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MEDICARE RULES



Fee schedule final rule brings new opportunities and risks in 2016

Expect to be paid for advance care planning in 2016, along with mostly stable Medicare payment rates and a host of new pay-for-performance measures, according to an analysis of the Physician Fee Schedule (PFS) final rule by *The Business of Medicine*.

The overall Medicare conversion factor for 2016 is \$35.8279. In 2015, the conversion factor was \$35.7547 for the first six months of the year and \$35.9335 from July 1 to the end of the year. **Remember:** The conversion factor is the dollar amount that relative value units (RVUs) are multiplied by to generate the bottom-line payment amount under Medicare's formula.

Payments were supposed to increase by 0.5% each year under the law passed by Congress that also repealed the longstanding Sustainable Growth Rate (SGR) formula. However, the lower conversion factor for 2016 reflects a budget neutrality adjustment of -0.2%, along with another negative adjustment for misvalued codes in 2016 under the "Achieving a Better Life Experience" or ABLE Act of 2014.

Let's take a look at the other highlights of the 2016 final rule, which was unveiled by CMS on Nov. 2.

- **Payment for advance care planning.** In 2016, CMS will implement two new CPT codes (**99497** and **99498**) that describe the provision of advance care planning services. CPT 99497 (advance care planning, including the explanation and discussion of advance directives such as standard forms by the physician, first 30 minutes, face-to-face with patient, family member, and/or surrogate) has a work RVU of 1.50 which puts it at the same payment rate as a level established patient visit (**99214**). CPT 99498 is for each additional 30 minutes of advance care planning and has a slightly lower RVU of 1.40. Under the 2016 conversion factor, 99497 would pay about \$108.50 and 99498 would yield \$104.90, though the exact amount will depend on your geographic location.

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- **Advance care planning can be billed as standalone services.** The term “advance care planning” is usually associated with either the “Welcome to Medicare” visit and the Annual Wellness Visit (AWV). CMS will pay for 99497 and 99498 as standalone services, or on the same day as any E/M service. If the advance care planning is performed as part of the Welcome to Medicare or AWV service, 99497 and 99498 are separately billable and should be reported with **modifier 33** (preventive service) to ensure your patients won’t get hit with a copay for it.

Value-based payment modifier. The Value-Based Payment Modifier (VBPM) program is part of Medicare’s shift from fee-for-service to pay-for-performance. The VBPM gives physicians payment incentives for better outcomes and efficient care, while penalizing physicians who underperform with negative payment adjustments. The 2016 PFS finalizes a proposal to apply the VBPM to non-physician providers (NPPs) such as physician assistants and nurse practitioners, starting with the 2018 payment adjustment period. For details on VBPM, check out our in-depth story on pg. 4.

- **Physician Compare program.** Another pay-for-performance initiative is the Physician Compare website, which uses star ratings to represent provider performance across a variety of metrics. “Benchmarks are important to ensuring that the quality data published on Physician Compare are accurately understood,” CMS writes in its fact sheet on the 2016 PFS final rule. Under the final rule,

providers will have five-star ratings that are intended to give patients a quick way to assess their quality.

- **New exceptions to Stark Law.** Also known as the physician self-referral law, Stark is getting new exceptions in 2016. The first will allow hospitals, federally qualified health centers and rural health clinics to pay physicians who employ NPPs. The 2016 final rule also creates a new exception for timeshare arrangements where hospitals or physician organizations share support staff, office space, equipment, supplies, and other items with physicians.

Remember, this article is intended to serve only as a high-level overview of the many changes coming in 2016 thanks to the PFS final rule. Look for more detailed guidance on topics such as the advance care planning codes and the Stark Law exceptions in future issues of *The Business of Medicine*.

— Grant Huang, CPC, CPMA (ghuang@drsmgmt.com). The author is Director of Content at DoctorsManagement.

CODING

ICD-10 impact to date: Slower workflow but no denials spike

One full month into the ICD-10-CM era, denial rates have remained steady but providers have seen a major jump in the time required to find diagnosis codes, administrators tell *The Business of Medicine*. The addition of two digits and much greater specificity compared to ICD-9 means that coders often have to query providers for more information.

“It instantly caused a disruption in the workflow when physicians aren’t used to documenting the new key words they need, and coders have to come back and review the charts to make sure we get it right,” says Michael Floyd, MBA, ATC, administrative director of Heartland Orthopedic in Alexandria, Minn.

The eight-physician practice, which also employs six non-physician practitioners, has just fired off its first volley of claims with ICD-10 for dates of service on and after Oct. 1. Elsewhere in the county health system that Heartland belongs to, ICD-10 claims have been submitted without a hitch, Floyd reports. Denials have occurred at approximately the same rate as before, he says.



Doug Driver retires from DoctorsManagement

We congratulate Doug Driver, a partner at DoctorsManagement, as he starts a new chapter in his life. Doug has been in the trenches as a DM Senior Management

Consultant since 2004. While we are sad to lose him as a colleague, we wish him well in all of his future plans (and we might be a little jealous of those good times ahead!). The DoctorsManagement team is deeply grateful for Doug’s contributions over the years and we hope to continue the great relationships he has built with his many customers over the past 11 years. Here’s to you, Doug!

Nationwide, the first month of ICD-10 has gone smoothly, says Robert Tennant, director of health information technology policy for the Medical Group Management Association (MGMA) in Washington. “The reports coming out of the clearinghouses are pretty consistent that, at least on the front end of claims processing, things are going pretty well,” he says. “The overall claims volume has stayed pretty steady and there haven’t been a lot of disruptions.”

While things could change now that the focus is shifting from initial claims submission to claims payment, Tennant is cautiously optimistic. “I think providers really got the message this summer that another delay was not forthcoming,” he says. “They took it to heart and knuckled down.”

Forget the ‘grace period’

While your Medicare claims won’t be denied for lack of specificity during the one-year grace period offered by CMS, you absolutely have to be using ICD-10 diagnosis codes on all services with a date of service on or after Oct. 1. **Note:** Most payers have local coverage determinations (LCDs) that demand highly detailed ICD-10 codes for specific services, and thus you could see denials if you don’t code to the highest level of specificity for such services.

Some private payers will honor the CMS grace period, but most won’t. The best strategy is to pretend there isn’t a grace period, Floyd says. “Our philosophy has been ‘grace period or not, let’s just get it right from the start.’ If we’re going to make a change, let’s not make it half-hearted.”

Physicians at his practice have done their homework in terms of ICD-10 training and education, Floyd acknowledges that it will take time before they become familiar enough with ICD-10 codes to make their accounts receivable process as fast as it was before Oct. 1. Floyd estimates the switch to ICD-10 will add an additional two weeks to their A/R cycle. Between ICD-10, the Medicare meaningful use program for EHRs, and the Medicare Physician Quality Reporting System (PQRS), his physicians feel like they’re being pulled away from clinical work. “There’s this constant feeling that it’s not about what they’re doing in the exam room, it’s about if they’re saying the correct phrases and marking the correct boxes,” he says.

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Meaningful use: CMS offers 2015 hardship exemption

You can breathe a little easier if you aren’t on track to report your meaningful use measures for Stage 2 in 2015, now that the year is drawing to a close. In [a recent frequently asked question \(FAQ\) posted online](#), CMS is allowing all providers to apply for a hardship exemption for 2015.

The agency all but admitted that the late publication of the Stage 2 modifications rule (which was actually incorporated into the recently released Stage 3 final rule) may have left many providers in limbo as to whether they would be able to meet Stage 2 attestation requirements, which previously required reporting measures for the entire year instead of 90 days. The full exchange is below:

Q: If an EP, eligible hospital or Critical Access Hospital (CAH) is unable to effectively plan for a reporting period in 2015 due to the timing

of the publication of the 2015 through 2017 Modifications final rule, can they apply for a hardship exception?

A: Yes, if a provider is unable to meet the requirements of meaningful use for an EHR reporting period in 2015 for reasons related to the timing of the publication of the final rule, a provider may apply for a hardship exemption under the “extreme and uncontrollable” circumstances category. Each hardship exemption application will be reviewed on a case-by-case basis, as required by law.

CMS notes that, in the past, it has usually approved exemptions for providers who apply. The agency estimates it has approved more than 85% of past exemptions. **Note:** The application form for these will be available in early 2016 at <https://www.cms.gov/EHRIncentivePrograms>.



Value-based purchasing rule gets closer in 2016

Physician groups with two or more eligible practitioners, as well as certain types of non-physician practitioners, will all be subject to value-based payment adjustments based on 2016

performance. CMS announced in the Medicare Physician Fee Schedule final rule.

The expanded eligibility for the value-based payment modifier (VBP) means the actual payment hits will be felt by providers in 2018, but the amounts will be based on 2016 data. Any adjustments made to 2016 payments will be based on data from the 2014 calendar year.

The VBP, first implemented in 2013, is designed to reward or penalize physician groups, divided by tax identification number (TIN), based on the quality and cost of care provided to Medicare patients. It's been gradually expanded, having initially applied only to groups with 100 or more eligible providers.

The Medicare Access & CHIP Reauthorization Act (MACRA) of 2015 will ultimately phase out the individual VBP program in 2018, making it part of a larger Medicare Incentive Payment System (MIPS) that includes the

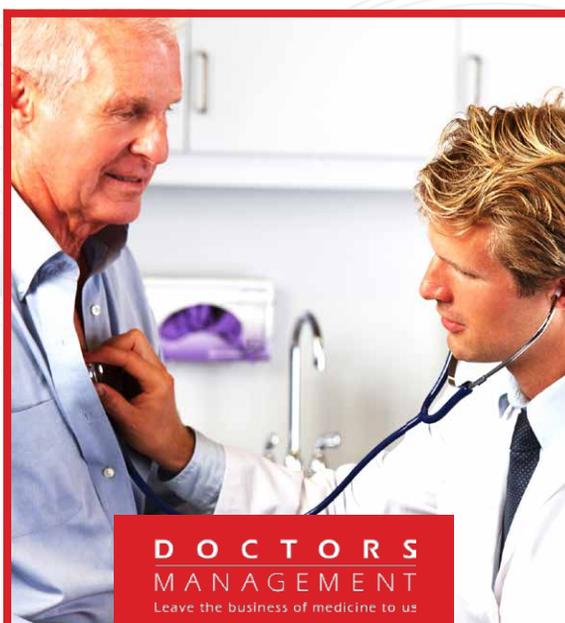
Physician Quality Reporting System (PQRS) and Electronic Health Record (EHR) incentives.

A quick refresher on VBP: It sets metrics, based on practice size, patient population, provider specialty and service mix, for the mean costs of furnishing care to Medicare patients. The performance of individual groups is detailed through Quality Use Resource Reports (QRURs), made available twice a year, that show performance compared to other groups.

After the data is collected, a payment adjustment factor is created and groups of 10 or more physicians may earn as much as four times the payment adjustment factor; smaller groups may earn as much as two times the adjustment factor. Poorly performing groups of 10 or more providers can lose as much as 4% of payments; smaller groups as much as 2%. Previously, the division of groups was 100 or more providers and 10 to 99 providers.

Here are the key changes being made by CMS to the 2016 program, which will be reflected in 2018 payments:

- The VBP will apply to these non-physician practitioners: Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists, when they are part of a group of two or more eligible providers or when they are in solo practice.
- Quality-tiering will be applied to groups of all sizes to include both upward, neutral and downward



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adjustments in 2018. Currently, only groups of 10 or more providers may see downward adjustments. In 2018, only PAs, NPs, CNSs, and CRNAs in groups consisting entirely of non-physician EPs and PAs, NPs, CNSs, and CRNAs who are solo practitioners will be ineligible for downward adjustments.

- The maximum upward adjustment for the CY 2018 Value Modifier will be four times the to be determined adjustment factor for groups of physicians with ten or more EPs; two times an adjustment factor, for groups of physicians with between two to nine EPs and physician solo practitioners; and two times an adjustment factor for groups that consist of non-physician providers and solo practitioners who are PAs, NPs, CNSs, and CRNAs.
- The potential payment risk will be a 4% cut for groups of physicians with ten or more EPs; 2% cut for groups of physicians with between two to nine EPs and physician solo practitioners, and 2% cut for groups of non-physician EPs and solo practitioners who are PAs, NPs, CNSs, and CRNAs.
- The value modifier will be waived for groups and solo practitioners if at least one eligible provider in the group who bills for services in 2016 is part of the Pioneer ACO Model, Comprehensive Primary Care Initiative (CPCI), or other similar Innovation Center model (such as Comprehensive ESRD Care Initiative, Oncology Care Model (OCM), and the Next Generation ACO Model) during the performance period.
- Starting with the 2017 payment adjustment period, the minimum episode side for increased Medicare spending per beneficiary measure will increase to 125 episodes for all groups and solo practitioners. The All-Cause Hospital Readmissions measure is being dropped from the quality composite calculation for solo providers and groups of nine or fewer providers.
- A downward payment adjustment will not be automatically applied to TINs that don't meet the criteria for the downward adjustment under the PQRS, when an informal PQRS review shows that at least 50% of eligible providers in the TIN meet criteria to avoid a downward payment adjustment. Groups initially determined to have not met the criteria to avoid the PQRS downward payment adjustments and initially subject to the automatic

downward adjustment under the Value Modifier would likely not yield data to have their quality composite calculated. These providers would be classified as "average quality."

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COMPLIANCE



Can you bill E/M services with screening colonoscopies?

A common but persistent coding quandry involves the billing of an E/M visit with a screening colonoscopy. This issue is a major one for gastroenterology practices, where providers frequently perform colonoscopies and scheduling a pre-op visit is a common practice.

The answer isn't widely understood because CMS has never addressed this specific scenario in its official guidance. There's also the issue of a screening colonoscopy vs. a surveillance colonoscopy (also referred to as a "diagnostic" colonoscopy), which further muddies these already murky waters. In this article we'll fully explore this scenario and offer what we believe to be the answer best supported by the published guidance, with an eye toward minimizing any compliance risks.

In a nutshell: An E/M visit for a patient *with no active symptoms* who is being scheduled for a *screening* colonoscopy is not separately billable. Trying to separately bill the E/M using modifier 25 (significant, separate E/M service) is inappropriate.

The sources for this logic are the Medicare Claims Processing Manual, Chapter 18, Section 60, entitled "Preventive and Screening Services," and also the National Correct Coding Initiative and the CMS Global Surgery Fact Sheet. All of these sources tell us that the pre-op evaluation for minor surgical procedures, a category that encompasses screening colonoscopies, is always included in the work for the procedures themselves.

You'll find, unsurprisingly, that many GI physicians aren't fans of this interpretation. Often, the screening is being

scheduled for a new patient, and thus the physicians perform a history and physical exam, in addition to answering patient questions and concerns about the procedure itself.

We can only stress that when a patient – new or established – presents without any active problems or complaints and is only in the office for a pre-op visit prior to a screening colonoscopy, CMS and most private payers *simply will not cover a separate E/M* service. Trying to bill for a service under these circumstances poses a significant compliance risk and, while you may get paid by using modifier 25 on the E/M, all it takes is a single complex review to overturn every case.

Surveillance colonoscopies

There is, however, a major exception to this rule and it has to do with colonoscopies that are not screening (i.e. preventive) in nature, but those that are diagnostic.

Exception to the rule: If the patient has a personal history of colon cancer or related GI disease, then a pre-op E/M is supported, even if the patient happens to be asymptomatic at the time of the exam.

Let's look at the distinction between screening and surveillance colonoscopies. A colonoscopy is classified as "screening" if it is being performed every 10 years for asymptomatic patients age 50-75 who have:

- No history of colon cancer, or
- no history of polyps, or
- no history of gastrointestinal disease.

A colonoscopy is classified as "surveillance" if it is being performed for patients who have:

- A personal history of colon cancer, or
- a personal history of colonic polyps
- a personal history of gastrointestinal disease.

Note: The crucial factor that makes a colonoscopy "surveillance" is personal and not family history. Patients who have a first-degree relative (e.g. mother, father) with colorectal and/or adenomatous cancer are considered to be at higher risk, but their colonoscopies would still be considered screening and *not* surveillance.

A second exception: Remember that our guidance refers to patients presenting without any active problems, who are asymptomatic. If patients have a chief complaint and some sort of problem or symptom, the E/M visit is fully justified based on those issues.

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HUMAN RESOURCES



IRS updates retirement plan requirements for employers

The IRS has been busy when it comes to the Employee Plans Compliance Resolution System (EPCRS). In March, it released Revenue Procedure 2015-27 that overhauled the correction process for overpayments. Then in early April, the IRS released Rev. Proc. 2015-28. Effective April 2, 2015 the document describes updated Self-Correction Program ("SCP") procedures that will provide relief to plan sponsors who fail to correctly implement employee elective deferrals.

Prior to April 2, 2015, if a plan sponsor failed to remit elective deferrals for any employees, the procedure under the SCP would require it to make a Qualified Nonelective Employer Contribution ("QNEC") in the amount of 50% of the missed deferral amount, make up any missed match contributions and the lost earnings on the full amount of the missed deferral (not the 50% QNEC) as well as the match contribution. Many industry groups and plan sponsors viewed this as a windfall to employees due to the fact the employee still received the monies via payroll (although after taxes and not set aside in a qualified plan arrangement). There are two new safe harbor methods depending on the means of enrollment employed by the plan.

Failure to implement automatic enrollment

If a plan sponsor fails to effectuate contributions pursuant to either automatic enrollment or automatic escalation plan design features, there will no longer be a 50% QNEC if the following conditions are met:

1. The failure does not extend beyond a 9 ½ month period following the end of the plan year (which aligns with the filing deadline for the Form 5500, including automatic extensions).
2. Deferrals begin, at the correct date, at the earlier of:
 - a. The first payroll following the date above, or
 - b. The first payroll following the end of the month after the plan administrator receives notice of the failure from the affected participant.
3. The plan sponsor must notify affected participants no later than 45 days following the date the correct deferrals begin. This notice is intended for participant to be able to change their deferral rates to make up the missed contributions.
4. The plan sponsor must make a QNEC for missed match contributions, plus earnings no later than the end of the second plan year following the year in which the failure first occurred.

In addition to the above, the IRS changed the way lost earnings are calculated. Going forward, if a participant did not make an affirmative investment election, the earnings may be based on the default investment option, provided that any cumulative losses will not result in a reduced QNEC.

Failure to implement elective deferral election

The IRS changed the procedure for elective deferral failures as well with the implementation of a 3-month rolling period for corrections. There will be no QNEC required for failures under the following:

Deferrals begin by the earlier of: a.) The first pay period on or after a 3-month period that begins when the failure first occurred, or b.) The first payroll following the end of the month after the plan administrator receives notice of the failure from the affected participant.

1. The plan sponsor must notify affected participants no later than 45 days following the date the correct deferrals begin (same as above for automatic enrollment plans).
2. The plan sponsor must make a QNEC for missed match contributions, plus earnings no later than the end of the second plan year following the year in which the failure first occurred.

For failures that extend beyond the rolling 3-month period described above, but corrected by the last day of the second plan year following the plan year in which the error occurred, a plan sponsor may make a 25% QNEC rather than a 50% QNEC (subject to the other requirements listed above).

The two correction methods may overlap. For example, if a participant opts out of an automatic enrollment in favor of a different deferral rate, any error would still be available for the safe harbor correction method described for automatic contribution arrangements above. However, if that same participant changed the deferral rate a year later, it would appear a correction would fall under the second correction method for elective deferrals.

This relief is available immediately and is additionally available for corrections of failures that occurred prior to April 2, 2015. There is currently a sunset provision of December 31, 2020 built into the revenue procedure, although that period can be extended.

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GI group, MD	Staples Advantage Account
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