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Reimbursement 2013

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Agenda

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

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Disclaimer

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

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Medicare Physician Payment Basics

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

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

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SGR Update

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

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SEQUESTRATION!

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

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Specialty Impact (w/o Sequester)

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

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

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

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GPCIs

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

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Radiation Takes A Hit

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

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MPFS 2013

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

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

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Primary Care and Care Coordination 2013

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

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Transitional Care Coordination 2013

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

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Use of the Codes 99495-99496

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

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Molecular Pathology Codes

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

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Preventive Services

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

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MPFS 2013

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

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

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MPFS 2013

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

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DME Face-To-Face Requirement

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

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

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

HOPPS 2013

HOPPS Rule

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

Select APC Payment Rates

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

Medicare Physician Fee Schedule

PQRS and E-Prescribing 2012

COMPARISON OVERVIEW – EHR, eRx and PQRS

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

PQRS 2013

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

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PQRS 2013

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

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PQRS Reporting

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

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A Measures Group for Oncology!

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

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Want to Report Measures Group?

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

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Why Participate?

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

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Purpose of Database

- 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 physician to optimize performance

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The Data

- Redesigned the Medicare.gov Heathcare Provider Directory into the Physician Compare website
- The Medicare Provider Enrollment, Chain, and Ownership System (PECOS) is used as the underlying data source
- Also using Medicare claims data to ensure only active healthcare professionals included on the site and improve the accuracy of group practice affiliations

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What is on the site now?

- Physician name, gender, addresses, and phone numbers
- Accepting new Medicare patients
- Medical school and clinical training information
- Languages spoken
- Hospital Affiliation
- Affiliation with group practices and other healthcare professionals
- Accept Medicare Assignment

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Timeline

- January 2011 – developed the Physician Compare Website (launched December 30, 2010)
- January 2013 – Implement a plan for making physician performance available on the website
- January 2015 – Report to Congress on the website and develop plans to use the data for consumer choice and value based purchasing
- January 2019 – demonstration project for creating financial incentives for Medicare beneficiaries to use high quality physicians

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Timeline

- 2013
  - PQRS – (2011, 2012)
  - GPRO (group practice reporting option)
  - eRx
  - EHR Incentive Program Participation
  - Board certification status
  - Accepting new Medicare patients

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Timeline

- 2014
  - PQRS Maintenance of Certification Incentive Program
  - 2012 and 2013 PQRS, GPRO, and ACO measures
  - GPRO composite measures
  - Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) data for GPRO's and ACO's – patient experience data
    - 2013 and 2014 surveys for group practices of 100 or more

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Timeline

- 2015
  - Individual Quality Measures
  - Specialty Society Measures

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Quality and Resource Use Report

- Phased approach to creating and distributing feedback reports
- Initial round includes physicians in Iowa, Kansas, Missouri, and Nebraska
- But, will come to you at some point

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Quality and Resource Use Report

- Purpose
  - Enable physicians to compare the quality and cost of your care both within your specialty and all physicians within a region
  - Identify possible components of a payment modifier to provide differential payment amounts based on quality and cost
    - Payment modifier to be phased in beginning in 2015

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Quality and Resource Use Report

- All cost data risk adjusted based on age, gender, Medicaid eligibility, and history of medical conditions
- PQRS data reported
- Cost data based on:
  - Medicare Part A institutional claims – hospital/skilled nursing care
  - Medicare Part B professional services claims

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Quality and Resource Use Report

- Three groups of patients for cost attribution
  - Patients whose care you directed
    - Physician billed 35% or more of all of a patient's outpatient E&M visits
  - Patients whose care you influenced
    - Physician billed fewer than 35% of a patient's outpatient E&M visits but 20% or more of their professional costs (example – surgeon or other "proceduralist")
  - Patients to whose you contributed
    - Physician billed fewer than 35% of a patient's outpatient E&M visits and less than 20% of their total medical professional costs

How It Fits Together

Carrots

2007-2011
- PQRS
- E-Rx
- EHR

Sticks

2012-2015
- E-Rx Penalties
- PQRS Penalties
- EHR Penalties

Carrot Sticks

2015-2017
- Value Modifier

Section 3007 of the Affordable Care Act

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

VM—Quality Tiering

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

Value Modifier Composite

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Value Based Payment Modifier

	Low cost	Average cost	High cost
High quality	+2.0x*	+1.0x*	+0.0%
Average quality	+1.0x*	+0.0%	-0.5%
Low quality	+0.0%	-0.5%	-1.0%

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Bet You Didn't Know…

About The VBM

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

E-Prescribing 2013

E-Prescribing – Incentive & Penalties

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

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E-Prescribing 2012-2013 By EP

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

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

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E-Rx Reporting

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

eRx – Penalties 2013

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

Meaningful Use: Stage 2

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Meaningful Use Stage 2

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

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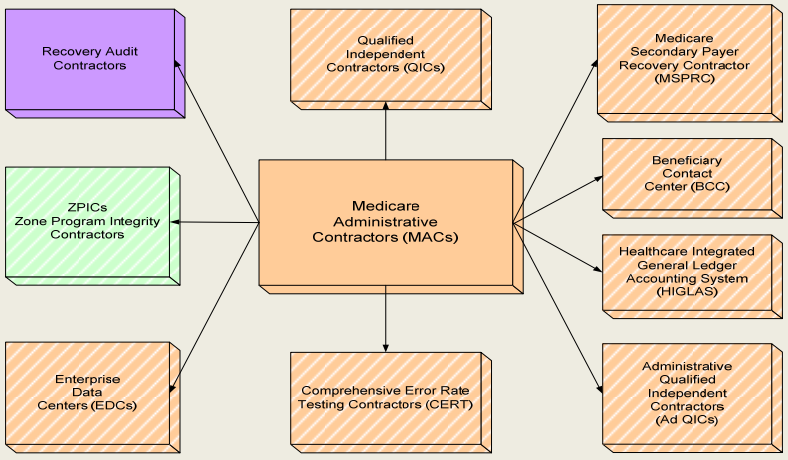
Stage 2 Time Line Through 2017

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

Audit Mania

Medicare Auditing Environment



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Understand Alphabet Soup

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

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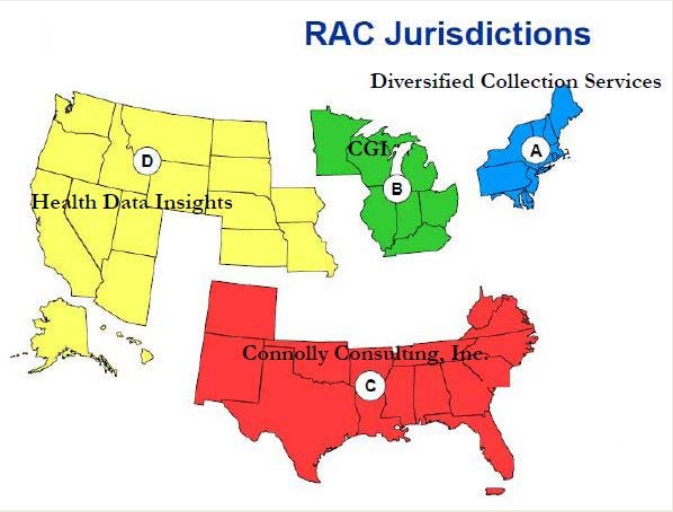

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CERTs Monitor MACs and Feed to RACs

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Comprehensive Error Rate Testing (CERT)

- Designed to monitor performance of MACs and to ensure claims administered properly
- Audits result in annual reports of rate of improper payments made to all providers
- High payment error rates ➔ Part A claim review (hospital) ➔ Part B claim review (physician)

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What Do CERTs Do?

- Randomly select claims processed by a Medicare contractor for CERT medical review
- Request copies of medical records from the provider using the medical review addresses on file in the Fiscal Intermediary Shared System (FISS) and the Multi-Carrier System (MCS)
- Perform the medical review of the claims selected
- Determine accuracy of claim payment
- Determine recoupment of monies if necessary
- Calculate the paid claim error rate
- Report this information to CMS

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What is a CERT error?

- No documentation, no signature
- Insufficient documentation
- Medically unnecessary service

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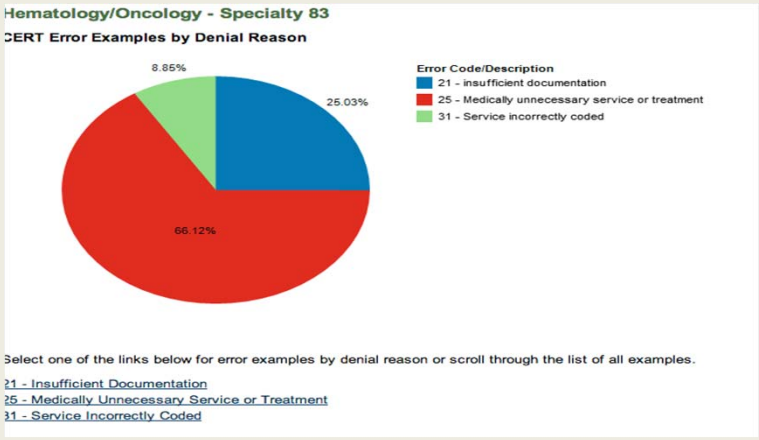
WPS CERT Audits



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CERT 99214: Documentation

Billed CPT 99214. Submitted documentation includes expanded problem focused history, no exam, no medical decision making, no additional workup, planned treatment or time spent was documented. CERT Medical director indicates, "The note documents counseling and coordination of care for multiple questions the beneficiary had and the visit was face to face but no time is documented in the medical record. The MD billed a 99214. The claim line should be denied as insufficiently documented since the service provided is counseling coordination of care but no time is recorded so determining an E/M level based on time and therefore pricing cannot be made"

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Fluids: Documentation

Billed HCPCS J7040 and J7050. These lines billed for normal saline 500 cc and normal saline 250cc. Submitted documentation supports that the saline billed was given as a flush after administration of chemotherapy and prophylactic medication administration. The normal saline is documented as a flush under the Hydration section of the chemotherapy administration sheet and the times given correlate with the chemotherapy and prophylactic medications given for DOS to support the normal saline as a flush. This type of service is included for the chemotherapy administration and is not separately billable.

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Drugs: Medically Unnecessary

Billed CPT 96375, 96413, 96415 and J1720. Chemotherapy (Rituximab) billed on line is denied due to lack of documentation of medical necessity, therefore chemotherapy adjuncts and administration of medications are not reasonable and necessary due to lack of a valid order.

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Give The Money Back!

- If you believe that an overpayment has been made, you can notify Medicare in one of the three ways. Regardless of how you notify Medicare of the overpayment, you must provide the following information:
  - Provider name and number
  - Beneficiary's Health Insurance Claim (HIC) number(s)
  - Claim number(s)
  - Reason for overpayment
  - Amount of overpayment
  - Method of repayment
  - Copy of the primary insurance Explanation of Benefits (Medicare Secondary Payer (MSP) situations only)
  - If you do or do not have a Corporate Integrity Agreement with the Office Inspector General (OIG)
  - If you are or are not participating in an OIG Self-Disclosure Protocol

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MAC May Get The Information

- By phone
- By mail
- Just by sending the $$

CPT Changes 2013

Transitional Care Codes

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

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

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

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

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

***--Not paid by Medicare**

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TCM Codes (CPT Definition)

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

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Some CPT Changes

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

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Some CPT Changes

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

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Some CPT changes

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

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Some CPT Changes

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

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New Lab Codes

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

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New Lab codes

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

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New Vaccine Codes

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

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New HCPCS 2013

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

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To Do List

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

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THANK YOU FROM ONPOINT ONCOLOGY LLC!