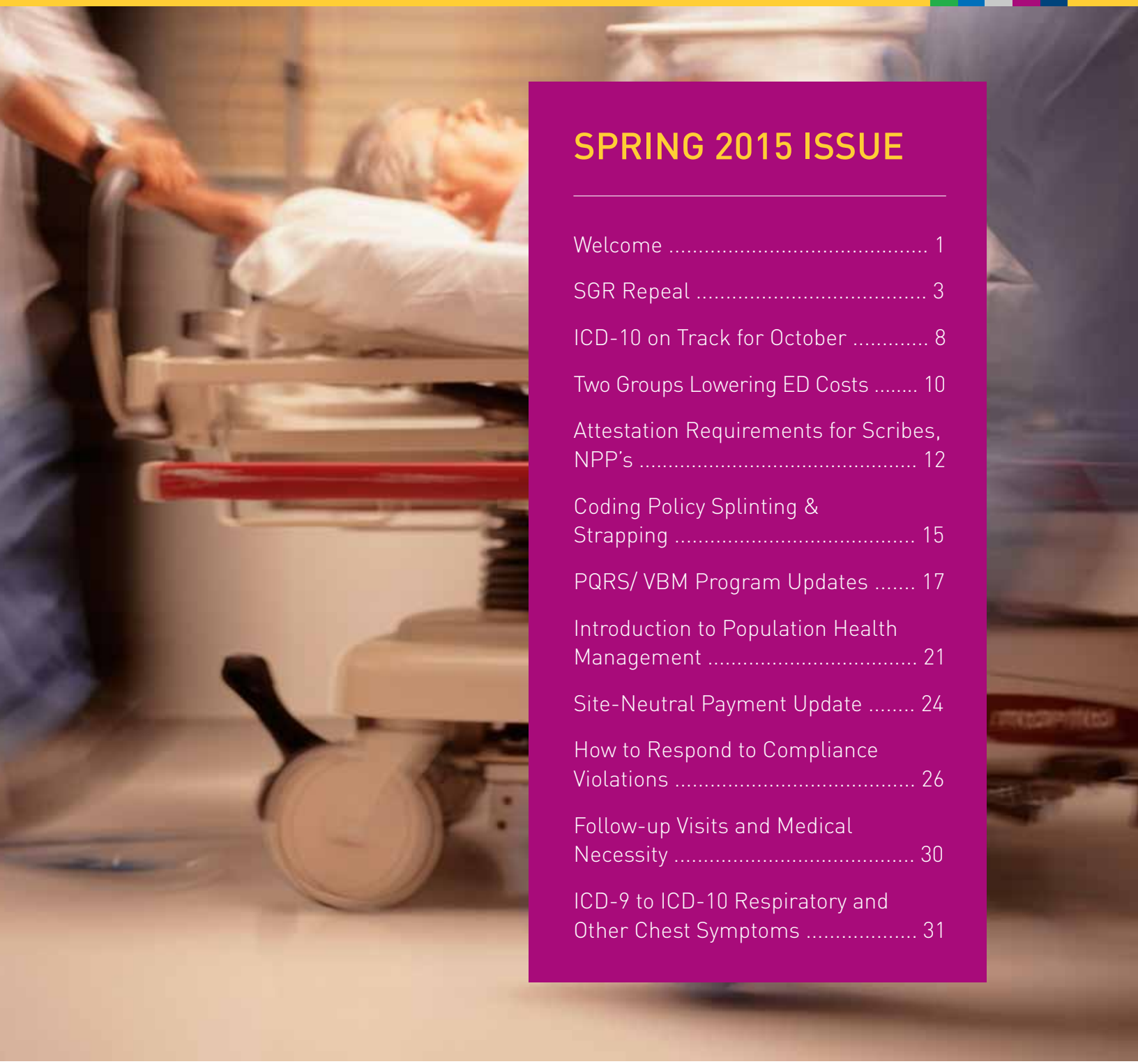
THE LEADING EDGE



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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: respiratory and other chest symptoms).

Our article on ER costs highlights 2 recent studies of young people under the age of 26 and Medicare patients enrolled in patient-centered medical homes that show a slight reduction in the number of emergency room visits, particularly for less-severe situations.

The next article highlights important coding criteria for splinting and strapping.

And we provide an update on the PQRS and VBM (Value Based Modifier) programs: each group and department should have its measures in place in order to avoid future reimbursement penalties.

Moving 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 important reminders about attestations needed when using a scribe or supervising a resident, an outline of how a Compliance Program should deal with violations when they occur and when/how follow-up visits can be coded and billed.

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.

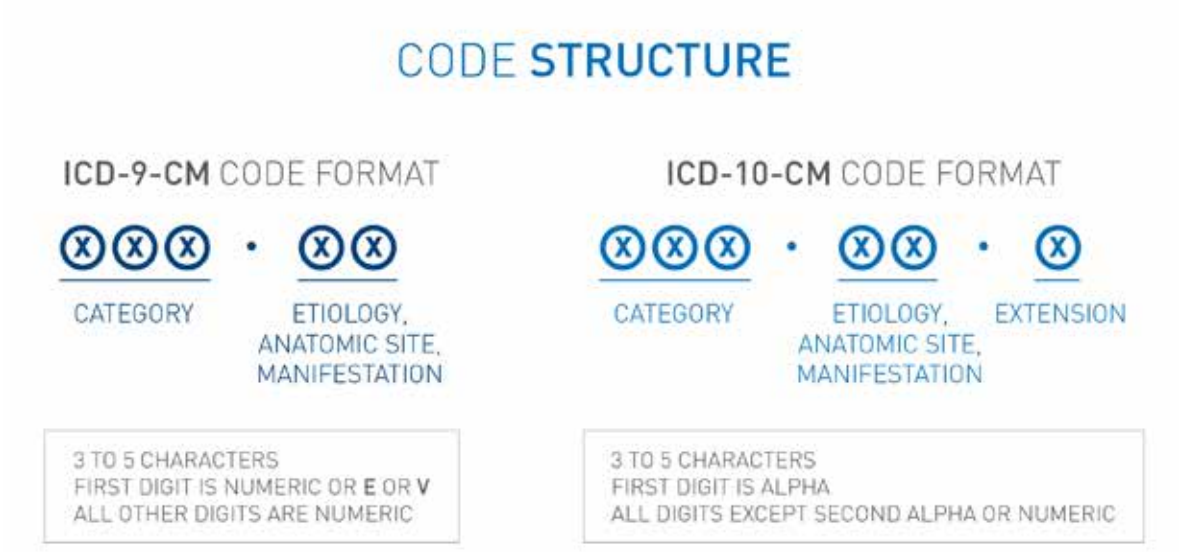
The Secretary has the authority to delay a portion of payment for services with a 10 and 90-day global period to incentivize reporting of information. The Secretary can cease the collection of information from surgeons once the needed information can be obtained through other mechanisms, such as clinical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

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.

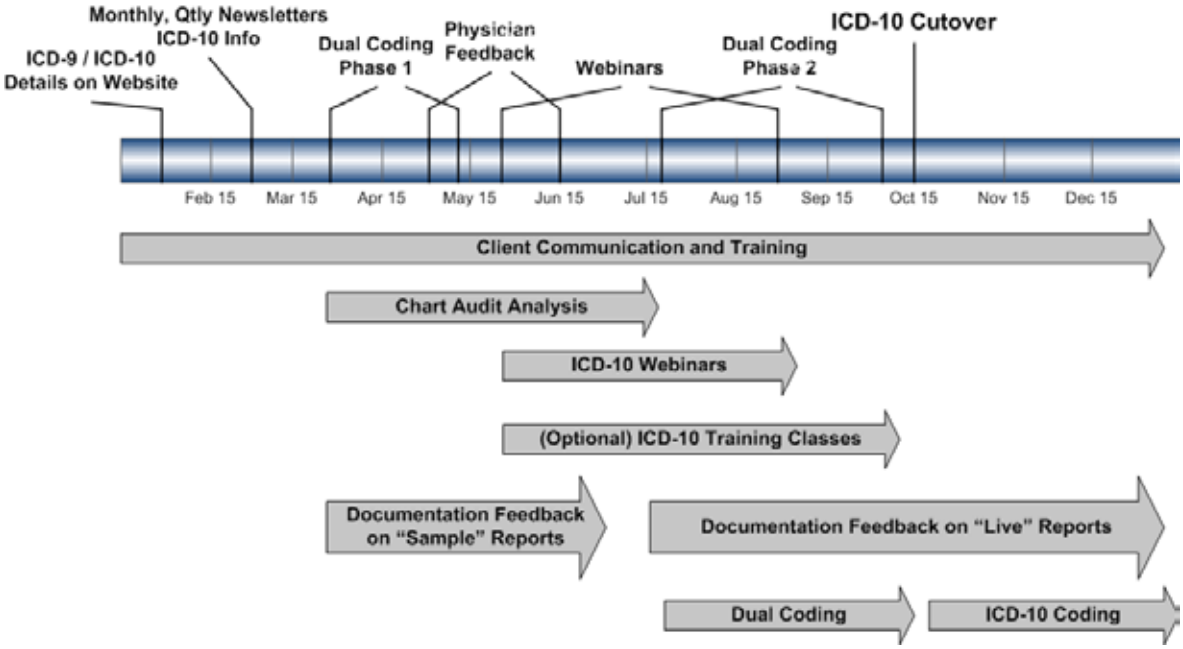
Most of us know that ICD-10 represents a larger set of diagnosis codes (69,000 vs. 14,000) that provide much more specificity including designations for anatomic site, visit specific information, technology, etc.



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.

Two Groups Lowering ER Costs

Two groups of people may be contributing to lower costs in the emergency room. The groups — young people under the age of 26 and Medicare patients enrolled in federally designated patient-centered medical homes — showed a slight reduction in the number of emergency room visits. While the studies did reveal fewer ER visits, it also found no change in ER visits that lead to hospitalization — the most expensive of ER trips.

Young People

A study published in the Annals of Emergency Medicine in March 2015, shows that following the implementation of the Affordable Care Act, the annual rate of emergency department visits by young adults age 19 to 25 decreased by 1.6 percent per 1,000 population in 2011. The study attributes the decrease in visits, in part, because the ACA allowed young adults to stay on their parents' insurance plan until age 26, enabling them to seek medical care outside of the ER. Previous to the ACA mandate, young adults had the highest uninsured rate of any age group but studies have confirmed that with the increased health insurance coverage, approximately 3% to 7% of young adults nationwide have gained insurance coverage.

The analysis compared this group of young adults with slightly older adults aged 27 to 29 years (control group), before and after the implementation of the law. The decrease represents 191,000 fewer emergency department visits among young people in this age group. The data showed decreases in weekday visits, non-urgent conditions, and conditions that could be treated in places other than the emergency room.

Another smaller study [1], published in September 2014, found similar results. The study was performed in three states – California, Florida and New York with a similar age group comparison (young adults ages 19-25 and older adults ages 26-31). Comparison was also done before and after the ACA provision and showed the younger group had a decrease of 2.7 ED visits per 1,000 patients, a relative change of -2.1%. The largest decrease was found in women (-3%) and blacks (-3.4%) with a total reduction of 60,000 ER visits in 2011.

Medicare Patients

The other study examined the rate of emergency department visits and hospitalizations for Medicare patients treated by patient-centered medical homes (PCMH). From 2008 to 2010, outpatient emergency department visits grew more slowly for Medicare patients being treated by PCMH practices than by non-PCMH practices. The rate of growth per 100 PCMH beneficiaries was 13 visits fewer for 2009 and 12 visits fewer for 2010. There was no effect on rates of inpatient hospitalization.[2]

According to Maria Raven, M.D. who critiqued the study, the investigators' findings represent an important contribution to the debate about how EDs can best fit into a delivery system that prioritizes efficiency and coordination of care across multiple settings. The patient-centered medical home model aims to reinvent primary care, making it "accessible, continuous, comprehensive, and coordinated and delivered in the context of family and community. In other words, the patient-centered medical home model aims to deliver the right care in the right

place at the right time. It follows that one measure of success for patient-centered medical homes would be ED visit reductions".[3]

However, she also indicated that it is not clear that alternative sites of outpatient care can deliver the type of off-hours access and range of services that are available in EDs, especially at standard outpatient reimbursement rates. It is overly simple to equate the cost of an ED visit identified as "primary care treatable" according to a discharge diagnosis to the cost of a visit with the same diagnosis in another setting. Recent work indicates that outpatient providers rely on EDs as a place to refer patients who require complex evaluations or other treatments that cannot be accomplished in a clinic.

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[1] Hernandez-Boussard, et al., The Affordable Care Act Reduces Emergency Department Use by Young Adults: Evidence from Three States," *Health Affairs*, September 2014, Vol. 33, No.9.
[2] Pines, Jesse,et al, "Emergency Department and Inpatient Hospital Use by Medicare Beneficiaries in Patient-Centered Medical Homes, *Annals of Emergency Medicine*, March 10, 2015
[3] Raven, Maria C., "Patient-Centered Medical Homes May Reduce Emergency Department Use: What Does This Tell Us?" *Annals of Emergency Medicine*, March 13, 2015.

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.

CODING Policy Splinting & Strapping

Splinting, strapping and casting are frequently performed in emergency rooms before a patient is sent to an orthopedist or other physician. Following is the AdvantEdge Corporate Compliance Coding Policy for Splinting and Strapping. This policy will be followed by our coders when coding for these services performed in the emergency department.

SPLINTS: Splints are non-circumferential immobilizers and allow for swelling in the initial phase. Splinting is useful for a variety of acute orthopedic conditions such as fractures, reduced joint dislocations, sprains, severe soft tissue injuries. Some examples include: knee immobilizer, posterior splint, Jones dressing, etc.

To determine if a splint is long versus short:

- If splint covers 1 joint = short
- If splint covers 2 joints = long
    - For example, a stirrup splint (Sugar Tong) splint applied to the upper extremity = long arm splint, since the splint covers both the wrist and elbow; unless provider documentation specifies otherwise.
    - A stirrup splint (Sugar Tong) applied to the lower extremity = short leg splint, since the splint covers only the ankle; unless provider documentation specifies otherwise.
    - Another example is a knee immobilizer; it covers one joint (knee) so it is considered a short leg splint.

STRAPPING: Strapping is the application of overlapping strips of adhesive tape to an extremity or body area to exert pressure and hold a structure in place, performed in the treatment of strains, sprains, dislocations, and certain fractures. Straps are utilized for support of the injury or for simple immobilization. Strapping codes are selected based on the anatomical area to which strapping is applied. Some examples of strapping include ace wrap, clavicle strap, Figure of 8, sling & swathe, post-op shoe, etc.

Note:

- **Medicare:** the provider must personally place the splint/strapping device as Medicare does not recognize Incident-to Services.
- **All Other Payors:** The provider must personally document application of the device **or participation** (observe, assist, supervise, or review) in the device placement in order for the procedure to be coded and billed under the provider's name, i.e., if an RN or tech places the device and the provider documents a neurovascular status post-application, the application is billable.
- Casting, splinting, and strapping are included in the orthopedic procedure package when a definitive orthopedic code is used. However, often the emergency provider examines and diagnoses an orthopedic injury, and must temporarily treat the injury with a splint or strap until the orthopedist sees the patient in the Emergency Department, or soon thereafter in the office. When this occurs, the codes for the Evaluation and Management Service and the splint/strap service may both be identified.
- A sling & swathe is a billable service (as noted in the strapping section above) due to the method in which the device must be applied; it requires the knowledge of the provider to

confirm accurate application. Please note: Simple slings (ex: shoulder sling, arm sling) are NOT billable services.

Examples of splints & strapping with corresponding CPT® code, if applicable;

Supply	Code
Cast – Cast Application	29049-29425
Splint-Splint Application	29105-29515
Buddy Taping	Not Coded
Clavicle Strap – Strapping	29240
Cervical Collar- soft foam/ stiff neck	Not Coded
Durabracer/3D Walker/Equalizer Boot-Splint	29505-29515
Figure 8 thumb-Splint	29130
Jones Dressing- Splint	29105-29515
Knee Immobilizer- Splint	29505
Shoulder Immobilizer-Splint	29105
Sling	Not Coded
Sling and Swathe –Strapping	29240
Swede brace/Splint – Splint	29105-29515
Thumb Spica- Splint	29130
Unna Boot –Strapping	29580
Dennis Brown Splint-Strapping	29590

CASTS: Casting involves circumferential application of plaster or fiberglass that completely immobilizes the affected area. Refer to the CPT manual to determine the most accurate code.

OTHER CASTING SERVICES: There are times based on the patient's clinical presentation where a provider may be required to remove or bivalve, window, or wedge a cast. In these situations, per complete documentation by the provider, services may be coded as listed. Please see the CPT manual for the appropriate codes.

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PQRS/ VBM Program Updates

In our winter edition of the Leading Edge, we published an article about the importance of participating in the Physician Quality Reporting System (PQRS) and the Value-based Modifier (VBM) programs for 2015 and presented a chart of recommended measures for emergency medicine physicians (EMPs). Since that time, CMS has published the MAV (Measure-Applicability Validation) requirements and clusters for 2015.

We have updated the recommended PQRS measures by including an additional measure, MAV cluster information, and a listing of all the PQRS denominator codes associated with each measure. You will find the updated PQRS Listing here.

Here we reiterate some basic information about the PQRS program but also provide information on the MAV process and clusters associated with our suggested EMP PQRS measures. Information in this article is based on *individual EP* reporting via the *claims-based or qualified registry* reporting methods only.

PQRS and Value-Based Modifier Penalties

Medicare reimbursement in 2017 will be affected by PQRS/VBM reporting for 2015.

- The VBM quality assessments are based on PQRS data, so EPs must successfully participate in PQRS to avoid the VBM penalties in 2017.
- PQRS: -2% penalty for not fully participating
- VBM: Physician groups up to 9 physicians: additional -2% penalty for not participating; potential for 0 to +2x% for participants based on quality/cost performance (where x is TBD)
- VBM: Physician groups with over 9 physicians: additional -4% penalty for not participating; potential for -4% to +4x% for participants based on quality/cost performance (where x is TBD)

Reportable Measures Update

PQRS Reporting Information

- Eligible professionals (EPS) must report a minimum of 9 measures across three NQS domains for at least 50% of the EPs Medicare Part B FFS patients.
- And, if the EP sees at least one Medicare patient in a face-to-face encounter, one of the. reported measures needs to be a measure from the new cross-cutting measure set.
- Those EPs who do not have 9 measures to report will go through the MAV process for CMS to verify that the EP submitted the maximum number of measures that he/she performs.
- CMS will no longer give EPs "an out" to avoid the penalty. In 2014, EPs only needed to report 3 measures to avoid the penalty but not qualify for the incentive.

EMP Measures and Cross-cutting Measures:

- Our chart originally suggested 21 different measures applicable to emergency medicine physicians. We have added an additional measure to the chart, #317 (see below), for 22 suggested measures. **Please note: There may be other measures that could be reported depending on your practice.**

EMPs should review all available measures before finally deciding on reportable measures.
- Measures 46, 111 and 226 are only available to those eligible professionals (EPs) that bill outpatient E&M CPT codes (99201 – 99215)

As part of the 9 measures to be reported across 3 domains, one cross-cutting measure must be reported for EPs who perform face-to-face services with their patients. Practices that perform Evaluation and Management (E/M) services as well as some procedure services will need to report one of these measures. Click here for a listing of all available cross-cutting measures.

We had suggested 2 cross-cutting measures:

- 46 – Medication Reconciliation: Percentage of patients aged 18 years and older discharged from any inpatient facility (eg, hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge
- 226 – Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

The American College of Emergency Physicians has also suggested measure #317:

- 317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Documented.

Measure Applicability Validation (MAV) Process

- An eligible provider may satisfy PQRS and avoid the penalty by reporting on less than 9 measures, subject to the MAV process to determine whether he/she reported as many measures as are applicable, and if they could have reported on any cross-cutting measures.
- Emergency physicians should be careful of reporting on any measures outside of their cluster as reporting additional measures may trigger additional clusters. The chart indicates which clusters, if any, each measure belongs to.

MAV Clusters – Claims-Based Reporting

MAV Clusters are measures related to a particular clinical topic or individual EP service that is applicable to a specific, individual EP or group practice. EPs who report less than 9 measures must determine if those measures are part of a MAV cluster. If the measures are part of a cluster, then the EP must report all the other measures within that cluster if they perform the CPT codes within those measures.

The following are measures that have been suggested for emergency medicine physicians to report for PQRS but are also contained in MAV clusters.

Claims-based Reporting

EMP Measures contained in Clusters with measures outside of the EMP recommended measures.

- Measure #226 is part of Cluster 5 which requires reporting 6 additional measures outside the EMP measures. (This is a cross-cutting measure)
- Measure #s 1, 117, 119, and 163 are part of Cluster 2, which also requires reporting measure #128, which is outside the EMP measures..

The following two Clusters are made up of measures within the EMP suggested measures.

Cluster 4 – Emergency Care

- #54 – Emergency Medicine: 12 Lead Electrocardiogram(ECG) Performed for Non-Traumatic Chest Pain
- #254 – Ultrasound Determination of Pregnant Location for Pregnant Patients with Abdominal Pain
- #255 – Rh Immunoglobulin (Rhogram) for Rh-Negative Pregnant Women at Risk of Fetal Blood Exposure
- A cross-cutting measure, if performed, would also have to be reported in addition to the above three measures.

Cluster 7 – Ear, Nose & Throat Care

- #91 – Acute Otitis External(AOE): Topical Therapy – Clinical Effectiveness
- #93 – Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use
- A cross-cutting measure, if performed, would also have to be reported in addition to the above two measures.

Qualified Registry Reporting

EMP Measures contained in Clusters with measures outside of the EMP recommended measures

- Measures #1 & #119 are part of Cluster 2, which requires reporting 2 measures, plus one which is outside the EMP measures
- #226 is part of Clusters 4, 5,10, 18,27,28 all of which have additional measures outside the EMP measures
- Measures # 331, 332, 333 are part of Cluster 13, which has one other measure outside the EMP measures

The following two Clusters are made up of measures within the EMP suggested measures.

Cluster 11 – Appropriate Test/Treatment for Children

- #65: Appropriate Treatment for Children with Upper Respiratory Infection(URI)
- #66: Appropriate Testing for Children with Pharyngitis
- A cross-cutting measure, if performed, would also have to be reported in addition to the above two measures.

Cluster 12 – Acute Otitis Externa

- #91 – Acute Otitis External(AOE): Topical Therapy – Clinical Effectiveness
- #93 – Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use
- A cross-cutting measure, if performed, would also have to be reported in addition to the above two measures.

Our clients should review their measures with their Client Managers to determine which measures will be reported for 2015. If you have not done this yet, it is important to do so as soon as possible in order to report on at least 50% of Medicare Fee-for-service patients.

Resources

Other resources are available for more information about these Medicare incentive programs.

2015 PQRS Basics

2015 Value-Based Modifier Basics

ACEP – PQRS/MAV Information

CMS Quality Reporting System

CMS – MAV Process

CMS Value-Based Modifier Program

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.

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.

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

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ICD-9 to ICD-10: Respiratory and Other Chest Symptoms

Diagnosis: Symptoms Involving Respiratory System and Other Chest Symptoms

ICD-9 Code(s): 786.00 – 786.2

Listed Under: Symptoms, Signs, And Ill-Defined Conditions 780-799 → Symptoms 780-789 → Symptoms involving respiratory system and other chest symptoms 786

ICD-10 Code(s) R06.0 – R06.9

Listed Under: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified R00-R99 → Symptoms and signs involving the circulatory and respiratory systems R00-R09 → Abnormalities of breathing R06

Diagnoses in shaded areas are titles only and are not billable

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description
Dyspnea and respiratory abnormalities	**786**	**R06.0**	**Abnormalities of breathing**
Respiratory Abnormality, Unspecified	786.00	R06.9	Unspecified abnormalities of breathing
Hyperventilation	786.01	R06.4	Hyperventilation
Orthopnea	786.02	R06.01	Orthopnea
Apnea	786.03	R06.81	Apnea, not elsewhere classified
Cheyne-Stokes respiration	786.04	R06.3	Periodic Breathing
Shortness of breath	786.05	R06.02	Shortness of breath
Tachypnea	786.06	R06.82	Tachypnea, not elsewhere classified
Wheezing	786.07	R06.2	Wheezing
Other respiratory	786.09	R06.00	Dyspnea, Unspecified
		R06.09	Other forms of dyspnea
		R06.3	Periodic Breathing
		R06.83	Snoring
		R06.89	Other abnormalities of breathing