MSSNY COMMITTEE ON INTERSPECIALTY
Thursday, October 22, 2015

Approval of the Minutes of the June 25, 2015 Committee
Dr. Steven S. Schwalbe presiding called the meeting of the MSSNY Committee on Interspecialty for October 22, 2015 to order. The first order of business was to approve the minutes from the last meeting which was held June 25, 2015. The minutes were approved.

Sunset Item
In keeping with MSSNY’s policy to review its position/policy statements that are 10 years old or older, the Committee was asked to evaluate the following:

195.971 Holding Medicare Payments:
MSSNY will advocate for repeal of Section 5203 of the Deficit Reduction Act and seek the support of the American Medical Association to help ensure that our members will not be placed in a financial bind as the result of this federal provision. (HOD 2006-262)

After limited discussion, it was decided that since this policy was time sensitive to 2006, the Committee recommends that it be sunset. This recommendation will be reported to the 2016 House of Delegates in April 2016.

Medicare CAC Local Coverage Determinations (LCDs) for consideration –

Debridement Services DL33614
The Committee members took exception with this policy relative to the non-physician practitioners being included in this treatment process. It was strongly recommended that a resolution be drafted for consideration by the MSSNY House of Delegates to seek a limitation under the proper Scope of Practice that Debridement be performed by MDs and DOs. Physical and Occupational Therapists (PT & OT) should not be permitted to use a scalpel or other invasive instruments to remove body tissue from a wound.

Committee Recommendation:
RESOLVED, That the Medical Society of the State of New York seek clarity from the NYS Board of Education relative to the proposed LCD, Debridement Services DL33614. It is the considered opinion of the members of the MSSNY Committee on Interspecialty that the use of a scalpel or other invasive instruments to remove body tissue from a wound is beyond the Scope of Practice for any non-physician practitioner.

**See NYSED reply dated 11/24/15 from Stephen Boese via email attached.

Coverage of Drugs and Biologicals for Label and Off-Label Uses DL33394  The members did not have a lot to say about this policy other than it will continue to impact newer and sometimes very expensive drugs as they come along.

Genomic Sequence Analysis Panels in the Treatment of Non-Small Cell Lung Cancer DL36376
Dr. Mary Fowkes, Pathologist, discussed the following points. We recognize that the National Comprehensive Cancer Network (NCCN) Non-Small Cell Lung Cancer (NSCLC) Panel “strongly endorses broader molecular profiling to identify rare driver mutations using multiplex/next-generation sequencing (NGS) to ensure that patients receive the most appropriate treatment” and that targeted genomic sequence analysis panel, solid organ neoplasm, DNA analysis, 5-50 genes (CPT 81445) is a useful representation of the aggregate of these gene tests, and may be used as long as the panel contains, at a minimum, 5 or more gene tests for molecular biomarkers determined to meet Medicare coverage criteria.
MSSNY sees a few concerns relating to the current CMS Indications and Limitations of Coverage criteria for NGS in NSCLC tumor patients. Although the current criteria are acceptable, they must allow utilization of the most cost efficient testing method available.

Additional concern:
1) Stage I and II tumors are currently not covered under the current indications. However, given that survival of stage III tumors is 6 weeks and NGS takes an average of 2 weeks to complete, when NGS is more cost effective than conventional testing, earlier stage tumors should not be excluded from coverage if clinically indicated by cancer working groups.

In summary: The current limitations should take into consideration changes in testing which are most cost efficient and take into consideration earlier diagnosis for more efficient implementation of targeted therapy for NSCLC.

Minimally-invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint DL36406 Dr. Wolpin, Orthopedist, indicated that this procedure is extremely rare. He also advised that he would discuss this with his specialty society and colleagues and provide further information on this LCD, as soon as possible.

The Interspeciality Committee members had no comments on the following two LCDs:

Molecular Pathology Procedures DL35000

Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT) DL35076

**Medicare Update**

Ms. Katherine Dunphy, Director, Congressional Affairs, NGS Medicare, provided the Committee with the Medicare Update.

**MACRA** - Medicare Access and CHIP Reauthorization Act of 2015

This act removed the Sustainable Growth Rate (SGR) methodology for annual updates to Medicare payments for physicians. It also sets an update at 0.5% for July 1, 2015 to December 31, 2015. The following updates are included:

- January 1, 2016 update will be 0.5%
- Extends the physician work geographic practice cost index (GPCI) floor of 1.0, and the therapy cap exceptions process, through December 2017
- The Secretary of HHS will consolidate performance incentives to a new program called a Merit Incentive Payment (MIP)
- Substantial further analysis and study to move from current payment models for physicians and APM participants.
- This is the time to focus on current incentives and integrate in to your practices in order to avoid the payment adjustments.
- MACRA extended the therapy caps exceptions process through December 31, 2017 and modified the requirement for manual medical review for services over the $3,700 therapy thresholds
- MACRA also extended the application of the therapy caps, and related provisions, to outpatient hospitals until January 1, 2018

Note: The current 2% sequestration of payments remains in effect until March 31, 2016.
**PQRS – Physician Quality Reporting System**

Eligible professionals who do not satisfactorily report data on quality measures for covered professional services will be subject to a payment adjustment under PQRS beginning in 2015/2016 (2013/2014 claims used as a database)

1.5% less than the MPFS amount for that service
2.0% adjustment in 2016 and subsequent years

For information on the PQRS payment adjustment, go to the direct link at:
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Insitutions/PQRS/Payment-Adjustment-Information.html

All questions should be directed to Northrup Grumman **EHR Information Center**: 888-734-6433, TTY: 888-734-6563, Hours of Operation: Monday – Friday, 7:30 a.m.–6:30 p.m. central time (CT) or the **PQRS Contact Quality Net Help desk** 866-288-8012 or email qnetsupport@hqcs.org

**ICD-10 Implementation**

All claims are processing timely
- Excellent support from all
- Monitor your claims for accurate coding
- Specialty societies were very helpful

However, paper claims submission have been presenting issues when the claims are submitted without the proper diagnosis indicator in Item 21 on the CMS 1500 claim form.

The ICD indicator field, which is in the top right corner of item 21, must be completed to identify the ICD-CM code set being reported. Enter either:
- 9 - to indicate the ICD-9 CM diagnosis code set
- 0 - to indicate the ICD-10 CM diagnosis code set

Enter the indicator as a single digit between the vertical, dotted lines. Failure to complete this field or incorrectly completing this field will result in claim rejection.

When the October 1, 2014 ICD-10 implementation date was delayed, Medicare began auto populating the ICD Indicator field with a ‘9’ on claims submitted without an indicator. Shortly before the implementation of ICD-10 on October 1, 2015, Medicare stopped auto populating the field so providers need to submit the correct indicator now.

Example for dates of service prior to October 1, 2015 billed with ICD-9 CM codes:

<table>
<thead>
<tr>
<th>A.</th>
<th>6827</th>
<th>B.</th>
<th>25000</th>
<th>C.</th>
<th>7038</th>
<th>D.</th>
<th>7295</th>
</tr>
</thead>
<tbody>
<tr>
<td>E.</td>
<td></td>
<td>F.</td>
<td></td>
<td>G.</td>
<td></td>
<td>H.</td>
<td></td>
</tr>
<tr>
<td>I.</td>
<td></td>
<td>L.</td>
<td></td>
<td>K.</td>
<td></td>
<td>L.</td>
<td></td>
</tr>
</tbody>
</table>

Example for dates of service on or after October 1, 2015 billed with ICD-10 CM codes:

<table>
<thead>
<tr>
<th>A.</th>
<th>L03119</th>
<th>B.</th>
<th>L601</th>
<th>C.</th>
<th>M79609</th>
</tr>
</thead>
<tbody>
<tr>
<td>E.</td>
<td></td>
<td>F.</td>
<td></td>
<td>G.</td>
<td></td>
</tr>
<tr>
<td>I.</td>
<td></td>
<td>L.</td>
<td></td>
<td>K.</td>
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</tr>
</tbody>
</table>

**Preventive Services**

2015 Flu Season is here. The ICD-10 is Z23. 2015 rates are posted on the www.ngsmedicare.com (SE1523) or click here: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/MerPartBDrugAvgSalesPrice/VaccinesPricing.html
Claim corrections are underway for Hepatitis/Pneumonia vaccines. These claims were inadvertently denied when the Z23 ICD-10 code wasn’t originally recognized. However, the claims are being adjusted, automatically.

NGS Medicare continues to see low utilization of the Wellness visit and other preventive services.

**Beneficiary Financial Responsibility**

<table>
<thead>
<tr>
<th>Year</th>
<th>Monthly Part B Premium for Beneficiary</th>
<th>Monthly Part B Premium for Beneficiary</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>$104.90</td>
<td>$159.30 *</td>
</tr>
<tr>
<td></td>
<td>Higher Part B Premium – $85,000/$170,000</td>
<td>Higher Part B Premium – $85,000/$170,000</td>
</tr>
<tr>
<td></td>
<td>Part B Coinsurance 20%</td>
<td>Part B Coinsurance 20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental Health Services 80%</td>
</tr>
</tbody>
</table>

Local Assistance for beneficiaries: New York: 1-800-701-0501

**NGS Medicare “Heads Up”**

Dr. Laurence Clark, NGS Medicare Medical Director, informed the Committee members that a recent review of CMS data is suggesting that something like 70% of the NATION’s transcranial Dopplers (93886) and 72% of sensory evoked potentials (95925-7) are being done in Downstate NY. These services appear to be being provided particularly in the nursing homes. NGS Medicare is seeing a lot of this, not from radiologists or neurologists, rather, family practitioners, IM and other primary care. NGS Medicare will be starting to research the validity of the volume of these services by initiating edits that will be starting soon. The edits are not intended to cause difficulty for medically necessary services; but should help to clarify the data. Dr. Clark provided the members with a “heads up” since although downstate NY is quite populous with Medicare beneficiaries, it doesn’t appear to support the over 70% of the number of services for the nation.

**Any specialty specific issues**

**Comprehensive Care for Joint Replacement**

Dr. Martin Wolpin, Orthopedist, discussed the issues related to Comprehensive Care for Joint Replacement and CMS’ intent to establish a new Medicare payment model that will bundle payment for primary total hip and knee replacement procedures. The following link from the American Academy of Orthopaedic Surgeons explains the intent of the process.


The members were also made aware of the AMA’s comments to CMS on this subject:


CMS provided the following information regarding their new payment models:

The joint replacement model email address is ecjr@cms.hhs.gov. People can direct their questions to that address. They may want to hold off a few weeks because CMS is expecting to release the final rule shortly.
The oncology model email address is OncologyCareModel@cms.hhs.gov. The applications are closed for that model but the CMS team monitors that email box frequently and will respond to questions.

CMS advised that they would be happy to do a follow up session with Committee or directly with a medical society to outline the requirements of the final rule and answer questions if there is sufficient interest.

After a significant discussion, the Interspecialty Committee re-considered Resolution 2015-253 and made the recommendation as shown above.

**Emblem Health Policy Change On Acne Surgery**

Dr. Robert Walther, Dermatologist, discussed the issues of a recent policy change by Emblem Health with regard to Acne Surgery (AMA-CPT Code 11040). Historically, Emblem covered this care for its insureds. Recently, with Emblem’s employment of McKesson Health Solutions ClaimsXten in February 2015, the insurer’s policy for acne treatment changed without notice to Emblem’s in-network dermatologists.

MSSNY had enlisted the aid of the American Academy of Dermatology to address this matter. However, Emblem chose to maintain its position by following the recommendations of the McKesson computer software.

The Committee members expressed their continued dismay regarding this policy change and asked that the matter be referred to the NYS Department of Financial Services (DFS) since this is a significant and costly policy amendment which MSSNY considers to be an adverse determination. Accordingly, that matter has been reported to DFS and we are awaiting their decision.

There were no further issues for discussion. The meeting ended at approximately at 12:02 PM and Dr. Schwalbe thanked the attendees for their participation.

Respectfully submitted,

Steven S. Schwalbe, MD, Chairman
From: Stephen Boese nysed.gov
Sent: Tuesday, November 24, 2015 12:21 PM
To: Regina McNally
Cc:
Subject: RE: Medicare policy versus NYS Scope of Practice

Regina,
I have researched your question and consulted with the Executive Secretaries to the PT and the OT Boards and have learned the following.

The Department has opined in the past that debridement of a wound using a scalpel is within the scope of physical therapy. You may see this statement here http://www.op.nysed.gov/prof/pt/ptalert13.htm. The OT Board also has a similar statement, attached.

I hope this information is helpful.

Stephen

Stephen J. Boese
Executive Secretary
Boards for Medicine,
Veterinary Medicine,
Dietetics & Nutrition,
Committees for Medical Physics,
Athletic Trainers, Perfusion.
New York State Education Department
Office of the Professions