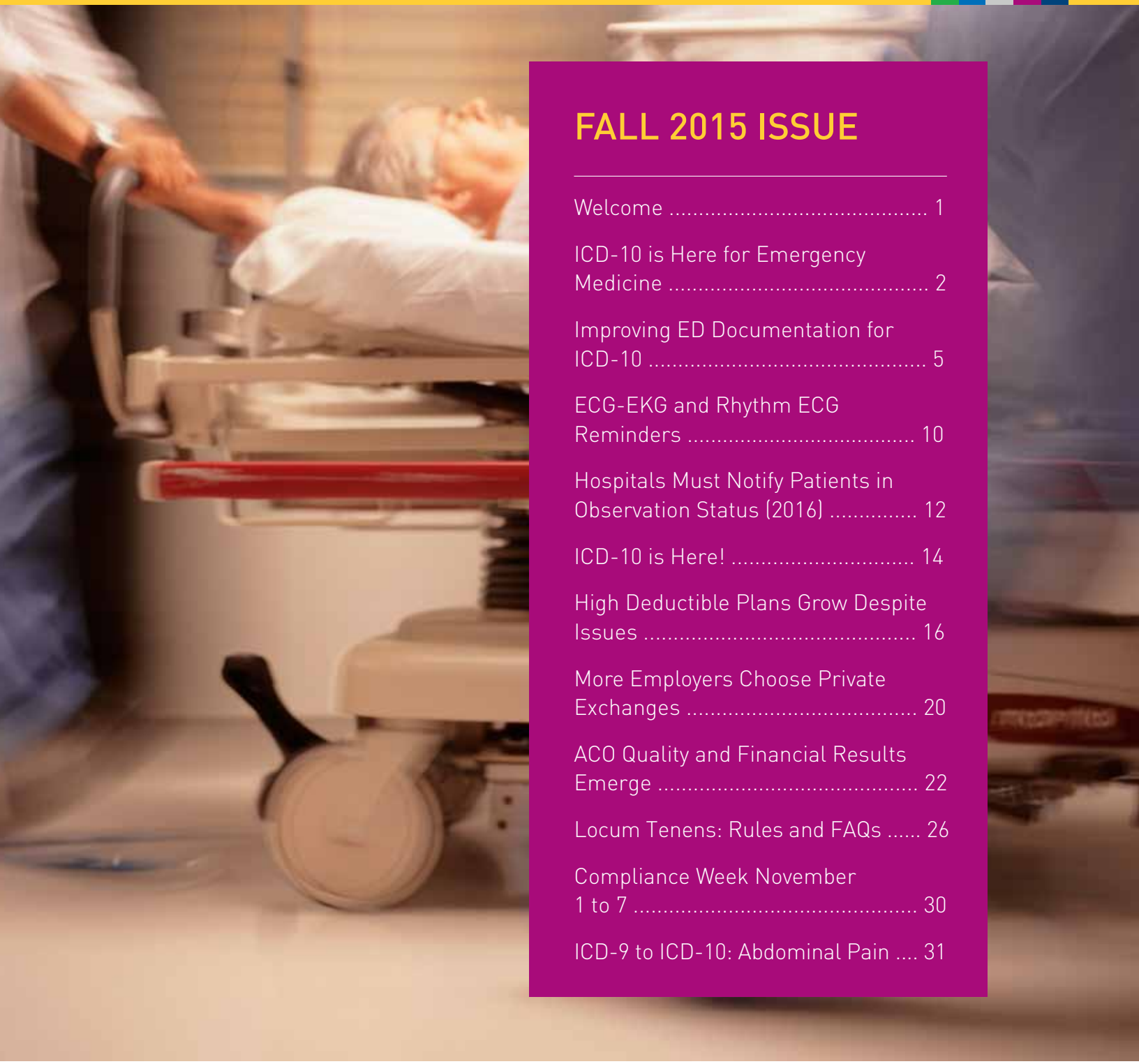
THE LEADING EDGE



FALL 2015 ISSUE

THE LEADING EDGE

Welcome!

This edition of the Leading Edge starts with a focus on ICD-10. As our ICD-10 Feature describes, October 1 is only the beginning and we won't really know the impacts until later this month and perhaps longer. In "ICD-10 is Here for Emergency Medicine", we provide documentation guidelines that we hope you will find helpful. Plus we continue our series of ICD-9 to ICD-10 comparisons.

There is now an ICD-10 Hotline and ICD-10 Survival Kit on our website. We encourage and invite ICD-10 questions and issues.

In other articles, we describe (thanks to AHIMA) how to improve ED documentation for ICD-10, particularly for injuries and the challenges around probable vs. definitive diagnoses. We also have documentation reminders for ECG-EKG and Rhythm EKG, given how common they are and the high incidence of associated denials.

We also call your attention to recent legislation that says, starting a year from now, hospitals must notify patients when they are in "observation status."

Our features concentrate on forces changing the insurance and reimbursement landscape, starting with Private Healthcare Exchanges. Employers are increasingly adopting them as a way to offer more choices to employees and retirees while better managing health insurance costs.

High deductible health insurance plans are growing rapidly, both in exchange and employer plans. We explain why even more seem inevitable. Unfortunately, evidence shows that some consumers don't understand these plans. This leads to unpaid deductibles and to patients skipping important needed care because of the cost.

Our last feature describes where ACO's are today. Recent CMS data shows savings, but only for some ACO's. But CMS priority to expand "alternative payment models" has led to more flexible Medicare ACO rules. And private ACO's continue to expand.

You can print any article in this newsletter as a PDF and there is a PDF "button" to download the entire newsletter for email or printing.

We appreciate your feedback and suggestions. Please call or email me with comments and topics: bgilbert@ahsrcm.com and (908) 279-8120.

Bill Gilbert

ICD-10 is Here for Emergency Medicine

The entire healthcare and emergency medicine industry has been preparing for ICD-10 for years. Now that it is here, are hospitals, ER practices and payers ready? We are in the middle of answering that question.

We do know that, like everyone else, over the past 3+ years, AdvantEdge has devoted a lot of time and resources to get ready. This includes our Coding teams, our systems and our entire staff. Most important, it includes work done with each client.

Each member of the AdvantEdge coding team is certified through one of the national certification bodies, i.e. AAPC or AHIMA, and each has demonstrated their understanding of ICD-10 CM code application by obtaining their proficiency from the accrediting bodies. Just as important, over the past several months, each coding team member has been hard at work gaining hands-on practical experience in using the ICD-10 resources to apply the appropriate codes.

The AdvantEdge billing system has been tested extensively with every payer that offered a test schedule and is ready to go.

ED Documentation Reminders

For ER physicians, here are some general documentation reminders:

- Think about how you are currently documenting – Are you
    - Saying which side the problem is on/where it is located? i.e. Right vs. Left
        - Capturing more detail for common situations? e.g. for chest pain
        - Intercostal
        - Precordial
        - Pleurodynia
    - Telling the coding teams if it is the first time this problem is being treated (initial episode of care) or is it something that has been treated before?
- Using the information provided by your client manager that indicates your most highly utilized diagnosis codes to make sure you understand what is needed to have the specifics needed to code accurately.
- Over the coming, months our goal is to work together to enhance your documentation, if needed, so that unspecified codes are reduced as much as possible (since it is widely expected that most payers will eventually deny most unspecified codes where a more detailed code is available).

An overview of emergency medicine documentation requirements is shown here.

ICD-9 Diagnosis	ICD-9 Description	Documentation Issues								
		Laterality	Episode of Care	Acute/ Chronic	Anatomical Site Specificity	Patient History	Injury How / What	Trimester	ICD-10	Documentation Suggestions
303.00	Acute Alcohol Intoxication					X			F10.229	• Abuse • Dependence
787.91	Gastroenteritis Viral			X	X				K52.89	• Type • Area of GI tract affected
382.9	Otitis Media	X		X		X			H66.90	• Serous • Allergic
786.50	Chest pain; Unspecified				X				R07.9	• Intercostal • Precordial • Pleurodynia
486	Pneumonia	X			X				J18.9	• Organism if known
813.05	Comminuted Displaced Fx RT Elbow radial head	X	X		X		X		S52.123A	
959.01	Head Injury		X			X	X		S09.8XXA	
845.00	Ankle Sprain	X	X		X		X		S93.409A	• ID specific anatomical structures involved
780.97	Altered Mental Status								R40.4 – Send Back if Only DX	
463	Acute Tonsillitis		X						J03.90	• Recurrent • Type (ulcerative, etc.)
493.92	Asthma Unspecified			X		X			J45.901	• Mild; Moderate; Severe • Status Asthmaticus v. Exacerbation
844.9	Knee Sprain, Elbow Contusion	X	X		X		X		S83.90XA	ID specific anatomical structures involved
789.00	Abdominal Pain; Unspecified				X			X	R10.9	• Quadrant
401.9	Hypertension; Unspecified					X			I10	• Other underlying disease if applicable
780.2	Syncope					X			R55	
599.0	Urinary Tract Infection								N39.0	• With v. without hematuria • Organism

To understand how common ICD-9 codes map or "cross walk" to ICD-10 codes, see our Emergency Medicine ICD-9/ICD-10 Mapping document.

As always, your Client Manager is available to answer questions and assist with the transition. In addition, we've added an ICD-10 Hotline to the AdvantEdge website.

Other reminders

ICD-10 was effective October 1 for everyone:

- **The good news:** any issues will be identified quickly and many people and organizations will be responding.
- **The bad news:** the cutover may slow payer response times and affect provider or coder productivity during the transition.

CMS and the AMA recently announced a "grace period" of one year – what does that mean? Basically that claims will not be denied if they are not as specific as ICD-10 codes allow, as long as a valid ICD-10 code is used. Here is some of the CMS and AMA language:

- For 12 months, Medicare review contractors **will not deny** physician or other practitioner claims based solely on the specificity of the ICD-10 diagnosis code—as long as the physician / practitioner used a "valid code" from the right "family" of codes."
- Medicare claims with a date of service on or after October 1, 2015, **will be rejected** if they do not contain a valid ICD-10 code.
- "Family of codes" is the same as the ICD-10 three-character category. Codes within a category are clinically related and provide differences in capturing specific information on the type of condition. For instance, category H25 (Age-related cataract) contains a number of specific codes that capture information on the type of cataract as well as information on the eye involved. Examples include: H25.031 (Anterior subcapsular polar age-related cataract, right eye), which has six characters; H25.22 (Age-related cataract, morgagnian type, left eye), which has five characters; and H25.9 (Unspecified age-related cataract), which has four characters. **One must report a valid code and not a category number. In many instances, the code will require more than 3 characters in order to be valid.**

Source: Clarifying Questions and Answers Related to the July 6, 2015 CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities

Improving ED Documentation for ICD-10

Approaches to Improve Emergency Department Documentation

Taking the right steps now will allow hospitals to improve emergency department documentation and adequately prepare for the future implementation of ICD-10-CM coding.

By Mary H. Stanfill, MBI, RHIA, CCS, CCS-P, FAHIMA

Originally published by AHIMA *Journal of AHIMA* 83, no.6 (June 2012): 38-41.

Obtaining the sufficient clinical documentation needed to support code assignment is a challenge in ICD-9-CM today. This challenge is expected to become even more problematic, however, with the increased specificity of ICD-10-CM—particularly for emergency department coding. This article explores multiple steps hospitals can take now to improve emergency department documentation in preparation for coding with ICD-10-CM.

Emergency department physicians focus on addressing acute symptoms; consequently, emergency department documentation reflects signs and symptoms as well as multiple differential diagnoses, but is often vague when it comes to more definitive diagnoses. The outpatient guidelines section of the Official ICD-9-CM Guidelines for Coding and Reporting apply to emergency department visits for patients who are discharged, which means coding professionals cannot code differential diagnoses (possible/probable conditions).[1] For this reason it's important for emergency department physicians to connect signs and symptoms to a definitive diagnosis.

Conversely, for patients admitted to the hospital through the emergency department, coding professionals need clinical documentation from the emergency department that clearly states possible/probable diagnoses, rather than merely listing acute symptoms. Thus, there are known challenges and clinical documentation gaps for ICD-9-CM coding of emergency department visits today. These documentation issues will still be a concern for correct code assignment with ICD-10-CM. In addition, the increased specificity and detail in ICD-10-CM codes is expected to be particularly relevant for the types of conditions treated in the emergency department. For example, the injury chapter in ICD-10-CM is one of the sections that were significantly revised, and the signs and symptoms chapter was greatly expanded to allow classification of symptoms with much more detail. Specific examples are shown in Table 1.

Table 1. Differentiating Documentation for Correct Code Assignment

The Injury chapter in ICD-10-CM was significantly revised and the signs and symptoms chapter was expanded to allow classification of symptoms with much more detail. This table illustrates the resulting difference in coding description from ICD-9 compared to ICD-10.

ICD-9-CM	ICD-10-CM
813.42 Other fractures of distal end of radius (alone) Documentation: site, open or closed	**S52.502A** Unspecified fracture of the lower end of left radius, initial encounter for closed fracture Documentation: site including laterality, open or closed, displaced or non-displaced, episode of care
847.0 Sprains and strains of other and unspecified parts of back; neck Documentation: site	**S13.4xxA** Sprain of ligaments of cervical spine **S16.1xxA** Strain of muscle, fascia and tendon at neck level, initial encounter Documentation: site; distinction as to sprain (ligament) or strain (muscle, tendon)

Impact of New Codes

As Table 1 illustrates, increased clinical documentation will be needed to code fractures in ICD-10-CM. Clinical documentation in emergency department records typically includes laterality, but documentation of the site of a fracture is often more vague than ICD-10-CM codes, and the distinction of displaced vs. non-displaced is often not documented. The second example in the table illustrates the differences in the code sets for sprains and strains, another frequent emergency room condition. In ICD-9-CM sprains and strains are classified to the same code; there is no distinction. However, in ICD-10-CM they are classified separately. For example, a *sprain* of the cervical area is assigned to subcategory S13.4, while a *strain* of the cervical area is classified in subcategory S16.1. So it will be important to differentiate sprains from strains in emergency department health records to determine which ICD-10-CM code applies. These are just a couple examples to illustrate the impact of ICD-10-CM on emergency department documentation.

Given the impending documentation gaps for ICD-10-CM coding in the emergency department, hospitals should take steps to prepare for ICD-10-CM and mitigate these documentation concerns.

They should begin by analyzing current clinical documentation to identify and prioritize their ICD-10 documentation gaps. This is most easily accomplished by coding a sample of emergency department health records in ICD-10-CM and noting specific documentation gaps as difficulties are encountered during the coding process. The record sample should include emergency department visits that reflect the emergency department's most frequent diagnoses and a sample of each emergency department template that is used to capture clinical documentation. This chart audit will identify specific documentation gaps and help determine where focused interventions will have the greatest impact. To determine approaches to resolve documentation gaps, consider where form changes or system prompts might be employed, what operational changes might impact clinical documentation, and where training might be needed.

Applying Template Revisions to Comply With ICD-10

Physician documentation in the emergency department is commonly captured via templates. Templates can be paper forms, but increasingly are built into emergency department information systems (EDIS) via system prompts. In either circumstance, physician documentation templates are complaint-driven and designed to capture relevant information for common emergency department conditions, such as chest pain, back pain, upper extremity injury, and upper respiratory infection. The templates are effective in helping physicians record a lot of clinical information quickly. They are intentionally designed to capture the specific elements required for evaluation and management code levels, with explicit language for the history, examination, and medical decision-making components. As a result, the templates are efficient and effective in some respects, but they lack details to prompt documentation of definitive diagnoses.

Once emergency department ICD-10-CM documentation gaps have been identified, this information can be used to determine the specific details that could be added to emergency department templates. For example, the upper extremity injury template likely includes a differential diagnosis of fracture, in addition to that of sprain/strain. Consider how to modify the template to prompt the emergency department physician to specify if a fracture diagnosis is displaced or non-displaced, or how to separate the prompt for sprain from strain. All emergency department templates should be reviewed and analyzed to identify where to build in prompts of additional information that is needed for ICD-10-CM. Once the desired modifications are identified, revise the templates to capture this clinical documentation.

Hospitals with an EDIS should contact the vendor to determine what ICD-10 updates they may already have planned and look for an opportunity to suggest specific changes to emergency department templates. HIM professionals in the hospital should reach out to the director of the emergency department to initiate this exploration of ICD-10 readiness with the EDIS vendor. Collaborate with the emergency department director to fully examine the EDIS vendor's plans for any and all system changes to comply with ICD-10-CM. You'll need to know, for example, what modifications to expect in screens and reporting formats. Use available resources, such as the ICD-10 vendor questionnaire available on the AHIMA website.[2] Also be sure to understand clinical documentation functionality in the EDIS and its capabilities to ensure end users are fully exploiting system functionality to capture clinical documentation.

Operational Impacts and Suggested Preparations

In preparation for ICD-10-CM coding in the emergency department, hospitals should also review outpatient coding policies and procedures with outpatient coding staff. In addition, review the diagnostic coding and reporting guidelines for outpatient services to ensure they are universally understood and applied. The ICD-10-CM official guidelines for coding and reporting are available on the Centers for Disease Control and Prevention Web site, and the outpatient guidelines mirror those that the industry currently follows for ICD-9-CM.[3] For example, outpatient conditions are still coded with ICD-10-CM to the highest degree of certainty, meaning that the working diagnoses or conditions on a list of differential diagnoses are not coded on emergency department outpatient visits.

Coding policies may also need to be updated to prepare for ICD-10-CM in the emergency department. For example, the following guideline is from Section IV.B: "The appropriate codes from A00.0 through T88.9 and Z00 through Z99 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit."[4] It may be helpful to formulate coding policies for consistency in coding and reporting external causes. The codes for external causes were greatly expanded in ICD-10-CM and include codes to describe not only the cause of an injury or condition and the intent, but also much more detail on the place of occurrence and the activity of the patient at the time of the event. Hospitals may want to explore external reporting requirements and set an internal policy on the depth of complexity at which they will capture these codes. This will help identify further potential emergency department ICD-10 documentation gaps. It's important to capture the details surrounding the onset of a condition in the emergency department, as this is the best opportunity to capture this clinical information. Even for patients admitted from the emergency department to inpatient care, details surrounding an event are best found in the emergency department documentation.

Emergency department ICD-10 documentation gaps present a new opportunity for clinical documentation improvement (CDI) specialists to branch into outpatient record review. Established CDI programs are beginning to carve out time specifically for outpatient review. Today, CDI efforts on outpatient records typically focus on areas identified at risk for loss in a charge analysis. For example, injections/infusions and medical necessity documentation to support services provided. But CDI specialists could also assist in meeting ICD-10-CM documentation requirements in the emergency department.

Before launching into outpatient review, the CDI specialist should first spend time in the emergency department to study the clinical workflow. A likely approach is to have CDI specialists schedule time in the emergency department early in the morning to review the charts from the night shift and clarify documentation gaps with the clinical staff before they have completed their shift. This can be repeated again later in the day, at the end of the day shift. In this manner, the CDI specialist can ask for clarification while the clinical staff is still there and the patients are fresh in their minds. For emergency department coding, the focus of the CDI specialist is to ensure clinical documentation suggests a diagnosis, instead of merely symptoms. This offers a great opportunity to begin to build in awareness of the clinical details needed for ICD-10-CM.

ICD-10-CM Training and Understanding

Another approach to prepare for ICD-10-CM and proactively address ICD-10 documentation gaps in the emergency department is to provide training for emergency department physicians. Training should initially provide an overview of ICD-10-CM, highlighting where additional specificity and detail is available in the new codes. Emergency physicians treat a broad spectrum of conditions, from minor infections to major cardiovascular events and trauma. In fact, patients with almost any condition can come into the emergency department. Therefore, emergency department physicians will need to be aware of the significant changes throughout the new code set that will require clinical documentation. Follow this general overview with more focused training to address the specific opportunities and ICD-10 documentation gap priorities that have been identified. Emergency department physicians should also be familiar with revised emergency department templates or EDIS functionality intended to prompt them for diagnosis details. It's also important to help physicians understand the impact their documentation has on the coding and reporting process.

Preparing for ICD-10

Clinical documentation should be as comprehensive as possible to ensure appropriate reimbursement, quality patient care, and a reflection of severity of illness. While unspecified codes are available in ICD-10-CM, unspecified codes impact the completeness of coded data and thus should only be used when no specific code is available or a more exact diagnosis is not yet known. Capturing sufficient clinical documentation to leverage the specificity available in ICD-10-CM will challenge emergency departments. For this reason hospitals should take proactive steps to identify ICD-10 documentation gaps that are physician- and facility-specific, dependent upon documentation habits and user application of templates and forms. They should subsequently prioritize the documentation gaps and plan focused interventions that will have the greatest impact for more complete coded data. Use multiple approaches, including the form or system prompt changes, operational changes, and focused training described in this article. Because it's difficult to change physician documentation habits, documentation improvement requires sufficient lead time to achieve measurable success. Hospitals should begin working now to improve emergency department documentation in preparation for coding with ICD-10-CM.

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[1] Centers for Disease Control and Prevention. "ICD-9-CM Official Guidelines for Coding and Reporting." August 11, 2011. Available online at http://www.cdc.gov/nchs/icd/icd9cm_addenda_guidelines.htm#guidelines.
[2] AHIMA. ICD-10 vendor questionnaire available for download free from http://ahima.org/icd10/resources.aspx (scroll down to "tools").
[3] Centers for Disease Control and Prevention. "ICD-10-CM Official Guidelines for Coding and Reporting." 2012. Available online at http://www.cdc.gov/nchs/icd/icd10cm.htm.
[4] Ibid, p 100 of 113 (2012).

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ECG-EKG & Rhythm ECG Reminders

ECGs and EKGs are often fully or partially denied. In this article, we explain the codes involved and offer advice for documenting these test.

Document what you do

- 12 lead, give a full report and make sure it is identifiable within your note;
- Rhythm strip – document the interpretation, and any decisions for your treatment plan based on this information.
- If you do both a 12 lead and a rhythm strip – it is recommended that the 93010 (more comprehensive code) be reported;
- Most payers deny the 93040 code (rhythm ECG) as being a component of the Evaluation and Management code;
- The group may want to code these for tracking purposes regardless of payer
- Additionally, the payers are likely to pay for only one ECG/EKG.

ECG/EKG codes are separated by the scope of the code

93000 – ECG with at least 12 leads; with interpretation and report;
93005 – Tracing only, without interpretation and report (technical component only)
93010 – Interpretation and report only
93040 – Rhythm ECG; 1-3 leads; interpretation and report only

Instructions for Reporting Electrocardiographic Recording

- Codes 93040-93042 are appropriate when an order for the test is triggered by an event, the rhythm strip is used to help diagnose the presence or absence of an arrhythmia, and a report is generated.
- There must be a specific order for an electrocardiogram or rhythm strip (by the billing physician is acceptable) followed by a separate, signed, written, and retrievable report.
- It is not appropriate to use these codes for reviewing the telemetry monitor strips taken from a monitoring system.
- The need for an electrocardiogram or rhythm strip should be supported by documentation in the patient medical record.

Can I get reimbursed if I bill for rhythm ECG?
Can I bill for both ECG and rhythm ECG interpretation?

- "Rhythm ECG, one to 3-leads; interpretation and report only" is a CPT-defined service (CPT 93040).
    - The potential for reimbursement for this service will depend upon the appropriateness of the service, the quality of documentation, the respective payer's policies, and whether or not the provider must comply with the payer's policies.
- CPT 93010 is defined as an "Electrocardiogram, routine ECG with at least 12-leads; interpretation and report only."
    - If it is generally accepted that a complete CPT 93010 encompasses an interpretation

and report of rhythm, then it would be inappropriate for a single provider to code for both 93010 and 93042 based upon a single 12-lead ECG tracing.

- However, if for a particular patient encounter both 12-lead ECGs and rhythm ECGs were medically necessary, performed, and interpreted by a provider, then CPT principles would allow the provider to code all the appropriate services.
    - Be sure to document each interpretation and report separately, and why serial strips needed to be done

Hospitals Must Notify Patients in Observation Status (2016)

Recent legislation requires hospitals to notify patients when they are placed in observation status and to discuss any expenses associated with care. However, some hospital-based physicians have concerns about the possible consequences.

The legislation was passed by the Senate by unanimous vote on July 27th after swiftly moving through the House of Representatives. It requires hospitals to notify Medicare patients in observation status for more than 24 hours. The legislation also requires notification of potential financial consequences by time of discharge or within 36 hours of discharge. These new requirements become effective on August 7, 2016 (one year from the President's signature).

The Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act requires a written explanation of a Medicare patients' status as an outpatient under observation, an explanation of why they are in that status, as well as an outline of the cost sharing and skilled nursing facility (SNF) implications. The written notification must be made available in appropriate languages and signed by the patient (or legal representative). If a patient or designee declines to sign it, the hospital staff will be responsible for documenting the refusal to sign the notification file.

According to the executive director of the Medicare Payment Advisory Commission (MedPAC) Mark Miller, in addition to the possibility of beneficiaries in observation status being liable for hospital charges for self-administered prescription drugs received in the hospital but not covered by Medicare, they also will not have Medicare coverage of subsequent SNF coverage (which requires three nights as an inpatient).

Hospitals' Concerns

The number of patients treated in observation status has grown significantly in recent years. The June report by MedPAC shows the number of outpatient observation stays increased by 96% from 2006 to 2013, although it is still a small portion of total hospital stays. Simultaneously, there was a 28% decline in the number of one-day inpatient stays, and inpatient stays of two or more days saw a decline of 15%. MedPAC estimates that nearly half of the 2013 decline in inpatient stays can be attributed to the shift from inpatient to observation.

According to Miller, the increasing implementation of observation status by hospitals is an attempt to avoid costly audits and any consequent payment denials by Medicare Recovery Audit Contractors (RACs). Subsequently, this shift led CMS to create a new short-stay payment policy which defers to a physicians' judgment when a two-midnight stay is required and exempts a hospital from RAC audits for stays of at least two midnights (Two-Midnight Rule). Enforcement of the new two-midnight policy is scheduled to begin in January, despite hospital concerns leading to multiple delays in its enforcement (subject to any changes in the final rule to be issued on or around November 1, 2015).

Narrow Utilization

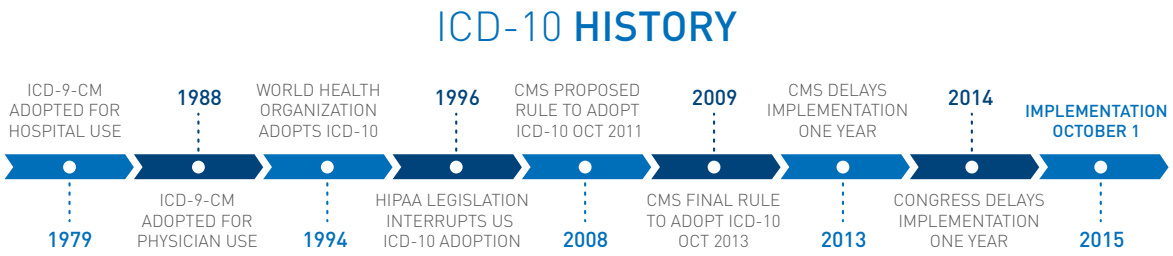
Though a majority of hospitalists are in support of the notification, patients continue to be vastly uninformed of their status. SHM reports that hospitals remain apprehensive since the notifications could fail to alleviate patient cost concerns, in addition to the possibility of causing confusion amongst patients. According to their 2014 survey of hospitalists, SHM found that of the 378 surveyed respondents, 43% did not know if patients were notified of their status and almost 10% reported patients were not notified.

Ann Sheehy, MD, a member of the Public Policy Committee at The Society of Hospital Medicine (SHM), testified at the 2014 Senate Aging Committee hearing that"one of the hardest aspects of observation is when a Medicare patient realizes they are under observation and what that means. Suddenly the anxiety over what they will have to pay out of pocket for hospital and nursing home care becomes an even greater concern for them than the medical problem that brought them in."

A CMS official testified at a May Senate hearing that CMS had previously encouraged hospitals to provide these notifications voluntarily and a number of hospitals have already begun providing status notifications. Connecticut is one of the states requiring notifications and, in an email response, vice president of communications for the Connecticut Hospital Association Michele Sharp commented "implementation of Connecticut's 2014 observation status law went smoothly, as hospitals in the state had already been communicating information to patients about their observation status, both verbally and in written form, even prior to that law."

Source: Daly, Rich, "Congress Passes Requirements for Observation Status Notification, Cost Assessments," *HFMA*, July 30, 2015

ICD-10 is Here!



Now that October 1 has arrived, we know that ICD-10, after years of delay, is real. But the impacts are only starting. Of course, physicians have updated their documentation, EMRs, superbills, etc. And AdvantEdge, like the rest of the industry, has updated its systems to handle the larger code set.

At this point, we don't really know how prepared payers are to accept the new codes. Testing and payers' statements suggest that most claims should be processed without being rejected. But that doesn't tell us how long it might take. Nor does it tell us whether we might see some new denials or other issues (the good news is that there are no new denial codes, existing CARC and RARC codes will continue be used). The bottom line: the cash flow risk to practices, hospitals and others isn't known yet. We should begin to understand the risk, or lack thereof, later this month.

A GAO report about CMS readiness for ICD-10 also concludes that we won't really know until claims are being processed [1].

It's worth noting that Medicare's decision to not require full ICD-10 specificity is a good transition step (for 12 months) but still requires a valid ICD-10 code (see the explanation at the end of this article). At the same time, Medicare just announced that the Guidance ("flexibilities") applies only to Part B Medicare fee-for-service claims, not to Medicare Advantage claims. **"Medicare Advantage risk adjustment payment and audit criteria remain unchanged."** And the HFMA is reporting that "The CMS clarification came amid indications that few private insurers outside of Medicare Advantage would provide the same post-payment flexibility."

We do know that there are many resources to help with getting the right ICD-10 code onto a claim form. As an example, AdvantEdge has the ICD-10 Hotline and Survival Kit available. CMS and many companies have spent the past months (and years) providing detailed suggestions and assistance.

A big issue for most hospital-based physicians and many other specialists is their dependence on the referring/ordering physician to provide enough detail to choose the ICD-10 code. Hopefully, the planning and communication that has been underway will prevent this from becoming a big issue. But many specialists are cautious until the new information flows are sorted.

The issue, of course, is that it hasn't been practical for physicians and other providers to adopt these changes until quite recently. As a result, most are expecting a drop in productivity. How much of a drop is a big unknown. The same applies to coding work.

The good news is that there are indications that the transition won't be as hard as many feared—as long as preparations have been made. For example, as coders have begun to get familiar with using ICD-10, their productivity has picked up rapidly. This is because no coder or physician has to deal with all 69,000 ICD-10 codes, just like they don't deal with all 14,000 ICD-9 codes. Most deal with a relatively small subset.

Of course, at this point in the first week of October, no one really knows whether the transition will be rocky or smooth. We are about to find out!

ICD-10 Reminders

ICD-10 was effective October 1 for everyone:

- **The good news:** any issues will be identified quickly and many people and organizations will be responding.
- **The bad news:** the cutover may slow payer response times and affect provider or coder productivity during the transition.

CMS and the AMA recently announced a "grace period" of one year – what does that mean?

Basically that claims will not be denied if they are not as specific as ICD-10 codes allow, as long as a valid ICD-10 code is used. Here is some of the CMS and AMA language:

- For 12 months, Medicare **will not deny** physician or other practitioner claims based solely on the specificity of the ICD-10 diagnosis code—as long as the physician / practitioner used a "valid code" from the right "family" of codes."
- Medicare claims with a date of service on or after October 1, 2015, **will be rejected** if they do not contain a valid ICD-10 code.
- "Family of codes" is the same as the ICD-10 three-character category. Codes within a category are clinically related and provide differences in capturing specific information on the type of condition. For instance, category H25 (Age-related cataract) contains a number of specific codes that capture information on the type of cataract as well as information on the eye involved. Examples include: H25.031 (Anterior subcapsular polar age-related cataract, right eye), which has six characters; H25.22 (Age-related cataract, morgagnian type, left eye), which has five characters; and H25.9 (Unspecified age-related cataract), which has four characters. **One must report a valid code and not a category number. In many instances, the code will require more than 3 characters in order to be valid.**

Source: Clarifying Questions and Answers Related to the July 6, 2015 CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities

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[1] "While CMS' actions to update, test and validate its systems, and plan for contingencies can help mitigate risks and minimize impacts of system errors, the extent to which any such errors will affect the agency's ability to properly process claims cannot be determined until CMS's systems begin processing ICD-10 codes" (GAO report, September 2015).

High-Deductible Plans Grow Despite Issues

As more consumers opt for lower annual premiums in exchange for larger out-of-pocket expenses, the popularity of High-Deductible Health Plans (HDHP) is increasing. Many are concerned that consumers don't realize the implications of the tradeoff which means providers often need to remind or educate their patients about their new financial obligation. Nonetheless, the trend toward more HDHP's continues.

Employers and healthcare policy makers hope that consumers using HDHPs will help put market forces back into medicine. Part of the logic is that consumers will shop around for lower prices when they have to write the check. To date, there is some, but limited, evidence of this behavior. At the same time, however, there is also evidence that some consumers put off needed care due to the out-of-pocket costs. Also working against price shopping, some HDHPs have "narrow" provider networks.

But the steady upward creep in health insurance deductibles has easily outpaced the average increase in a worker's wages over the last five years, according to a new analysis released on Sept 22 by the Kaiser Family Foundation. Also, there is evidence that deductibles are now causing consumers to forgo needed care, including for chronic conditions.

In response to HDHPs, more and more providers are posting prices on their websites, in addition to publishing quality-performance and customer-satisfaction survey results to allow consumers to make informed choices about their healthcare.

Consumer Impact

According to the Kaiser Study, 81% of workers who receive their insurance through an employer now pay a deductible. And those deductibles have climbed from a yearly average of $900 in 2010 for an individual plan to above $1,300 this year (8% more than last year), while employees working for small businesses have an even higher average of $1,800 a year. One in five workers has a deductible of $2,000 or more. Of course, many of the policies being sold to individuals on the state exchanges also rely on high deductibles to keep premiums low.

At the same time, and partly (some would argue mainly) because of this trend, total premiums are increasing modestly. The cost of a plan for both a single person and a family rose an average of 4 percent this year, according to Kaiser, well below the double-digit increases that were the norm a decade ago. The average cost of a family plan rose to $17,545, with employees paying an average of $5,000 toward their premiums.

But as wages have stagnated, the steady increase in deductibles is squeezing many on HDHPs, with workers feeling increasingly vulnerable to high medical bills. The National Center for Health Statistics reports that, in 2014, 36.9 percent of people under age 65 with private health insurance were enrolled in an HDHP. And the percentage is higher in 2015.

What concerns policy experts and employers is evidence that higher deductibles are making people forgo care, even when they have serious conditions. "It may be tamping down on unnecessary care, but we're seeing a lot of evidence of skimping on necessary care," said Sara

R. Collins, vice president for health care coverage and access at the Commonwealth Fund, a nonprofit group that conducted a survey last fall about the effect of out-of-pocket health care costs on consumers.

Forty percent of people with private health insurance whose deductible equaled 5 percent or more of their income said they had decided not to go to the doctor when they were sick or had chosen not to get a test or go to a specialist, according to the survey.

A recent analysis by Truven Health Analytics of employers' insurance claims showed that companies saw lower utilization, with fewer of their workers going to the doctor or getting lab tests, when workers had a high-deductible plan. But they also saw a decline in care for people with chronic conditions. In some cases, even when preventive care was covered under a high-deductible plan, workers were getting fewer mammograms and cervical cancer screenings. [1]

Employer Incentive

High-deductible plans are on the rise as the option of choice for both employees and employers. In its 2015 Health and Well-being Touchstone Survey, PricewaterhouseCoopers reported that 83% of employers offered a high deductible plan in 2014, rising from 67% in 2014. One-third of employers reported that the high-deductible plan was their most popular.

"There's clearly an incentive on the part of employers to offer these," stated Maribeth Shannon, Program Director at the California Healthcare Foundation in a Dallas Morning News article. "Some of it's financial. Some of it's philosophical. There are a lot of employers who feel employees should have a little skin in the game, a little more responsibility for the healthcare costs they consume."

In addition, the ACA's so-called "Cadillac Tax" on high-value health plans could further fuel the growth of high-deductible plans. But the tax and its implications have been met with decidedly mixed reviews, including proposed legislation to eliminate or reduce the tax. Beginning in 2018, current ACA provisions require employers offering benefit-rich health plans that exceed annual limits to pay a 40% excise tax (over $10,200 for individual coverage and $27,500 for family coverage). The goal of this tax is to help fund the ACA and slow the growth of healthcare costs. However, many employers have begun looking into ways to avoid the tax by scaling back their offerings or increasing deductibles and co-pays.[2]

Over the past two years, several large companies, including J.P. Morgan, Wells Fargo, General Electric and Honeywell, began offering consumer-driven HDHP plans as the only option. Bank of America employees earning more than $100,000 have no choice but to select a consumer-directed high-deductible plan, according to a recent *New York Times* article.

Mercer's 2014 national survey of employer-sponsored health plans, found employers' average cost for a high-deductible plan paired with a tax-advantaged health savings account to be 18% less than a Preferred Provider Organization (PPO). On average, HDHPs cost employers 20% less than a Health Maintenance Organization (HMO). The average cost of HDHPs was $8,789 per employee, compared to $10,664 for PPOs and $11,052 for HMOs.

"While new plan implementations are driving up consumer-directed high-deductible plan

enrollment, we are also seeing growth in enrollment in existing plans as employees become more comfortable with consumerism and employers provide them with tools to help manage the higher deductible," stated Beth Umland, Mercer's Director of Research for Health and Benefits, in a statement that accompanied the announcement of the survey results.

Health Plan Consumerism

Supporters of the shift away from traditional insurance plans acknowledge that "consumerism" in healthcare faces challenges, ranging from decreasing competition in medicine as hospitals and insurers merge, to the potential that high-deductible health plan consumers will forgo needed care due to their out-of-pocket costs.

Currently, patients directly pay 11% of the $3 trillion spent annually on healthcare. As reported in the Wall Street Journal, that is equal to $330 billion, which is more than Americans spend annually on anything other than shelter, food or transportation.

Consumers with high-deductible plans typically pay most of their healthcare costs out-of-pocket until annual deductibles are met. The assumption is that they are more likely to "shop around" and compare prices for office visits, procedures, lab testing and other healthcare services. It comes as no surprise that "When you talk to consumers, they tend to gravitate to the plan with the lowest premium," as stated in a USA Today article by Douglas Ghertner, President of Change Healthcare, a company focused on helping consumers shop for healthcare services. Where consumers have a choice, it is clear that lower monthly premium cost is the main appeal for high-deductible consumer-directed health plans.

It is common to find high-deductible health plans paired with health-savings accounts (HSAs) which allow employees to use pre-tax dollars to pay for medical expenses. (An individual is only eligible for an HSA if their HDHP has single deductibles over $1300 or family deductible over $2600). Of course, annual deductibles of $2,500 or more for an individual employee and $5,000 or more are now common for a plan with in-network doctors and hospitals. Tracy Watts, Mercer's National Leader for Health Care Reform has stated "It's a major shift from the old 'first-dollar coverage' mentality. These tools put the consumers in the driver's seat, giving them the ability to make smart financial decisions about their healthcare spending."

To help employees cope with HDHPs, employers should ensure families with the plans contribute to health-savings accounts. They should also encourage employees to be receptive to trends that increase competition, such as telemedicine, expert second opinions and medical tourism, suggests David Goldhill, President and CEO of Game Show Network, and Paul Howard, Ph.D., Manhattan Institute Senior Fellow and Director of the Manhattan Institute's Center for Medical Progress. "The rise of high-deductible plans also requires a shift in states' priorities. Liberating information on the cost and outcomes of various medical services becomes key. So does reforming laws that restrict nurses' scope of practice, limit corporate practice of medicine, or require certificates of need. Paring back these anticompetitive regulations would encourage capital to flow toward nimble startups challenging overpriced, entrenched providers."

Hospital Impact

Financial risk for hospitals has also begun to shift as patients assume more out-of-pocket responsibility, according to a new report from Crowe Horwath LLP.[3]

For the report, 444 hospitals' transactions were analyzed through June of this year. Since ACA health insurance exchanges opened to extend coverage to millions of previously uninsured Americans in 2013, provider revenue sources have transitioned to more dependable payer reimbursements as the number of uninsured self-pay patients' falls.

According to the analysis, accounts receivable (AR) from insured self-pay patients rose 13% in the last year. They saw a 22% decrease in uninsured self-pay patients over the same period, largely due to the previously uninsured enrolling in Medicaid in states that expanded their programs under ACA. Insured self-pay dollars overshadowed uninsured self-pay dollars 22 to 1 in the first quarter of 2015. But according to the analysis, the fact that average collection amounts for insured self-pay patients are also up slightly between the first quarter of last year and the first quarter of 2015 is even better news. This is because payments from insured self-payers have a much bigger impact on providers' bottom lines than uninsured payments (the 22 to 1 factor).

The Crowe Horwath report warns, "While the uninsured self-pay patient population appears to be performing better from an AR perspective, the expanding insured self-pay patient volume and AR highlights the need for providers to focus on this area of growing financial risk." Providers are encouraged to develop plans aimed at improving the process for collections from patients with more financial responsibility. As an example, for payment plan options for patients who cannot pay the entirety of their initial balances, providers can track self-pay patient collections and use other approaches such as using plan-specific charity care data when negotiating payer contracts and developing policies that provide payment options for patients who cannot pay the entirety of their initial balances.[4]

As powerful economic forces continue to lead more consumers into high-deductible plans and patients seek how to best spend their healthcare dollars; practices, providers, agencies, and hospitals continue to improve their patient (self-pay) collection processes.

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More Employers Choose Private Insurance Exchanges

Building on policy and economic imperatives to contain the growth of healthcare costs, employers and health insurance companies are expanding their use of private health exchanges.

The Affordable Care Act created the concept of a public "insurance exchange" as a new way for individuals and small businesses to buy health insurance. The primary objective is to keep premiums reasonable through competition among insurers and to allow consumers the opportunity to find a health plan that fits their individual needs.

Private exchanges take this idea and extend it to employers. So a private exchange is an online health insurance marketplace for a company's employee base. The difference between an exchange and traditional health insurance is that employees choose from a variety of insurers and plans; unlike traditional plans from one insurer. The mechanics are that employers provide their workers a defined contribution toward the premiums. Employee choices are broader and often include vision and dental options from several participating insurance companies.

Aon PLC (traditionally a provider of insurance and reinsurance brokerage, human resources solutions and HR outsourcing services) now runs private exchanges for corporations. Aon has noted a significant increase in employer interest saying that more employers have approached them about private exchange quotes to see how much money they can save, and more insurance carriers want to be on Aon's private platform. (The impending "Cadillac Tax" is an additional incentive for employers; see our Second Quarter issue for more details). Other HR consulting companies, including Mercer, Towers Watson and Buck Consultants, operate private exchanges, as do some insurers.

The consulting firm Accenture reports that nearly 6 million workers selected health plans through private exchanges for 2015, doubling the number from 2014. Though this is a small portion of the employed market, Accenture predicts 40 million of the approximately 150 million people with employer health insurance will be choosing their plans through private exchanges by 2018. In 2015, Hallmark Cards sought predictability in its healthcare costs and a less complex role in offering health benefits and moved 6,100 full-time, active employees to Aon's fully insured private exchange.[1]

One of the biggest employers to jump into a private exchange, drugstore operator Walgreens Boots Alliance, has used Aon's private exchange for two years now. Of the 200,000 eligible Walgreens employees, nearly three-quarters have chosen a bronze or silver plan, with United-Healthcare enrolling the most members this year. 39% of Walgreens employees making less than $25,000 per year chose a bronze plan, while only 21% of workers with annual salaries above $100,000 picked a bronze plan. Not surprisingly, the price of health plans is a dominant consideration for lower-wage workers.[1]

The growth in private exchanges is not limited to active employees: companies are looking at private exchanges for their retirees, in addition to current staff. The BCBS Association is building an exchange for all of its affiliate plans with the goal of enrolling retired workers in Medicare Advantage, supplemental Medigap policies or Part D prescription drug plans. In 2014, AT&T moved its Medicare-eligible retirees to a private exchange run by Aon.

At the same time, private exchanges remain far from common. Numerous studies and surveys have shown that consumers and employees place more value in their doctors and provider networks than the actual number of coverage choices they have. Companies worry that private exchanges indirectly encourage plans where employees shoulder more out-of-pocket costs and some employers are reluctant to shift their workers into fixed-dollar benefit structures.

Despite this apprehension, those employers who have adopted private exchange plans are noticing a change in engagement amongst employees. In the past, employees would often spend a couple of minutes browsing over their health plan options, or in some cases, ignore the process entirely. The private exchanges have spurred employees to take the annual enrollment period more seriously and to be much more aware of their care options.

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ACO Quality & Financial Results Emerge

Accountable care organizations now cover approximately 23 million lives, according to Leavitt Partners. As ACOs expand there have been growing pains: Recent CMS data shows just one in four ACOs qualified for shared savings in 2014, 27 Medicare Shared Savings Program ACOs discreetly left the program and Pioneer ACOs have dwindled to 19.

Yet interest in ACOs and value-based care persists. In January, an additional 89 MSSP ACOs joined the ranks and 20 major health systems, payers and other stakeholders pledged to convert 75 percent of their business to value-based arrangements by 2020. In March, CMS launched its newest pilot, the Next Generation ACO. The estimated number of ACOs in public and private programs tops 740, according to Leavitt Partners, and if trends continue, ACOs have the potential to cover at least 75 million lives. [1]

In June, CMS released a final rule modifying the Medicare Shared Savings Program (MSSP), impacting the 330 ACOS in 47 states which currently serve 4.9 million Medicare beneficiaries.

Then in August, CMS released the 2014 results for 353 ACOs showing they generated net savings of $411 million in 2014 and improved in most quality measures, although many of ACOs did not generate enough savings to receive bonuses. Kaiser reported that 196 ACOs saved money last year, while 157 cost more than expected. But Kaiser believes the CMS results show the ACO program performing better than it actually is, calculating that the program showed a net loss of $3 million in 2014, vs. the $411 million in savings reported by CMS.

A recent study in the JAMA Internal Medicine by Harvard researchers found that CMS' Pioneer accountable care organizations are reducing the number of services they provide to patients that have minimal clinical benefit, suggesting that the program is having its intended impact.

The Final Rule

The final rule seeks to resolve several issues identified in the proposed rule and it updates payment policies, payment rates, and quality provisions for services furnished on or after January 1, 2016. HHS Secretary Sylvia Mathews Burwell's longer-term vision to move away from FFS put CMS in a position where it needed to retain most of the current MSSP participants and attract new providers. This meant it had no choice but to agree to the most substantive changes requested by provider organizations.

On December 1, 2014, CMS issued a proposed rule that was met with many critical responses on key provisions. Most notably the National Association of ACOs (NAACOS) and the American Hospital Association (AHA) said ACO participation should be more financially rewarding and flexible. The rule allowed MSSP ACOs operating under the lowest-risk Track 1, which involves a one-sided (upside-only) participation agreement, to enter into a similar three-year agreement in the same track if they satisfied the quality criteria and did not generate losses greater than the negative minimum savings rate in at least one of their first two performance years. Although the final rule removed the requirement that ACOs entering the program under Track 1 transition to Track 2 after one agreement period, it did specify that ACOs may operate under the one-sided model for no more than two agreement periods-clearly emphasizing that the

two-sided model is the future of the program.

Almost immediately after the proposed rule was published, NAACOS contended that prospective assignment of beneficiaries should be used in Track 1 instead of only in the two-sided higher-risk, higher-reward Track 3 (also created within the proposed rule).

Opponents of the proposed rule warned that the proposed sharing of cost savings could adversely affect program participation by creating a disincentive for ACOs to continue in the program and discouraging other providers from forming ACOs. CMS responded in the final rule by increasing the upper limit of the sharing rate during the second one-sided agreement to 50%, consequently maintaining the limit of the first performance period. In addition CMS asserted again that the established methodology (preliminary prospective assignment with retrospective reconciliation) works effectively, and thus declined to implement prospective assignment in Track 1.

CMS has complied with most of the major changes requested by provider organizations and conveyed a message of flexibility. In doing so, it has avoided a departure of current ACOs with CMS estimating that at least 90% of eligible MSSP ACOs will renew their participation and that new providers will join the program so that the longer-term vision of "accountable care" can be realized. In support of the ACO concept, on January 26, U.S. Department of Health and Human Services (HHS) Secretary Sylvia Mathews Burwell announced plans to aggressively increase the share of Medicare spending under accountable care and other alternative payment models through 2018.[2]

2014 ACO Results

CMS released the 2014 results for 353 ACOs on August 25th showing that 20 Pioneer and 333 Medicare Shared Savings Program ACO's generated net savings of $411 million in 2014 and improved in most quality measures. Some of the more intriguing points of the results:

- 97 ACOs earned bonuses totaling $422 million out of $833 million in savings they produced. For ACOs in their first year, organizations must report quality scores but do not have to meet performance targets. Savings are awarded under formulas that account for performance on quality targets after the first year in the program.[3]
- 15 of the 20 participating Pioneer ACOs generated a total of $120 million in savings in 2014, their third performance year. This is up 24% from the second performance year when they generated $96 million in savings. Of those that generated savings, 11 earned shared savings payments of $82 million. A particularly strong improvement was seen in medication reconciliation (70% to 84%), screening for clinical depression and follow-up plan (50% to 60%) and qualification for an electronic health record incentive payment (77% to 86%).
- Five Pioneer ACOs generated losses and three owed CMS shared losses of $9 million.
- The mean quality score among Pioneer ACOs increased to 87.2% in performance year three from 85.2% in performance year two, which was itself an improvement from 71.8% in performance year one. They improved an average of 3.6% compared to performance in year two over 28 of the 33 quality measures and showed significant improvement in medication reconciliation, clinical depression screening and follow-ups, and EHR incentive payment qualification.[4]
- The average performance score for patient and caregiver experience increased in five of seven measures compared to the prior year.
- The pool of beneficiaries attributed to a Pioneer ACO grew 2% over 2013 to 622,265.

- Of 333 MSSP ACOs, 97 saved a total of $806 million and earned $347 million in shared savings for 2014, up from $315 million in shared savings in 2013. 89 other MSSP ACOs reduced costs, but did not meet the minimum threshold to share in savings.
- The results indicate ACOs improve over time: among ACOs that entered the program in 2012, 37% generated shared savings, compared to 27% of those that entered in 2013, and 19% of those that entered in 2014.
- 92 ACOs in the Medicare Shared Savings Program earned bonuses, but six did not receive payouts because they did not meet the quality requirements. Quality improved on 27 of 33 quality measures for those ACOs with more than one year of performance results.
- Total savings per ACO increased from $2.7 million per ACO in performance year one to $4.2 million per ACO in performance year two to $6.0 million per ACO in performance year three.
- No Track 2 MSSP ACOs owed CMS losses. Total net savings to the Medicare Trust Funds was $465 million, an increase from 2013.

Acting CMS Administrator Andy Slavitt said in a news release, "These results show that accountable care organizations as a group are on the path towards transforming how care is provided. Many of these ACOs are demonstrating that they can deliver a higher level of coordinated care that leads to healthier people and smarter spending."

Another reason is the limited financial incentives of Medicare ACOs, she said. Few stand to lose money if they fail to achieve savings, known as "downside risk". Pioneer ACOs are at risk for losses, but Medicare's Shared Savings Program made the potential for losses voluntary. Those that agreed also receive larger potential payouts.

Some states have also embraced the ACO approach for Medicaid. According to a blog post in the journal *Health Affairs*, New Jersey has certified three of six applicants for its Medicaid ACO Demonstration Project and insurers may well benefit by following the three community coalitions during the three-year demonstration project. The community-based ACO approach offers an "exciting new model for providing care to Medicaid recipients," Joan Randall, chief operating officer of The Nicholson Foundation, wrote in the blog. This is due to the requirement for ACOs to serve a specific geographical region that they define that includes at least 5,000 Medicaid members. The ACOs also must include all hospitals within the specified area in addition to 75% of Medicaid primary care providers and four or more qualified behavioral health providers.[5]

In a statement, Charlotte based Premier Inc. vice president of population health management Joe Damore said, "We believe ACOs hold great promise and are particularly pleased that more than 45% of the MSSP and Pioneer ACOs participating in Premier's population health management collaborative, one of the largest ACO collaboratives in the country, qualified for shared savings payments. Critical to their success, collaborative members focus on 10 key strategies to operate a highly-successful population health management entity, including benchmarking performance with peers, population health data management, leveraging a gap assessment tool and sharing best practices."[6]

CMS expects the number of beneficiaries served by ACOs to continue to grow. Since its introduction, the number of Medicare beneficiaries served by ACOs has consistently grown from year to year, and early indications suggest the number will continue to increase throughout next year.

Kaiser Report

Almost half of all Medicare accountable care organizations are costing the government more than originally estimated, according to a new report from *Kaiser Health News*.

The report says CMS believes the ACO program is performing better than it actually is due to using historical benchmarks and an alternative method for calculating savings.

After paying bonuses to 97 ACOs that reported savings last year, the Medicare ACO program recorded a net loss of $3 million, *Kaiser* reported.

That loss could be attributed to the low number of ACOs accepting financial risk. *Kaiser* found only 7% of ACOs last year accepted a financial risk deal, where they would be eligible to earn larger bonuses but would also have to pay CMS if their patients cost more than estimated.

Reluctance by ACOs to accept financial risk has been so prevalent that CMS has allowed the groups six years to participate without penalties, instead of phasing out the no-risk option. CMS has also introduced incentives over the past year for ACOs members to assume greater risk, and potentially reap greater awards. [7]

JAMA Internal Medicine

Researchers at Harvard Medical School looked at 31 healthcare services that were deemed of little clinical benefit, such as certain cancer screenings and certain preoperative, imaging and cardiovascular tests.

They measured service count and spending per 100 Medicare beneficiaries before the Pioneer program began, from 2009 to 2011, and in the first year of the program, which started in 2012. Pioneer ACOs in their first year performed 1.9% fewer low-value services, or 0.8 fewer services per 100 beneficiaries. They also reduced spending on those services by 4.5%.

Those organizations that had been performing the largest number of low-value services prior to 2012 saw the largest reduction, or a decline of 1.2 services per 100 beneficiaries.

"Despite the limitations of the study, our findings … are consistent with the conclusion that the overall value of healthcare provided by Pioneer ACOs improved after their participation in an alternative payment model," the authors wrote. [8]

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Locum Tenens: Rules and FAQs

The AdvantEdge Compliance Office would like to remind everyone of the Medicare guidelines when contracting with a temporary substitute physician, commonly known as a 'locum tenens'. The FAQ's below are from several CMS MAC's and answer questions commonly posed by physicians and administrators.

The Basics:

A physician may hire a substitute physician to take over his/her practice when they are absent for reasons such as illness, pregnancy, vacation or continuing medical education. The substitute physician, known as a 'locum tenens', generally does not have their own practice and many move from area to area as needed.

- The regular physician generally pays the substitute physician a fixed per diem amount.
- The substitute physician's status is that of independent contractor, rather than employee, and his/her services are not restricted to the contracting physician's office.
- Services of non-physician practitioners (e.g., CRNAs, NPs and PAs) may not be billed under the Locum Tenens or Reciprocal Billing reassignment exceptions. Locum provisions apply only to physicians.
- The 'regular' physician cannot be submitting claims (providing services in another facility) while a locum tenens is 'standing in' for the regular physician. The regular physician is presumed (required) to be 'unavailable'. The regular physician, who is away, cannot be practicing somewhere else while having a locum covering for him/her at their primary location.

FAQ's

1. The Medical Group has a signed contract and has HIRED a new physician to replace one who has left. Can the newly HIRED physician act as a locum for a physician who recently left, while the group awaits enrollment for the new hire?
    - No, a locum tenens is NOT an employee; rather, their status must be that of an independent contractor.

2. Our practice is in the process of enrolling Dr. X. While awaiting the credentialing process, can we use Dr. X as a locum tenens for a physician who is on vacation?
    - No, in such a case, the locum tenens concept is not applicable. Locum tenens is only appropriate for absent physicians who retain a substitute physician for no longer than 60 continuous calendar days.

3. How can a group that loses a physician use locum tenens while recruiting a new physician?
    - The group can contract with a locum tenens physician and pay him/her a fixed amount per diem. The payment to the contracted physician is considered to be paid by the regular physician (the group pays the locum tenens physician on behalf of the regular physician.) [1] The group may bill for the contracted physician for up to 60 continuous days. The claim contains a modifier Q6. The claim must contain both the group NPI and the regular physician NPI. The group must keep on file a record of each service provided by the substitute physician and make this record available to any MAC upon request.

4. If a physician terminates and leaves our group and we contract with a locum tenens physician, what are the guidelines for this situation? When do we have to notify Medicare of the change?
    - If a physician terminates and leaves your group, a contracted locum tenens physician can see the exited physician's patients for up to a 60-day continuous period, beginning with the first day the locum physician sees one of the exited physician's patients.
        - **IMPORTANT NOTE:** CMS requires that providers report certain "reportable events" within specific timeframes. You must report a change of ownership or control, including any revocation or suspension of a Federal or State license within 30 days of a reportable event. Also, the group has up to 90 days to notify Provider Enrollment that the physician left the group. To learn more, refer to the CMS Provider Enrollment Fact Sheet titled "The Basics of Medicare Enrollment for Physicians and Other Part B Suppliers."

5. In replacing a physician who has left the practice, is there a requirement that the locum start within a certain time period from the departure date of the regular physician?
    - No, but the eligibility period for the locum tenens physician substitution may be affected because the practice is required to notify Provider Enrollment of the change in practice status (physician left practice) within 90 days.

6. Our regular physician has been terminated from the group due to suspected illegal activities which will most likely affect his medical license in the near future. Should I contract with a locum tenens to provide services while we search for a new provider?
    - If the groups 'regular' physician is not in good standing, it is not advisable to use the exited NPI's number to continue to bill for services provided by a locum. These services will most likely come into question, with possible future retraction of payment.

7. Our regular physician will need to be absent for an extended period of time. Can we arrange for the same locum tenens physician to see the regular physician's patients during the extended absence?
    - The period for which a single locum tenens physician may substitute cannot be more than 60 continuous days. The 60-day period begins the first day the locum tenens physician provides services for Medicare patients of the regular physician. An exception to this 60-day rule is for regular physicians who are called to active duty in the armed forces. In that case, the time is unlimited.

8. Our organization operates multiple sites throughout the state and often employs locum tenens to fill in for regular physicians. Can we bill for the locum tenens under another provider's NPI number if that provider is not located (regularly scheduled) at the site where the locum tenens is practicing?
    - No, the regular physician must be temporarily unavailable. Because there is no "regular physician" who is temporarily unavailable, the situation would not permit billing under the locum tenens rule. Moreover, a physician who does not work at the site in question could not be considered the regular physician in the context of the locums rule because that physician is not "unavailable" for one of the permissible reasons.

9. Can a locum tenens physician see new patients?
    - Yes, as long as the patient requested or was seeking services from the regular physician.

10. Does locum tenens apply to a deceased provider?
    - No, Medicare only permits payment for services furnished prior to a physician's death. When a physician becomes deceased, his/her billing number, NPI and enrollment are deactivated and cannot be used after the date the physician passes away. Therefore, a locum tenens arrangement would not be permitted.

11. Is the 60-day period cumulative or consecutive?
    - The 60-day continuous day period begins the first day the locum tenens physician provides services for Medicare patients of the regular physician. This period continues for up to 60 calendar days, with no breaks, even if the locum tenens does not see patients on some of those days. In situations where the regular physician is going to be absent for more than 60 days, an alternative plan for physician coverage and patient care should be created. An exception to the 60-day continuous rule is for regular physicians who are called to active duty in the armed forces. This time is unlimited.

12. Our physician will be out for 60 continuous calendar days, beginning June 1st. Will Medicare allow two different locum tenens physicians to substitute for the same regular physician?
    - A regular physician may use more than one locum tenens to substitute for his/her absence during the same 60-day period; however, the substitutes cannot act on the same day. Assuming that each locum tenens physician is providing services within his/her respective 60-day continuous period, locum tenens physician Dr. A can provide services, for example, on Monday, Wednesday, and Fridays, and locum tenens Dr. B can provide services on Tuesday, and Thursday, but Dr. A and Dr. B cannot be scheduled as the substitute for the regular physician on the same day.

13. Does the locum physician have to be of the same specialty as the physician who is absent?
    - No.

14. Our practice has a high volume and our physicians are unable to see all of the patients. Can we use a locum physician and bill under the provider who is out for the day if it is their regular day off?
    - No, in such a case, the physician is a regularly scheduled physician and the locum tenens concept is not applicable.

15. We had two providers leave our specialty group. We are using two locums to cover as we recruit replacements. Can we assign a locum to an absent provider and always bill their services under this provider, or do we have to bill the provider that was 'requested'? In some cases, they are new patients.
    - A locum tenens physician is the substitute for a physician who is absent. Once entered into, the locum tenens physician should not substitute for a different absent physician. It is the expectation that the locum tenens will see only those patients that requested the regular physician for which the locum is substituting. This would include a new patient.

16. If a practice wants to "try out" a doctor they are considering hiring, can the practice bill under locum tenens?
    - No, this does not meet the CMS definition for locum tenens.

17. If a practice just "needs help" to get through a busy period, i.e. a doctor is ill and working part time, can the practice hire a locum to bill under the part time doctor's name/number?
    - No, locum tenens is only applicable when the locum physician is substituting for the regular physician for those periods defined in the Internet Only Manual (IOM). It does not apply when the regular physician is working part time due to an illness.

Remember, to the extent that services billed were discovered to have been submitted incorrectly, the entity should do a voluntary disclosure and refund monies improperly paid and received, in compliance with the reverse false claims provision of the False Claims Act. Failure to do so would result in those claims being deemed false claims, and FCA damages and penalties would apply.

CMS guidelines are found in the CMS Medicare Claims Processing Manual, Publication 100-04, Chapter 1, Section 30.2.11.

[1] This works until the physician who left the group is linked to a new group, but in no case longer than 60 continuous days.

Compliance Week: Nov 1-7

Starting November 1st through the 7th, AdvantEdge employees can access the Compliance Corner page for helpful tips and resources for Compliance Week.

ICD-9 to ICD-10: Abdominal Pain

Diagnosis: Abdominal Pain

ICD-9 Code(s): 789.00
Listed Under: Symptoms, Signs, And Ill-Defined Conditions 780-799 → Symptoms 780-789 → other symptoms involving abdomen and pelvis 789

ICD-10 Code(s): R10.9
Listed Under: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified R00-R99 → Symptoms and signs involving the digestive system and abdomen R10-R19 → Abdominal and pelvic pain R10

Note: Short description: Abdmnal pain unspcf site.

Approximate conversions between ICD-9-CM codes and ICD-10-CM/PCS codes may require clinical interpretation in order to determine the most appropriate conversion code(s) for your specific coding situation.

Diagnoses in shaded areas are titles only and are not billable

DIAGNOSIS	ICD-9	ICD-10	ICD-10 Description (if different)
Abdominal pain	**789.0**	**R10**	**Abdominal and pelvic pain**
Abdominal Pain Unspecified Site	789.00	R10.9	Unspecified Abdominal Pain
Abdominal Pain Right Upper Quadrant	789.01	R10.11	Right Upper Quadrant Pain
Abdominal Pain Left Upper Quadrant	789.02	R10.12	Left Upper Quadrant Pain
Abdominal Pain Right Lower Quadrant	789.03	R10.31	Right Lower Quadrant Pain
Abdominal Pain Left Lower Quadrant	789.04	R10.32	Left Lower Quadrant Pain
Abdominal Pain Periumbilic	789.05	R10.33	Periumbilical Pain
Abdominal Pain Epigastric	789.06	R10.13	Epigastric Pain
Abdominal Pain Generalized	789.07	R10.84	Generalized Abdominal Pain
Abdominal Pain Other Specified Site	789.09	R10.10	Upper Abdominal Pain, Unspecified
		R10.2	Pelvic And Perineal Pain
		R10.30	Lower Abdominal Pain, Unspecified