider's recommendations, affordability of prescriptions and recommended food, all contribute to patient non-compliance and sicker patients. Care management of these patients consists of medical staff meeting patients where they are and ensuring they understand what is prescribed for them and why. [6] This can include scheduling follow-up services at the time of the appointment, follow-up phone calls to ensure patients are complying with a physician's orders, etc.

Even CPT billing codes have made way for managing patient care with the addition of codes for care management services, inclusive of non-face-to-face services, and transitional care management services. These codes include establishing, implementing, revising or monitoring care plans, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan and prognosis.[7]

Good care management includes stopping patient leakage where patients seek care externally. Once the patient steps outside the practice or clinic without notice to their physician, care of the patient becomes disrupted. Understanding how to hold on to your patients, retrieving those who have left and understanding why they left, enables a practice or clinic to not only focus on good medical care but also allows the practice to reap the financial rewards of a good patient base.

Data Analytics – Understanding your Patient Population

If care management leading to a healthier patient population is the goal, how do providers get there? In order to change the direction from episodic and fee-for-service to better population health and value-based care, PHM requires some new skill sets and new infrastructures for delivering care.

Patient data can tell a practice or clinic much about their patient population, such as their

hospital admissions, transfer and discharge summaries, pharmaceutical and patient reported data. Patient data may be assembled in various ways – through claims, EHR or other automated programs. Whether your practice, clinic or hospital can afford automated systems to track data or you start small by manually organizing and charting patient data, you should begin gathering the following information to support your PHM functions:

- Population identification
- Target the patients the practice should focus on, including which issues related to a given patient should be focused on,
- Identification of care gaps
- Determine whether particular providers are practicing at the expected performance level,
- Determine whether any cost problems are due to excess utilization,
- Patient engagement, and
- Measure outcomes

Data analytics are only useful if physicians and other providers understand what the results mean and incorporate those results into the workflow so they are present when a clinician is with the patient. Data can be monitored on a large, organizational scale and on an individual, physician-to-patient level.

The data must be clean and accurate, especially if it is going to be used in reports about provider performance and patient outcomes. The same data analysis that is used in PHM can be reused for programs such as CMS' Physician Quality Reporting System, the Medicare and Medicaid EHR incentive programs, health plan pay for performance programs and patient-centered medical home recognition programs. In order to do this, the performance measures used in PHM should be aligned with the payment programs' metrics.

Where do we go from here?

Population health management is still evolving and while some early studies show improved clinical outcomes, financial success and cost reduction is yet to be seen. Good leadership, getting all staff on board and setting targets for what the organization is trying to achieve are all essential.

For a PHM program to be effective, there is a need to focus on the data and information that will influence clinical and financial decisions, including entering into risk-based contracting. By gathering the appropriate information and eventually applying technology and automation to every aspect of population health management, provider practices and health systems should have an easier time transitioning from episodic/fee-for-service care to population health/value-based care.

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[1] "Population Health Management – A Roadmap for Provider-Based Automation in a New Era of Healthcare," *Institute for Health Technology Transformation*, 2012
[2] Stoto PhD, Michael, "Population Health Care in the Affordable Care Act Era," *Academy Health*, February 21, 2013.
[3] Lahlou, MD, Ayoub, "Is PHM Right for your Organization?," *MGMA Executive View*, Winter 2014
[4] Oss, Monica e., "The Brave New World of SMI Population Management – New Care Coordination Model, New Financing Model," Open Minds, February 16, 2015.
[5] Cassidy, MPA, Bonnie, "Population Health Information Management Presents a New Opportunity for HIM," *AHIMA*, August 2013
[6] Grimshaw, Heather, "Opening New Doors," *MGMA Connection*, March 2014.
[7] American Medical *Association, CPT Manual* 2014, 2015.

ASCs and EHRs

First Step in Exempting ASC Physicians from EHR MU until ASC Certification Standards are Created

In late February, the U.S. House of Representatives' Ways and Means Committee voted to approve the Electronic Health Fairness Act of 2015 (H.R. 887). The Act exempts patient encounters performed in an Ambulatory Surgery Center from being counted towards meaningful use of electronic health records (EHR) until ASC certification standards are created. The bill is designed to allow enough time to develop ASC-specific standards for EHR. The exclusion of ASC encounters would sunset three years after the Secretary of the Department of Health and Human Services determines that certified EHR technology is applicable to ASCs. If the bill is enacted this spring, it would affect the determination of meaningful use for services performed during calendar years 2016 through 2018.

Under the EHR Meaningful Use Incentive program, eligible professionals (EPs) who furnish at least 50 percent of their patient encounters during the reporting period in locations with certified EHR technology are eligible for the Medicare EHR Meaningful Use Incentive Program. This includes physicians who practice in multiple settings.

However, the HITECH Act did not provide incentives specific to ASCs. So while ASC facilities do not receive incentive payments or payment reductions, the procedures that physicians furnish in ASCs are included in the total number of patient encounters of which at least 50 percent have to be furnished in a setting with certified EHR technology. This puts physicians who work in an ASC at a disadvantage by holding them accountable for using certified EHR technology despite the fact that there are a limited number and type of EHR systems suitable for ASCs.

Physicians who practice in an ASC without certified EHR technology can take steps to avoid a payment reduction, though the options are less than ideal. They can apply for a time-limited, hardship exception or treat patients in the more expensive hospital outpatient department setting. It is felt that applying for time-limited hardship exceptions may take away the incentive for them to have a certified EHR in their office practice.

The CBO (Congressional Budget Office) estimates that enacting H.R. 887 would enable almost 2,000 providers to avoid payment reductions that otherwise would average about $3,000 a year. Beginning in 2015, Medicare's payment rates will be reduced by between 1 percent and 5 percent for providers who fail to meet the meaningful-use criteria.

The CBO also estimates that enacting H.R. 887 would increase direct spending by $17 million over the fiscal year 2016-2020 period, but would have no further budgetary effect after 2020.

Attestation Requirements

Required Scribe, Teaching Physician & NPP Attestations

Per CMS guidelines, physician involvement with scribes, residents, and NPPs (Non-Physician Practitioners) has specific documentation requirements. It is essential that the following attestations and documentation are present when NPPs, Scribes, and/or residents are utilized.

SCRIBES

- A scribe works side by side with the practitioner as a documentation assistant
- A scribe cannot work independently
- A scribe can be a:
    - -Non-physician Practitioner (NPP)
    - Nurse
    - Medical Student
    - Vendor
- Medicare requires the following documentation & attestations
    - Who performed the service
    - Who recorded the service & for whom the scribe is transcribing
    - A notation from the physician/NPP that he/ she reviewed the documentation for accuracy
    - Signed and dated by the performing physician/ NPP
- The record must clearly delineate the scribe's contribution to the record, i.e., "my name is XXX and I am scribing for Dr. XXXX" which should be found somewhere at the beginning of the record
- The signature should be footnoted by a phrase that clearly states they are acting as a scribe on behalf of the provider.
- The attending provider must review the record and include a notation that the documentation is accurate.

Sample Provider Attestation
"Documentation assistance provided by a scribe. Information recorded by the scribe was done at my direction and has been reviewed and validated by me". Dr XXX XXXXX, 12/21/14

TEACHING PHYSICIANS / RESIDENTS

According to CMS, the Teaching Physician must be present during the key portion of the patient's visit:

- History
- Exam
- MDM

In order to bill for these visits, the Teaching Physician must attest to the Resident's documentation on the above mentioned portions by documenting their own findings.

Sample Teaching Physician Note/Attestation:

Attending Note:

_____*Resident's history reviewed, patient interviewed and examined.*
*Briefly, the pertinent HPI is*_____
*My personal exam of patient reveals*_____
*I agree with assessment and care plan, and confirm the diagnosis (s) above. With exception of*_____
*Signature*_____ *Date* _____

NON PHYSICIAN PRACTITIONER (NPP) / SPLIT SHARE VISITS

- A split/shared visit is a medically necessary encounter with a patient, where the physician and a qualified NPP (NP, PA, etc.) each personally perform a substantive portion of an E&M visit face-to-face with the same patient on the same date of service,
- This service is NOT performed by ancillary personnel, and
- The NPP and the Physician must be employed by, contracted with, or otherwise leased to the same entity and linked to the same entity/group/Tax ID/Medicare group number.

For Medicare:

1. **Independent NPP Services**
When an NPP provides a service within the NPP scope of practice with no direct, significant physician involvement, claims submitted for such independent NPP services must show the NPP as the provider of services.

2. **Split/shared Visit**
When an Inpatient NPP and MD each participate in the care of a patient; it may be permissible, in some instances, to bill Medicare Part B for the shared service using the MD as the billing provider. CMS refers to this as a "split/shared E/M service." In order to use this mechanism for billing shared/split services, two important rules must be followed:

- The NPP and the Physician must be employed by, contracted with, or otherwise leased to the same entity and linked to the same entity/group/Tax ID/Medicare group number.
- The physician must perform and document a face-to-face encounter with the patient which may include documentation from at least one of the three key components (history, exam, or MDM). However, if there was no face-to-face encounter between the patient and the physician (e.g., the physician participated in the service by only reviewing the patient's medical record), then the service may only be billed under the NPP's name and number as an Independent NPP service.

Only if both of the above rules are met is it permissible for the NPP service to be billed using the MD's name/number. If so, the Coder will identify the MD as the billing provider and the NPP as the assisting provider.

If both rules are not met, the NPP service must be considered an "independent service" and billed according to those regulations.

To repeat, this Split/Shared Visit Method applies only in situations where the physician and the NPP are employees of or contracted with the same group/entity/tax ID or an appropriate lease agreement exists between the entity employing/contracting with the Physician and the entity employing/contracting with the NPP. This employment/contract/leasing arrangement allows the Physician and the NPP to be enrolled with Medicare under the same entity/tax ID/ Medicare group number.

When the physician and NPP are (i) employed by/contracted with the same group/entity/Tax ID (or their respective entities have entered into the appropriate leasing arrangement), (ii) enrolled in Medicare as such, and (iii) the MD documents any face-to-face portion of the E/M encounter with the patient, the chart can be billed to Medicare under the physician's billing number. It does not have to be billed under the NPP's number.

Examples of acceptable documentation:

- The physician may document a relevant history in the chart.
- The physician may document a relevant examination in the chart.
- The physician may document the Medical Decision-Making in the chart (provided there is documentation of a face-to-face encounter with the patient)
- The physician may document a statement that attests to his or her involvement in the patient's care. An example of such a statement could be, "I personally evaluated and examined the patient in conjunction with the NPP and agree with the management and disposition of the patient."

Examples of unacceptable documentation:

- Merely a signature by the physician is not acceptable for billing under the physician. While this may satisfy hospital, state, and/or federal supervision regulations it does not meet the minimum requirements for billing a shared visit to Medicare.
- A statement of "agree with above" is not acceptable for billing under the physician.
- In order to bill under the physician, the physician must perform and document a face-to-face encounter with the patient which may include documentation from at least one of the three key components (history, exam, or MDM).
- If there was no face-to-face encounter between the patient and the physician (e.g., the physician participated in the service by only reviewing the patient's medical record), then the service may only be billed under the NPP's name and number as an Independent NPP service.

How to Respond to Compliance Violations

Learn how to respond appropriately to detected compliance offenses and develop corrective actions.

An employee, by definition, is *'a person who works for another person or for a company for wages or a salary'*; note that it is not defined as 'a person who never makes mistakes'.

For most practices and hospitals, the majority of compliance and privacy related violations will implicate an employee in some form or manner. The number of staffers involved with patient data during its lifecycle in a practice or hospital is typically **everybody**, and **everybody** does not have the same mindset when it comes to compliance, no matter how in-depth the annual training may be. Take for example the employee who is swamped with patient calls while attempting to bill the correct CPT code, or the medical receptionist over-collecting patient co-pays, the nurse exploring her boyfriend's medical records or the office manager who does not have time to 'deal with' encrypting emails, after all... is anyone out there really interested in Mary Smith's conjunctivitis?

Reality is that your employees are the weakest link in your compliance and privacy programs. Thankfully, most times it is not intentional or malicious but simply not taking the time to do the right thing. You have taken the time to create policies that promote a culture of compliance; this article is intended to focus on best practices when responding to those unfortunate offenses when they are detected.

The OIG has published the seven elements of an effective compliance program; in this article, we focus on #5.

1. Conducting internal monitoring and auditing;
2. Implementing compliance and practice standards;
3. Designating a compliance officer or contact;
4. Conducting appropriate training and education;
5. **Responding appropriately to detected offenses and developing corrective action;**
6. Developing open lines of communication; and
7. Enforcing disciplinary standards through well-publicized guidelines.

This excerpt from the Department of Health and Human Services, Office of Inspector General OIG Compliance Program for Individual and Small Group Physician Practices, provides a great deal of specific guidance.

When an organization determines it has detected a possible violation; the next step is to develop a corrective action plan and determine how to respond to the problem. Violations of a compliance program, significant failures to comply with applicable Federal or State law, and other types of misconduct threaten the provider's status as a reliable, honest, and trustworthy provider of health care. Consequently, upon receipt of reports or reasonable indications of suspected noncompliance, it is important that the compliance officer or designee investigate the allegations to determine whether a significant violation (of applicable law or the requirements of the compliance program) has indeed occurred, and, if so, take decisive steps to correct the

problem.[1] As appropriate, such steps may involve a corrective action plan, [2] the return of any overpayments, a report to the Government, [3] and/or a referral to law enforcement authorities.

One suggestion is that a provider develop its own set of monitors and warning indicators as part of its compliance plan. These might include:

- *Significant changes in the number and/or types of claim rejections and/or reductions;*
- *Correspondence from carriers and insurers challenging the medical necessity or validity of claims;*
- *Illogical patterns or unusual changes in the pattern of CPT, HCPCS or ICD–9/10 code utilization; and*
- *High volumes of unusual charge or payment adjustment transactions.*

If any of these warning indicators become apparent, immediate follow-up is required. Subsequently, the compliance procedures may need to be changed to prevent the problem from recurring. For potential criminal violations, providers are advised to have compliance program procedures for prompt referral or disclosure to the appropriate Government authority or law enforcement agency.

When an overpayment is identified, it is advised that the practice or hospital take appropriate corrective action, including prompt repayment to the affected payor or patient. It is also recommended that the compliance program include a full internal assessment of any report of a possible violation. If a practice or hospital ignores reports of possible fraudulent activity, it is undermining the very purpose of implementing a compliance program.

Other recommended compliance program standards and procedures include:

- Provisions to ensure that a violation is not compounded once discovered.
- In instances involving individual misconduct, standards and procedures for individuals involved: e.g. retrain, discipline, or, if appropriate, termination.
- Conduct a review of all confirmed violations (to prevent the compounding of any violation), and, if appropriate, self-report the violations to the applicable authority.
- Modifying the compliance program when a violation occurs and is not detected on a timely basis. Organizations that detect violations could analyze the situation to determine whether a flaw in their compliance program failed to anticipate the detected problem, or whether the compliance program's procedures failed to prevent the violation. In any event, it is prudent, even absent the detection of any violations, to periodically review and modify your compliance program.

How to Develop a Corrective Action Plan

Where to begin? It is very challenging to develop a corrective action plan without having well-established written policies and procedures to start with. Before writing these policies and procedures; it is recommended that you take time to review the mission and values of your organization. Without understanding the core values; the policies and procedures will be just words on paper. What are your goals and objectives?

Below is an example of a policy to help you "begin at the beginning" to provide the necessary structure for a process for policy development and maintenance of approved policies and procedures.

Policy Name: Policies and Procedures Development and Administration

Policy: It is the policy of the Organization for policies and procedures to follow a consistent process for development, approval, review and implementation.

Procedures:

1. Written Format
    1. Use a standard format.
    2. State specific rather than generic guidelines.
    3. Use simple terminology to make statements short and concise.
    4. Include no more than one idea in any single sentence.

2. Definitions
    1. Policy: A guide to the philosophy behind the Organization's objectives and procedures; a policy provides the framework from which consistent actions and decisions can be made.
    2. Procedures: Chronological steps or methods for implementing a policy.

3. Policy Categories (subject to change with growth of the organization)
    1.Purpose/Mission
    2. Medical/Legal
    3. Clinical
    4. Safety
    5. Operations
    6. Financial
    7. Human Resources

4. Policy Development
    1. A policy and procedure committee (PPC) with representation from all departments in the organization that initiates and reviews policy development.
    2. The policy and procedure task force meets regularly to review and recommend the policies and procedures of the organization.
    3. Management to assist in policy and procedure development and review with sign off of draft policies and procedures.
    4. All policies and procedures are presented to the PPC for review and approval before final signature.

5. Final Policy Approvals

Final drafts are approved by the head of the organization (for a larger organization, you may want to add; "and appropriate senior administrative employees.") Then list the department and position responsible, e.g. Operations: Director of Operations, Clinical: Chief Medical Officer"

6. Implementation

Approved policies and procedures are distributed to all department managers. Managers are responsible for distribution and implementation of all policies within their departments. All employees must acknowledge, by their signature, receipt and that they have read the approved

policies. (If your organization is smaller, then this section might read, "Approved policies and procedures are distributed by the president/CEO. Employees must sign approved policies after reading them.")

7. Policy Amendments

1. Policy amendments are presented to the policy and procedure committee for review.
2. Acquire final approval(s) as outlined above.

8. Review of Policies

Each policy is reviewed every year to ensure adherence to applicable Federal and State laws, OIG compliance guidance, and HIPAA privacy and security regulations.

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[1] *Instances of noncompliance must be determined on a case-by-case basis. The existence or amount of a monetary loss to a health care program is not solely determinative of whether the conduct should be investigated and reported to governmental authorities. In fact, there may be instances where there is no readily identifiable monetary loss to a health care provider, but corrective actions are still necessary to protect the integrity of the applicable program and its beneficiaries, e.g., where services required by a plan of care are not provided.*

[2] *The practice or hospital may seek advice from its legal counsel to determine the extent of liability, if any, and to plan the appropriate course of action.*

[3] *The OIG has established a Provider Self Disclosure Protocol that encourages providers to voluntarily report suspected fraud. The concept of voluntary self-disclosure is premised on recognition that the Government alone cannot protect the integrity of the Medicare and other Federal health care programs. Health care providers must be willing to police themselves, correct underlying problems, and work with the Government to resolve these matters. The Provider Self-Disclosure Protocol can be located on the OIG's web site at: www.hhs.gov/oig.*

Follow-up Visits and Medical Necessity

E&M Follow-Up Visits and Medical Necessity (InPatient and OutPatient)

Per the AMA Current Procedural Terminology (CPT®), follow-up visits for outpatient visits (99211-99215), inpatient visits (99231-99233), and follow-up observation services (99224-99226) require only 2 of 3 elements (history, exam and medical decision making (MDM)), as opposed to new patient encounters which require 3 of 3 elements.

However, since a follow up visit can qualify for a level (3) visit with History and Exam alone, and no consideration of medical necessity, it is questionable whether this coding methodology truly reflects the acuity and level of care provided during the visit. Especially considering that it has been demonstrated, via Medicare audits of follow up visits, that medical necessity is a critical element of every chart when assessing the level of service.

Therefore, effective immediately, all follow-up visits must be coded by AdvantEdge coders with MDM as 1 of the 2 elements utilized for code selection.

For example, if a chart contained the following documentation:

History= Comprehensive
Exam = Comprehensive
MDM= Moderate

CPT based coding (no longer utilized by AdvantEdge) would be:

CPT Guidelines

Outpatient:	99215
Inpatient:	99233
Observation Follow-up:	99226

The correct coding would be:

Coding Based on Medical Necessity

Outpatient:	99214
Inpatient:	99232
Observation Follow-up:	99225

CPT is a registered trademark of the American Medical Association.

ICD-9 to ICD-10 Malignant Melanoma of Skin

Diagnosis: Malignant Melanoma of Skin

ICD-9 Code(s): 172.0 – 172.9

Listed Under: Neoplasms 140-239 → Malignant Neoplasm Of Bone, Connective Tissue, Skin, And Breast 170-176 → Malignant melanoma of skin 172-

ICD-10 Code(s) C43.0 – C43.9

Listed Under: Neoplasms C00-D49 → Melanoma and other malignant neoplasms of skin C43-C44 → Malignant melanoma of skin C43-

and,

ICD-10 Code(s) D03.0 – D03.9

Listed Under: Neoplasms C00-D49 → In situ neoplasms D00-D09 →

In ICD-9 coding, malignant melanoma of skin does not recognize the sides of the body and includes in situ diagnoses. ICD-10 recognizes the side of the body and has additional codes for "in situ" diagnoses.

Diagnoses in shaded areas are titles only and are not billable

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description
Malignant Melanoma of skin	**172**	**C43**	**Malignant Melanoma of skin**
		D03	**Melanoma in situ**
Skin of lip	172.0	C43.0	Skin of lip
		D03.0	Melanoma in situ of lip
Skin or eyelid, including canthus	172.1	C43.10	Malignant melanoma of unspecified eyelid, including canthus
		C43.11	Right eyelid, including canthus
		C43.12	Left eyelid, including canthus
		D03.10	Melanoma in situ of eyelid, unspecified eyelid, including canthus
		D03.11	Right eyelid, including canthus
		D03.12	Left eyelid, including canthus
Skin of ear and external auditory canal	172.2	C43.20	Unspec. ear and external auditory canal
		C43.21	Right ear and external auditory canal
		C43.22	Left ear and external auditory canal
		D03.20	Melanoma in situ of unspecified ear and external auditory canal
		D03.21	Right ear and external auditory canal
		D03.22	Left ear and external auditory canal

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description
Other and unspecified parts of face	172.3	C43.30	Unspecified part of face
		C43.31	Nose
		C43.39	Other parts of face
		D03.30	Melanoma in situ of unspecified part of face
		D03.39	Other parts of face
Scalp and Neck	172.4	C43.4	Scalp and Neck
		D03.4	Melanoma in situ of scalp and neck
Trunk, except scrotum	172.5	C43.51	Anal skin
		C43.52	Skin of Breast
		C43.59	Other parts of trunk
		D03.51	Melanoma in situ of anal skin
		D03.52	Skin of Breast
		D03.59	Other parts of trunk
Upper limb, including shoulder	172.6	C43.60	Unspec. upper limb, including shoulder
		C43.61	Right upper limb, including shoulder
		C43.62	Left upper limb, including shoulder
		D03.60	Melanoma in situ, unspec. upper limb, including shoulder
		D03.61	Right upper limb, including shoulder
		D03.62	Left upper limb, including shoulder
Lower limb, including hip	172.7	C43.70	Unspecified lower limb, including hip
		C43.71	Right lower limb, including hip
		C43.72	Left lower limb, including hip
		D03.70	Melanoma in situ, unspecified lower limb, including hip
		D03.71	Right lower limb, including hip
		D03.72	Left lower limb, including hip
Other specified parts of skin	172.8	C43.8	Overlapping sites of skin
		D03.8	Melanoma in situ of other sites
Site unspecified	172.9	C43.9	Site unspecified
		D03.9	Melanoma in situ, unspecified