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# MSSNY COMMITTEE ON INTERSPECIALTY

## Thursday, October 26, 2017

**Approval of the Minutes of the June 29, 2017 Committee meeting**

Dr. Steven S. Schwalbe, presiding, called the meeting for October 26, 2017 to order. The first order of business was to approve the minutes from the last meeting held on June 29, 2017. The minutes were accepted and approved as written.

**Medicare CAC Local Coverage Determinations (LCDs) for consideration** -

- Frequency of Hemodialysis

There was a great deal of testimony about this draft LCD at the Medicare CAC meeting. There was commentary presented that three times a week may not be the proper schedule for many people because some people are limited in how long they can undergo dialysis either for medical reasons or because patients cannot tolerate the procedure for as long as needed. Some patients may require more frequent sessions of shorter duration. This was echoed by nephrologists from all three locations. The policy seems to suggest that if a nephrologist schedules someone more than three times in a week that it would raise a red flag. In addition the policy seems to indicate that if you go over three times per week that this must be an acute issue, but this is not always the case.

Interspecialty members had no comment. Since the Interspecialty Committee does not have representation from the Nephrology Society, it was suggested that the Draft LCD be shared with MSSNY member nephrologists. This has been done.

- Vitamin D Assay Testing

At the Medicare the CAC meeting, the endocrinologists were generally supportive of this policy and with an exception. They mentioned Lupus needs both tests and possibly more frequent testing.

Interspecialty members had no comment. Since the Interspecialty Committee does not have representation from the Endocrine Society, it was suggested that the Draft LCD be shared with MSSNY member endocrinologists. This has been done.

- Magnetic Resonance Image Guided Intensity Ultrasound

This is a technique which is possibly going to rival Deep Brain Stimulation and Thalamotomy. The position of the carrier is that more information is needed regarding the effectiveness and the safety of the technique as opposed to Deep Brain Stimulation before it can be an approved technique.

Interspecialty members had no comment. Since the Interspecialty Committee does have representation from the Neurosurgery and Radiology, both societies have been given the Committee agenda and links to the draft LCD.

- Prostate Rectal Spacers

This draft LCD may be one of the more contentious LCDs. This is also a relatively new technique, and as most of you are probably aware radiation to the prostate is often limited by the complications which occur in the rectum. The idea of the Prostate Rectal Spacers by inserting them would hopefully attenuate some of those complications.

The position of the carrier is that there is insufficient evidence regarding the technique for them to allow it under their policy. The urologists and the radiation oncologist that I contacted were essentially in agreement with that, but we have information from the national specialty society, American Society for Radiology and Oncology, which has a different viewpoint.

After considerable discussion, the MSSNY Interspecialty Committee will lend its support to the position of the American Society for Radiation Oncology and the American College of Radiology.

**Other Medicare CAC Information** – JK CAC Meeting PPT

**Medicare Legislative Update**

Ms. Katherine (Kathy) Dunphy, NGS Medicare, provided the Committee with highlights of her presentation.

Kathy mentioned a new initiative called: **Targeted Probe and Educate Medical Review Strategy**

- Program that combined a review of a sample of claims with education to help reduce errors in the claims submission process
- Review of 20-40 claims per provider, per item or service, per round, for a total of up to three rounds of review
- After each round, providers are offered individualized education based on the results of their reviews

As a result of the successes demonstrated during the pilot, including an increase in the acceptance of provider education as well as a decrease in appealed claims decisions, CMS has decided to expand the process to all MAC jurisdictions later in 2017.

- The MACs will select claims for items/services that pose the greatest financial risk to the Medicare trust fund and/or those that have a high national error rate
- MACs will focus only on providers/suppliers who have the highest claim error rates or billing practices that vary significantly out from their peers.
- Process includes a review of 20-40 claims followed by one-on-one, provider-specific, education to address any errors with in the provider's reviewed claims
- Providers/suppliers with moderate and high error rates in the first round of reviews, will continue on to a second round of 20-40 reviews, followed by additional, provider specific, one-on-one education

- Providers/suppliers with high error rates after round two will continue to a third and final round of probe reviews and education
- Providers/suppliers with continued high error rates after three rounds of TPE may be referred to CMS for additional action

Please refer to the following link for more information of this topic:
https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Targeted-Probe-and-EducateTPE.html

**New Medicare Card:**

CMS will begin mailing new cards in April 2018 and will meet the congressional deadline for replacing all Medicare cards by April 2019. The gender and signature line will be removed from the new Medicare cards. The Railroad Retirement Board will issue their new cards to RRB beneficiaries. CMS will work with states that currently include the HICN on Medicaid cards to remove the Medicare ID or replace it with an MBI.

CMS will conduct intensive education and outreach to all Medicare beneficiaries, their families, caregivers, and advocates to help prepare for this change.

**The 21st Century Cures Act**

Improving Medicare local coverage determinations (LCD)

- Medicare Administrative Contractors to post details of LCDs 45 days before effective date

Medicare site-of-service price transparency

- Hospital outpatient departments and ambulatory care centers must post the estimated payment amount for a service and the beneficiary liability

Preserving Medicare beneficiary choice under MA beginning in 2019

- First 3 months each year, those who are MA eligible can change coverage

Allowing people with End-Stage Renal Disease to choose an MA Plan beginning in 2021

- Organ procurement will be covered by Original Medicare

**ICD-10**

Watch for changes made by the specialties. October Monthly Medicare Review contains all the ICD-10 updates to the NGS LCDs, effective October 1, 2017.

**MOON**

Medicare Outpatient Observation Notice (MOON)

Office of Management & Budget (OMB) approved standardized notice (CMS Form CMS-10611) to inform a Medicare beneficiary they are receiving outpatient observation services and Not receiving inpatient services

- The form requires a statement of the beneficiary's health issues.
- Start the process after 24 after admission; issue within 36 hours.
- Applies to all hospitals and critical access hospitals (CAH)

All hospitals, including CAHs, must begin using the MOON notice **no later than 3/8/2017.** The role of the physician is signing the order to admit the beneficiary. This is a mandate for hospitals.

For more information please review the following: JK CAC Meeting PPT

**MSSNY's Legislative Update**

Mr. Morris (Moe) Auster of MSSNY's Governmental Affairs Division provided the members with a brief update.

The Medicare Physician Fee Schedule Final Rule for 2018 was published on November 2, 2017. Here are some highlights -

**Patients Over Paperwork**
CMS recently launched the "Patients Over Paperwork" Initiative, a cross-cutting, collaborative process that evaluates and streamlines regulations with a goal to reduce unnecessary burden, increase efficiencies, and improve the beneficiary experience. This effort emphasizes a commitment to removing regulatory obstacles that get in the way of providers spending time with patients. The Medicare Physician Fee Schedule final rule includes the following as part of this initiative:

- reducing reporting requirements
- removing downward payment adjustments based on performance for practices that meet minimum quality
- reporting requirements

**PAYMENT PROVISIONS**
Changes in Valuation for Specific Services
CMS reviews the resource inputs for several hundred codes under the annual process referred to as the potentially mis-valued code initiative. Recommendations from the American Medical Association-Relative Value Scale Update Committee (RUC) are critically important to this work. For CY 2018, CMS is finalizing the values for individual services that generally reflect the expert recommendations from the RUC without as many refinements as CMS made in recent years.

**Overall Payment Update and Mis-valued Code Target**
The overall update to payments under the PFS based on the finalized CY 2018 rates will be +0.41 percent. This update reflects the +0.50 percent update established under the Medicare

Access and CHIP Reauthorization Act (MACRA) of 2015, reduced by 0.09 percent, due to the misvalued code target recapture amount, required under the Achieving a Better Life Experience (ABLE) Act of 2014.

After applying these adjustments, and the budget neutrality adjustment to account for changes in RVUs, all required by law, the final 2018 PFS conversion factor is $35.99, an increase to the 2017 PFS conversion factor of $35.89.

**Medicare Telehealth Services**

For CY 2018, CMS is finalizing the addition of several codes to the list of telehealth services, including:

- HCPCS code G0296 (visit to determine low dose computed tomography (LDCT) eligibility);
- CPT code 90785 (Interactive Complexity);
- CPT codes 96160 and 96161 (Health Risk Assessment);
- HCPCS code G0506 (Care Planning for Chronic Care Management); and
- CPT codes 90839 and 90840 (Psychotherapy for Crisis).

Additionally, we are finalizing our proposal to eliminate the required reporting of the telehealth modifier GT for professional claims in an effort to reduce administrative burden for practitioners.

We are also finalizing separate payment for CPT code 99091, which describes certain remote patient monitoring, for CY 2018. Lastly, we will consider the stakeholder input we received in response to the proposed rule's comment solicitation on how CMS could expand access to telehealth services, within the current statutory authority.

In the proposed rule, we sought comment on whether to make separate payment for CPT codes that describe remote patient monitoring or other existing codes that describe extensive use of communications technology. Some commenters raised concerns with our proposal, citing concerns that existing CPT codes were overly broad and not always reflective of current technology. Other commenters were supportive of the proposal generally but noted that CPT is currently working on codes that more accurately describe remote patient monitoring. In the final rule, we are finalizing separate payment for CPT code 99091 (Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, for 2018 pending anticipated changes in CPT coding.

Lastly, in the proposed rule, we sought comments on ways to further expand access to telehealth services within our current statutory authority. We appreciate the thoughtful input we received in response to this comment solicitation and will consider this input in future rulemaking.

**Care Management Services**

CMS is continuing efforts to improve payment within traditional fee-for-service Medicare for chronic care management and similar care management services to accommodate the changing needs of the Medicare patient population. CMS is finalizing its proposals to adopt CPT codes for CY 2018 for reporting several care management services currently reported using Medicare G-

codes. Also we are clarifying a few policies regarding chronic care management in this final rule. We are committed to working with stakeholders on any further refinements to the code set that may be warranted, especially describing the professional work involved in caring for complex patients in other clinical contexts.

**Improvement of Payment Rates for Office-based Behavioral Health Services**
CMS is finalizing an improvement in the way physician fee schedule rates are set that will positively impact office-based behavioral health services with a patient. The final policy will increase payment for these important services by better recognizing overhead expenses for office-based face-to-face services with a patient.

**Evaluation and Management Comment Solicitation**
Most physicians and other practitioners bill patient visits to the PFS under a relatively generic set of codes that distinguish level of complexity, site of care, and in some cases whether or not the patient is new or established. These codes are called Evaluation and Management (E/M) visit codes. Billing practitioners must maintain information in the medical record that documents that they have reported the appropriate level of E/M visit code. CMS maintains guidelines that specify the kind of information that is required to support Medicare payment for each level. We agree with continued feedback from stakeholders that these guidelines are potentially outdated and need to be revised.

CMS thanks the public for the comments received in response to the proposed rule's comment solicitation on the E/M guidelines and summarizes these comments in the final rule. Commenters suggested that we provide additional avenues for collaboration with stakeholders prior to implementing any changes. We will consider the best approaches for such collaboration, and will take the public comments into account as we consider the issues for future rulemaking.

**Appropriate Use Criteria for Advanced Diagnostic Imaging**
CMS is finalizing a start date for the Medicare Appropriate Use Criteria (AUC) Program for Advanced Diagnostic Imaging. The program will begin in a manner that allows practitioners more time to focus on and adjust to the Quality Payment Program before being required to participate in the AUC program. The Medicare AUC program will begin with an educational and operations testing year in 2020, which means physicians would be required to start using AUCs and reporting this information on their claims. During this first year, CMS is proposing to pay claims for advanced diagnostic imaging services regardless of whether they correctly contain information on the required AUC consultation. This allows both clinicians and the agency to prepare for this new program.

CMS posted newly qualified provider-led entities and clinical decision support mechanisms in July of this year. Qualified provider-led entities are permitted to develop AUC, and qualified clinical decision support mechanisms are the tools that physicians use to access the AUC. Physicians may begin exploring these mechanisms well in advance of the start of the Medicare AUC program through the voluntary participation period that will begin mid-2018 and run through 2019.
During this time CMS will collect limited information on Medicare claims to identify advanced imaging services for which consultation with appropriate use criteria took place.

In addition, by having qualified clinical decision support mechanisms available (some of which are free of charge) clinicians may use one of these mechanisms to earn credit under the Merit-Based Incentive Payment System as an improvement activity. This improvement activity was included in the 2018 Quality Payment Program final rule.

**Medicare Diabetes Prevention Program Expanded Model**

The final rule also implements the Medicare Diabetes Prevention Program (MDPP) expanded model starting in 2018. The MDPP expanded model was announced in early 2016, when it was determined that the Diabetes Prevention Program (DPP) model test through the Center for Medicare and Medicaid Innovation's Health Care Innovation Awards met the statutory criteria for expansion. The final rule includes additional policies necessary for suppliers to begin furnishing MDPP services nationally in 2018, including the MDPP payment structure, as well as additional supplier enrollment requirements and supplier compliance standards aimed to enhance program integrity.

**Physician Quality Reporting System (PQRS)**

Under the PQRS, individual eligible professionals and group practices who did not satisfactorily report data on quality measures for the CY 2016 reporting period are subject to a downward payment adjustment of 2.0 percent in 2018 to their PFS covered professional services. 2016 was the last reporting period for PQRS. The final data submission timeframe for reporting 2016 PQRS quality data to avoid the 2018 PQRS downward payment adjustment was January through March 2017. PQRS is being replaced by the Merit-based Incentive Payment System (MIPS) under the Quality Payment Program (QPP). The first MIPS performance period is January through December 2017.

CMS proposed and is finalizing a change to the current PQRS program policy that requires reporting of 9 measures across 3 National Quality Strategy domains to only require reporting of 6 measures for the PQRS with no domain requirement. We are also finalizing similar changes to the clinical quality measure reporting requirements under the Medicare Electronic Health Record Incentive Program for eligible professionals who reported electronically through the PQRS portal.

CMS finalized these changes based on stakeholder feedback and to better align with the MIPS data submission requirements for the quality performance category. For MIPS, eligible clinicians need only report 6 quality measures for the quality performance category, except those reporting via the Web Interface, and there is no requirement to ensure that the measures span across 3 National Quality Strategy domains.

**Patient Relationship Codes**

In May 2017, CMS posted the operational list of patient relationship categories that are required under section 101(f) of MACRA. In this rule, we finalized certain Level II HCPCS modifiers to be used on claims to indicate these patient relationship categories. Further, we finalized a policy that the reporting of these HCPCS modifiers may be voluntarily by clinicians associated with these patient relationship categories beginning January 1, 2018. We anticipate that there will be a learning curve with respect to the use of these modifiers, and we will work with clinicians to ensure their proper use.

**Medicare Shared Savings Program**
CMS is finalizing several modifications to the rules for accountable care organizations (ACOs) participating in the Medicare Shared Savings Program. These modifications are designed to reduce burden and streamline program operations. The new policies include the following:

- Revisions to the assignment methodology for ACOs that include FQHCs and RHCs by eliminating the requirement to enumerate each physician working in the FQHC or RHC on the ACO participant list;
- Reduction of burden for ACOs submitting an initial Shared Savings Program application or the application for use of the skilled nursing facility (SNF) 3-Day Rule Waiver; and
- The addition of three new chronic care management codes (CCM) and four behavioral health integration (BHI) codes to the definition of primary care services used in the ACO assignment methodology.

**2018 Value Modifier**
In order to better align incentives and provide a smoother transition to the new Merit-based Incentive Payment System under the Quality Payment Program, we are finalizing the following changes to previously-finalized policies for the 2018 Value Modifier:

- Reducing the automatic downward payment adjustment for not meeting the criteria to avoid the PQRS adjustment from negative four percent to negative two percent (-2.0 percent) for groups of ten or more clinicians; and from negative two percent to negative one percent (-1.0 percent) for physician and non-physician solo practitioners and groups of two to nine clinicians;
- Holding harmless all physician groups and solo practitioners who met the criteria to avoid the PQRS adjustment from downward payment adjustments for performance under quality-tiering for the last year of the program; and Aligning the maximum upward adjustment amount to 2 times the adjustment factor for all physician groups and solo practitioners.
- Given final policy changes for the Physician Quality Reporting System and the Value Modifier, we finalized that we will not report 2018 Value Modifier data in the Physician Compare downloadable database as this would be the first and only year such data would have been reported. However, to promote transparency we will continue to make available the Value Modifier public use and research identifiable files.

In addition, CMS finalized policies for **Year 2 of the Quality Payment Program** to further reduce the burden and give physicians more ways to participate successfully. CMS is keeping many of the transition year policies and making some minor changes. Major highlights include:

- Weighting the MIPS Cost performance category to 10% of your total MIPS final score, and the Quality performance category to 50%.
- Raising the MIPS performance threshold to 15 points in Year 2 (from 3 points in the transition year).
- Allowing the use of 2014 Edition and/or 2015 Certified Electronic Health Record Technology (CEHRT) in Year 2 for the Advancing Care Information performance category, and giving a bonus for using only 2015 CEHRT.
- Awarding up to 5 bonus points on your MIPS final score for treatment of complex patients.

- Automatically weighting the Quality, Advancing Care Information, and Improvement Activities performance categories at 0% of the MIPS final score for clinicians impacted by Hurricanes Irma, Harvey and Maria and other natural disasters.
- Adding 5 bonus points to the MIPS final scores of small practices.
- Adding Virtual Groups as a participation option for MIPS.
- Issuing an interim final rule with comment for extreme and uncontrollable circumstances where clinicians can be automatically exempt from these categories in the transition year without submitting a hardship exception application (note that Cost has a 0% weight in the transition year) if they were have been affected by Hurricanes Harvey, Irma, and Maria, which occurred during the 2017 MIPS performance period.
- Decreasing the number of doctors and clinicians required to participate as a way to provide further flexibility by excluding individual MIPS eligible clinicians or groups with ≤$90,000 in Part B allowed charges or ≤200 Medicare Part B beneficiaries.
- Providing more detail on how eligible clinicians participating in selected APMs (known as MIPS APMs) will be assessed under the APM scoring standard.
- Creating additional flexibilities and pathways to allow clinicians to be successful under the All Payer Combination Option. This option will be available beginning in performance year 2019.

The Quality Payment Program final rule with comments can be downloaded from the Federal Register at: https://www.federalregister.gov/documents/2017/11/16/2017-24067/medicare-programs-cy-2018-updates-to-the-quality-payment-program-and-quality-payment-program-extreme.

On the state legislative side, MSSNY continues to work with a lot of the hospital groups and labor groups, health insurance companies, businesses. It is an odd coalition but frankly we all have a lot of stake in this with efforts to help make sure the various health insurance subsidies for a whole host of programs are continued in NY State - funding for CHIP - there over 350,000 kids enrolled in it; and funding for other cautionary programs.

Starting on January 2018 the law goes into effect that we worked on last year with many groups, helps to make sure that if a patient of yours is being required by their insurer to go through a Step Therapy Program Protocol. The new law give the physician an opportunity to have the plan reconsider its position regarding coverage for a drug that the patient can tolerate.

MSSNY continues to urge physicians to contact the Governor- to request a veto of the Governor of the Expansion Bill. A lot of physicians have weighed in; about 3,000 physicians have actually sent letters to the Governor urging that the bill be vetoed.

MSSNY has been working in conjunction with the Hospital Association, HANYS and MLMIC and several Specialty Societies across the state on generating grass roots to seek the Governor's veto. MSSNY has worked with County Societies leaders across the state to generate OP ED articles in local papers. OP EDs have appeared in Buffalo, Westchester, Syracuse, Albany and Middletown papers.

We're still pushing for a veto and a call for the Commission to come up with a more comprehensive proposal. Those efforts are ongoing. We strongly encourage you to keep up your Grassroots contacts. We generate a lot of contacts, but we want those contacts to continue so that when the bill is ultimately sent to the Governor's office those communications are really fresh in their mind.

**Old Business**

Dr. Gary Rudolph was elected as the Vice Chair of this Committee and once again congratulations to Dr. Rudolph.

In addition, Dr. Steven Schwalbe is the nomination as the MSSNY representative to the Medicare Carrier Advisory Committee.

Congratulations all around!

There being no additional business for today's meeting, the call was concluded. Dr. Schwalbe thanked the attendees for their participation and the call ended.

Respectfully submitted,

Steven S. Schwalbe, MD, Chairman

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October 17, 2017

National Government Services, Inc.
LCD Comments
Virginia Muir
P. O. Box 7108
Indianapolis, IN, 46207-7108
PartBLCDComments@anthem.com
(Submitted electronically)

RE: **PROPOSED/DRAFT Local Coverage Determination (LCD): Prostate Rectal Spacers (DL37485)**

Dear Ms. Muir:

The American Society for Radiation Oncology (ASTRO)[1] and the American College of Radiology (ACR)[2] appreciate the opportunity to provide input on the National Government Services, Inc. draft Local Coverage Determination (LCD): Prostate Rectal Spacers (DL37485). We are concerned by National Government Services' decision to classify the material and device associated with this treatment as not medically necessary.

**About the Product/Procedure:**
Rectal Spacers are absorbable hydrogel spacers designed to reduce unintentional rectal injury in men undergoing prostate radiotherapy. Using ultrasound guidance, the hydrogel is administered as a liquid that expands in the space between Denonvilliers' fascia and the rectal wall, where it solidifies into a soft, but firm, hydrogel within 10 seconds. It is important to note that the spacer material remains intact during the course of radiation therapy (approximately 3 months), after which it liquefies and is naturally absorbed and cleared in the patient's urine within 6 months. The hydrogel is composed of water and polyethlyne glycol (PEG) a compound used widely in pharmaceuticals and cosmetics due to its high level of biocompatibility, lack of toxicity, and long term safety profile.

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[1] *ASTRO members are medical professionals, who practice at hospitals and cancer treatment centers in the United States and around the globe, and make up the radiation therapy treatment teams that are critical in the fight against cancer. These teams often include radiation oncologists, medical physicists, medical dosimetrists, radiation therapists, oncology nurses, nutritionists and social workers, and treat more than one million cancer patients each year. We believe this multi-disciplinary membership makes us uniquely qualified to provide input on the inherently complex issues related to Medicare payment policy and coding for radiation oncology services.*

[2] *The American College of Radiology (ACR) is a professional organization representing more than 36,000 radiologists, radiation oncologists, interventional radiologists, nuclear medicine physicians, and medical physicists. The ACR, founded in 1924, is a professional medical society dedicated to serving patients and society by empowering radiology professionals to advance the practice, science and professions of radiologic care.*

On July 1, 2016, temporary HCPCS C-code C9743 (injection/implantation of bulking or spacer material (any type) with or without image guidance, for Hospital Outpatient and ASC's only), was deleted and replaced by Category III code, 0438T. This code is used to report rectal placement of spacer gels.

The leading side effects of prostate cancer radiotherapy, collectively known as "rectal toxicity" (diarrhea, rectal bleeding, urgency, pain, etc.), result from unintended radiation injury to the rectum. These complications can last for years and significantly impact patients' quality of life. Rectal spacer gels were developed to push the rectum away from the high dose region during treatment, providing protection to other vital organs that might otherwise require treatment due to side effects. As protracted rectal toxicity is expensive to manage, rectal spacer gels ultimately reduce the overall cost of care for patients receiving radiotherapy for prostate cancer.

**Clinical Evidence:**
NGS alleges that there is insufficient evidence showing reductions in toxicity and improvement in health outcomes to demonstrate that rectal biodegradable gel spacers are reasonable and necessary for the treatment of prostate cancer. However, a randomized clinical trial has shown that the biodegradable gel material reduces toxicity for patients treated with radiotherapy for prostate cancer[3]. Specifically, this Level I clinical data demonstrates greater than 70% reductions in acute rectal pain and chronic rectal complications and improved bowel quality of life scores for such patients treated with a rectal spacer versus those patients treated without a spacer. Based on published clinical outcomes data from this pivotal trial, the perirectal hydrogel spacer provides physicians with an option to help ensure patients are provided with the best clinical outcomes with the fewest adverse effects.

The benefits documented in this initial report were confirmed with a subsequent report of the same trial, with a median follow-up period of 3 years. There was a sustained 75% reduction in any rectal toxicity persisting at 3 years, as well as significant reductions in urinary toxicity.[4]

ASTRO and ACR support federal and private payer reimbursement for the procedure of rectal spacer gel placement and the material itself, and urge National Government Services to reconsider their classification of transperineal placement of biodegradable material as not medically necessary. Multiple clinical trials with long-term follow up have proven the procedure to be safe and beneficial for patients. In addition to FDA approval,[5] the procedure was

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[3] Mariados N, Sylvester J, Shah D, et al: Hydrogel spacer prospective multicenter randomized controlled pivotal trial: dosimetric and clinical effects of perirectal spacer application in men undergoing prostate image guided intensity modulated radiation therapy. Int J Radiat Oncol Biol Phys 92:971-977, 2015.
[4] Hamstra, D.A. et al: Continued Benefit to Rectal Separation for Prostate RT: Final Results of a Phase III Trial. Int J Radiation Oncol Biol Phys, 97:5:976-985, 2017.
[5] De Nove Classficiation Request for SPACEOAR System. Decision Summary. http://www.accessdata.fda.gov/cdrh_docs/reviews/den140030.pdf. Accessed 3.7.17.

approved for Category I status by the AMA CPT® Editorial Panel (page 5, tab 34).[6] As it is currently written, this LCD could compromise the quality of cancer care received by Medicare beneficiaries and their quality of life following treatment.

ASTRO and ACR appreciate your consideration of our comments. Should you have any questions or require further assistance, please contact Jessica Adams, Health Policy Analyst, at 703.839.7396 or Jessica.adams@astro.org, or Anita McGlothlin, Senior Analyst, at amcglothlin@acr.org.

Respectfully submitted,

Laura I Thevenot
Chief Executive Officer

William T. Thorwarth, Jr., MD, FACR
Chief Executive Officer

Enclosed: *Continued Benefit to Rectal Separation for Prostate Radiation Therapy: Final Results of a Phase III Trial*

[6]CPT® Editorial Summary of Panel Action September-October, 2016. https://www.ama-assn.org/sites/default/files/media-browser/public/cpt/sept-oct-2016-cpt-summary-of-panel-actions.pdf. Accessed 3.7.17.

# National Government Services
# JK CAC Meeting

## For Audio Connection to this Meeting call

(866) 591-0127

## Conference code:

84328134

National Government Services

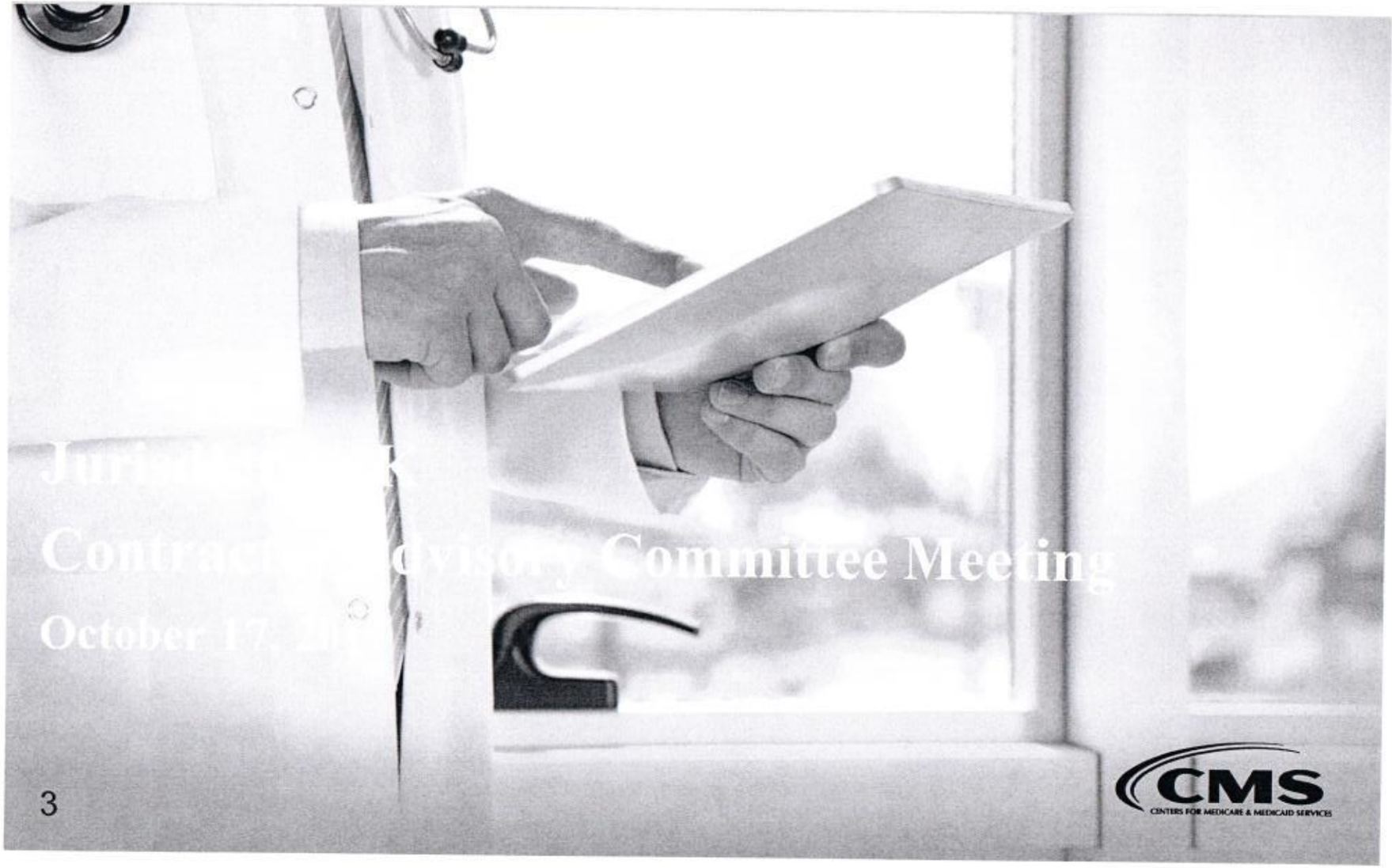
CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

# RECORDING

- This call is being recorded and transcribed, only for purposes of preparing Minutes.

National Government Services

National Government Services



# Jurisdiction [illegible]

# Contractor Advisory Committee Meeting

October 17, 20[illegible]

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

# WELCOME

Stephen Boren, M.D.
Laurence Clark, M.D.
Craig Haug, M.D.

JK Contractor Medical Directors

National Government Services

# Agenda

- Welcome
- Introductory Comments
- JK Draft Local Coverage Determinations
- Targeted Probe and Educate Program
- Medicare Legislative Updates
- CERT Update
- Open Forum

National Government Services

# JK Draft Local Coverage Determinations

- New Draft LCDs
  - Prostatic Rectal Spacers (DL37485)
  - Vitamin D Assay Testing (DL37535)
  - Magnetic Resonance Image Guided H igh Intensity Focused Ultrasound (MRgFUS) for Essential Tremor (DL37421)
  - Frequency of Hemodialysis (DL37475)

National Government Services

# Prostatic Rectal Spacers (DL37485)

- Prostate rectal spacers are various materials or devices placed between the prostate and anterior wall of the rectum for use in men receiving radiation therapy for prostate cancer. The anterior wall of the rectum is considered a major dose-limiting factor in radiation therapy of prostate cancer.
- Physical separation is proposed to allow reduced toxicity and treatment intensification.
- Although the concept of reducing the radiation dose to the rectum during prostate cancer radiation is attractive, there is currently insufficient evidence to show reductions in toxicity and improvement in health outcomes and to conclude that these spacers are reasonable and necessary

National Government Services.

# Vitamin D Assay Testing (DL37535)

- The CDC reported approximately 300,000 hip fractures, 60,000 fall related deaths and 33 billion dollars in health care expenditures in 2014.
- This LCD identifies the indications and limitations of Medicare coverage for Vitamin D; 25 hydroxy and Vitamin D; 1, 25 dihydroxy laboratory assays in the medical management of patients.

National Government Services

# Vitamin D Assay Testing (DL37535)

- **Indications of Coverage**
  - Measurement of 25-OH Vitamin D, CPT 82306, level is indicated for patients with: chronic kidney disease stage III or greater, cirrhosis, hypocalcemia, hypercalcemia, hypercalciuria, hypervitaminosis D, parathyroid disorders, malabsorption states, obstructive jaundice, osteomalacia, and
  - Osteoporosis (see policy parameters)
  - osteosclerosis/petrosis
  - rickets
  - vitamin D deficiency on replacement therapy related to a condition listed above; to monitor the efficacy of treatment.

National Government Services

# Vitamin D Assay Testing (DL37535)

## Indications of Coverage

- Measurement of 1, 25-OH Vitamin D, CPT 82652, level is indicated for patients with:
  - unexplained hypercalcemia (suspected granulomatous disease or lymphoma)
  - unexplained hypercalciuria (suspected granulomatous disease or lymphoma)
  - suspected genetic childhood rickets
  - suspected tumor-induced osteomalacia
  - nephrolithiasis or hypercalciuria

National Government Services

# Vitamin D Assay Testing (DL37535) Analysis of Evidence

- It is established that 25-hydroxyvitamin D is more reflective of total body stores of vitamin D than the shorter lived, active metabolite, 1,25 dihydroxyvitamin D.
- The benefits of treatment of Vitamin D supplementation may be modest, and those benefits made difficult to quantify by general health, habits such as exercise and smoking, and other contributory factors such as ethnicity and medication treatment regimens.
- However, the prevalence of osteoporosis, fall risk and skeletal fractures, and the general tolerance of the current recommended daily requirements mitigate for early supplementation
- Once a beneficiary has been shown to be Vitamin D deficient, by assay or clinical findings, the correctly chosen assay (25 hydroxyvitamin D, or 1,25 di-hydroxyvitamin D) may be used to assure correct supplementation to attain the serum levels outlined in Limitations. Continued findings outside those parameters (again outlined in the Limitations section) may warrant additional testing.

National Government Services.

# Magnetic Resonance Image Guided High Intensity Focused Ultrasound (MRgFUS) for Essential Tremor (DL37421)

- This LCD addresses use of Magnetic Resonance Guided Focused Ultrasound Surgery System (MRgFUS) for the treatment of idiopathic essential tremor (ET) patients with medication-refractory tremor.
- MRgFUS is a promising new treatment approach that has attributes, positive and negative, distinct from both traditional thalamotomy and deep-brain stimulation (DBS). However, long-term effectiveness and safety remain uncertain and warrant a direct comparison with DBS, the current surgical standard.
- NGS, therefore, concludes that Medicare coverage criteria are not yet met for MRgFUS in the treatment of medication-refractory ET.

National Government Services

# Frequency of Hemodialysis (DL37475)

- Hemodialysis for ESRD patients at 3 times (3 X) per week is noted to be 'conventional' treatment. CMS established payment for hemodialysis based on conventional treatment.
- Hence, Medicare reimburses HD treatments 3 times per week (13/14 sessions per month depending on length of month). In CMS-1651-F (November 4, 2016), CMS outlines the process for medical justification for additional treatment payments. The following statements are made:
- *Under this policy, the MACs determine whether additional treatments furnished during a month are medical necessary and when the MACs determine that the treatments are medically justified, we pay the full base rate for the additional treatments. .*

National Government Services

# Frequency of Hemodialysis (DL37475)

- **Indications of Coverage**
  - This LCD sets out medical conditions likely to meet medical justification for additional payments:
  - Metabolic acidosis
  - Fluid positive status not controlled with routine dialysis
  - Hyperkalemia
  - Pregnancy
  - Heart Failure
  - Pericarditis
  - Incomplete dialysis secondary to hypotension or access issues

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# Frequency of Hemodialysis (DL37475)

- **Limitations of Coverage**
  - The following are considered not reasonable and necessary and therefore will be denied as not medically justified for payments.
  - Plan of Care (POC) number of sessions above 3 times per week (for example the POC states 5 times per week)-those above 3 times per week are not medically justified for additional payment
  - Planned inadequate or short dialysis
  - Convenience of patient or staff

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# Draft LCDs

**Official Comment Period ends on November 30, 2017**

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# Draft LCD Comments

To comment on a draft LCD during a formal comment period:

- PartBLCDComments@anthem.com

- National Government Services, Inc.
  LCD Comments
  P.O. Box 7108
  Indianapolis, IN 46207-7108

National Government Services

# Targeted Probe and Educate Program


Nancy Krupka, MS, BSN, RN

*Manager Medical Review- Part A, HH &H-JK*

Mary King-Maxey, BA

*Manager, Medical Review- Part B-JK*


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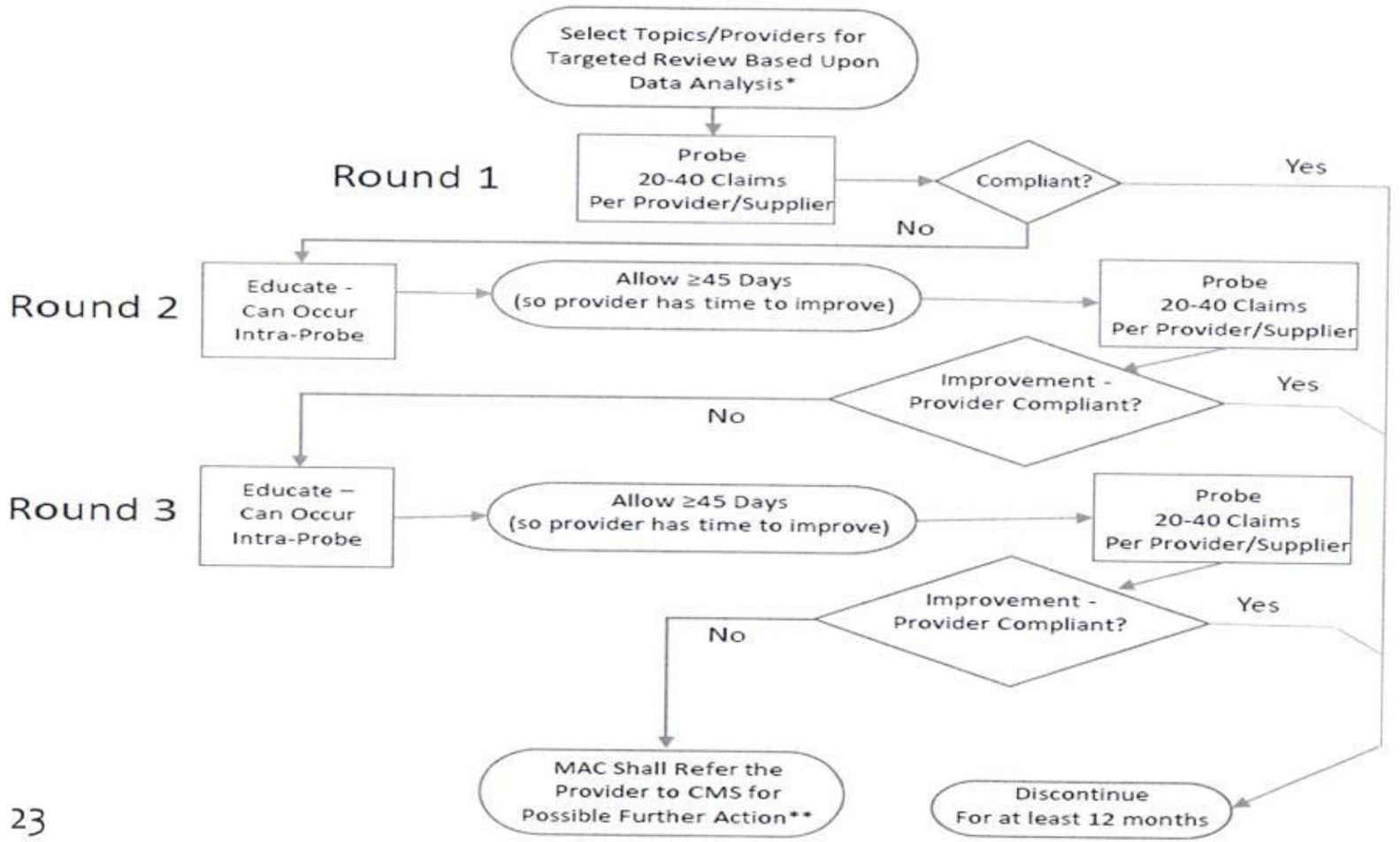
* Program that combined a review of a sample of claims with education to help reduce errors in the claims submission process
  * Review of 20-40 claims per provider, per item or service, per round, for a total of up to three rounds of review
  * After each round, providers are offered individualized education based on the results of their reviews

As a result of the successes demonstrated during the pilot, including an increase in the acceptance of provider education as well as a decrease in appealed claims decisions, CMS has decided to expand to all MAC jurisdictions later in 2017

* The MACs will select claims for items/services that pose the greatest financial risk to the Medicare trust fund and/or those that have a high national error rate
* MACs will focus only on providers/suppliers who have the highest claim error rates or billing practices that vary significantly out from their peers.

* Process includes a review of 20-40 claims followed by one-on-one, provider-specific, education to address any errors with in the provider's reviewed claims
* Providers/suppliers with moderate and high error rates in the first round of reviews, will continue on to a second round of 20-40 reviews, followed by additional, provider specific, one-on-one education
* Providers/suppliers with high error rates after round two will continue to a third and final round of probe reviews and education
* Providers/suppliers with continued high error rates after three rounds of TPE may be referred to CMS for additional action


Select Topics/Providers for Targeted Review Based Upon Data Analysis*
Round 1
Probe 20-40 Claims Per Provider/Supplier
Compliant?
Yes
No
Round 2
Educate - Can Occur Intra-Probe
Allow ≥45 Days (so provider has time to improve)
Probe 20-40 Claims Per Provider/Supplier
Improvement - Provider Compliant?
Yes
No
Round 3
Educate – Can Occur Intra-Probe
Allow ≥45 Days (so provider has time to improve)
Probe 20-40 Claims Per Provider/Supplier
Improvement - Provider Compliant?
Yes
No
MAC Shall Refer the Provider to CMS for Possible Further Action**
Discontinue For at least 12 months

* https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Targeted-Probe-and-EducateTPE.html

* www.ngsmedicare.com

# Medicare Legislative Update
# October 2017

National Government Services

# Topics

Medicare continues to change!

Proposed 2018 Rule and 21st Century Cures Act and PQRS

New Medicare Card and Medicare Updates

Operational tips and working with National Government Services





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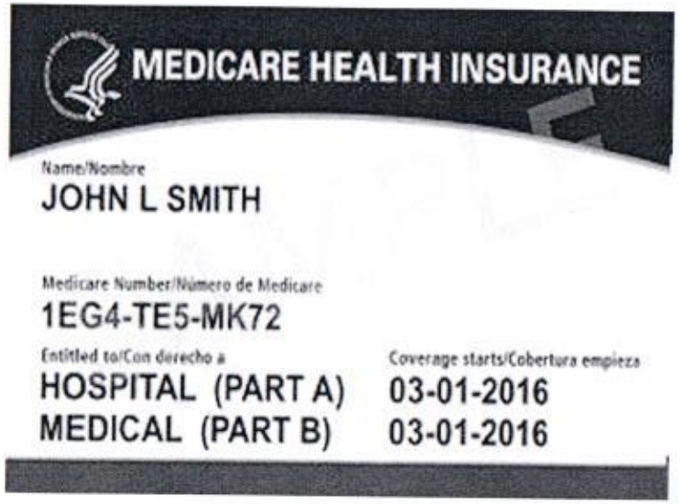
# The New Medicare Card

Starting April 2018






CMS CENTERS FOR MEDICARE & MEDICAID SERVICES



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# The New Medicare Card

The Health Insurance Claim Number (HICN) is a Medicare beneficiary's identification number, used for processing claims and for determining eligibility for services across multiple entities (for example, Social Security Administration (SSA), Railroad Retirement Board (RRB), States, Medicare providers, and health plans).

The MACRA legislation requires that CMS mail out new Medicare cards with a new Medicare Number (also referred to as Medicare Beneficiary Identifier – (MBI)) by April 2019.

The new Medicare numbers won't change Medicare benefits. People with Medicare may start using their new Medicare cards as soon as they get them.





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# Prepare for the Medicare Beneficiary Identifier - MBI

CMS will begin mailing new cards in April 2018 and will meet the congressional deadline for replacing all Medicare cards by April 2019

The gender and signature line will be removed from the new Medicare cards

The Railroad Retirement Board will issue their new cards to RRB beneficiaries

CMS will work with states that currently include the HICN on Medicaid cards to remove the Medicare ID or replace it with an MBI

CMS will conduct intensive education and outreach to all Medicare be beneficiaries, their families, caregivers, and advocates to help prepare for or this change





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# 2018 Proposed Rule for Physician Fee Schedule comment period closed 9/11/17

- Overall Payment Update and Mis-valued Code Target
  The proposed 2018 PFS conversion factor is $35.99, an increase to the 2017 PFS conversion factor of $35.89.
- Malpractice Relative Value Units (RVUs)
- Care Management Services
- Improvement of Payment Rates for Behavioral Health Services
- Evaluation and Management Comment Solicitation
- Emergency Department Visits Comment Solicitation

Anticipate final rule will be published in November for January 1, 2018 fee schedule update.

# 21st Century Cures Act

Improving Medicare local coverage determinations (LCD)

- Medicare Administrative Contractors to post details of LCDs 45 days before effective date

Medicare site-of-service price transparency

- Hospital outpatient departments and ambulatory care centers must post the estimated payment amount for a service and the beneficiary liability

Preserving Medicare beneficiary choice under MA beginning in 2019

- First 3 months each year, those who are MA eligible can change coverage

Allowing people with End-Stage Renal Disease to choose an MA Plan beginning in 2021

- Organ procurement will be covered by Original Medicare

# Updates were made on October 1, 2017!

**Watch out for changes by specialty!**

**NGSMedicare - October Monthly Medicare Review contains all updates to NGS LCDs.**

Visit the ICD-10 website for official resources, including:

Updates to the Clarifying Questions and Answers

CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities

Step-by-step resource list to help you quickly locate contacts

2017 ICD-10-CM diagnosis code set and guidelines

2017 ICD-10-PCS inpatient procedure code set and guidelines





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# Provider Review of MOON implementation

Medicare Outpatient Observation Notice (MOON)

- Office of Management & Budget (OMB) approved standardized notice (CMS Form CMS-10611) to inform a Medicare beneficiary they are receiving outpatient observation services Not receiving inpatient services
- The form requires a statement of the beneficiaries health issues.
- Start the process after 24 after admission; issue within 36 hours.

Applies to all hospitals and critical access hospitals (CAH)

All hospitals, including CAHs, must begin using the MOON notice **no later than 3/8/2017**

**Role of the physician signing the order to admit the beneficiary.**

**This is a mandate for hospitals.**





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# 2018 changes are coming

| 2017 | 2018 |
| --- | --- |
| Monthly Part B Premium for Beneficiary $109. (70% ) Income above $85,000 up to $107,000 pay higher part B Premium $134. | Monthly Part B Premium for Beneficiary ? Income above $85,000 up to $107,000 pay higher part B Premium |
| Part B Deductible $183. | Part B Deductible ? |
| Part B Coinsurance 20% | Part B Coinsurance 20% |
| Mental Health Services 80% | Mental Health Services 80 % |
| Part A IH Deductible $1316. | Part A IH Deductible ? |





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# Medicare Open Enrollment

## October 15, 2017 – December 7, 2017: Open Enrollment

Continue "Card Awareness" outreach through messaging embedded in regular Open Enrollment events and earned media, steady drumbeat messaging via press, social media, speaking engagements, blogs, etc.

Card messaging should supplement, but not supersede "review and compare" actions for Open Enrollment

## January 2018 – March 2018: New Cards are Coming!

Ramp up pre-mailing outreach and identify opportunities for sharing messages and materials with providers and people with Medicare





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# Expand and Improve billing for Preventive Services

| Period of eligibility: | Year 1<br>(first 12 months) | Year 2<br>(second 12 months) | Year 3 and after<br>(third 12 mo. and each 12-mo. period following AWV) |
|---|---|---|---|
| **Medicare benefit:** | **"Welcome to Medicare"**<br><br>Initial Preventive Physical Exam (IPPE) | **Initial Annual Wellness Visit**<br><br>(AWV) | **Subsequent Annual Wellness Visit**<br><br>(AWV) |
| **Billing code:** | G0402 | G0438 | G0439 |





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# Seasonal Influenza Virus Vaccine and more! Use educational materials

**Administration Code:** G0008

**Diagnosis Code:** Z23

**90630** – Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use

**90653** – Influenza vaccine, inactivated (IIV), subunit, adjuvanted, for intramuscular use

**90654** – Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use

**90655** – Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.25 mL dosage, for intramuscular use

**90656** – Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.5 mL dosage, for intramuscular use

**90657** – Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 mL dosage, for intramuscular use

**90658** – Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use

**90660** – Influenza virus vaccine, trivalent, live (LAIV3), for intranasal use

**90661** – Influenza virus vaccine, trivalent (ccIIV3), derived from cell cultures, subunit,

# NGS Focus - Reducing the provider burden

Reduction in Claim Submission Errors

Reduction in unnecessary appeals

Elimination of Handwritten Paper Claims for Part B for JK
in place for J6 in early 2017.

Increase use of NGSConnex

Increase use of ERA

Provider Revalidation

Overpayment Recovery

# NGS Recent Activity to Improve E&M billing

Major recent activity on improving billing and provider awareness:

1. Large, well attended E&M sessions
2. Information posted on

   www.ngsmedicare.com

   Medical policy and review / E&M documentation
3. Next session is scheduled for November 8, 2017

   with Medical Directors participating.





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# Important Notice for JK Paper claims submitters

NGS will no longer accept handwritten claims

Connex with enhancements is the solution

| Effective | State/Locality | State |
|---|---|---|
| 7/10/2017 | Maine, New Hampshire, Rhode Island, Vermont | |
| 8/7/2017 | New York (Upstate: Localities 03 and 99) | New York Locality/Area and County Information |
| 9/11/17 | Connecticut | |
| Provider Contact and Educate | **Massachusetts** | |
| Provide Contact and Educate | **New York (Downstate: Localities 01, 02, and 04)** | **New York Locality/Area and County Information** |

# Qualified Medicare Beneficiaries (QMB)

People who are eligible to receive benefits from **both** the **Medicare** and **Medicaid** programs at the same time are known as "**dual eligible beneficiaries**."

CMS has two excellent resources to help our providers understand dual eligible beneficiaries under the Medicare and Medicaid programs.

- The Dual Eligible Beneficiaries Under the Medicare and Medicaid Programs Fact Sheet
- The Special Edition MLN Matters Article SE1128 Revised: Prohibition on Balance Billing Dually Eligible Individuals Enrolled in the Qualified Medicare Beneficiary (QMB) Program

Starting in October 2017, Medicare remittances will contain a remark that the beneficiary is eligible for QMB benefits





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# 2016 PQRS Feedback Reports and Annual QRURs Available

- The 2016 PQRS Feedback Reports and 2016 Annual Quality and Resource Use Reports (QRURs) are available if you are subject to the 2018 PQRS downward payment adjustment
- The 2016 Annual QRURs show how physicians performed in 2016 on the quality and cost measures used to calculate the 2018 Value Modifier, as well as their practice's 2018 Value Modifier payment adjustment
- You may request an informal review of your 2016 PQRS results and/or 2018 Value Modifier calculation during the informal review period that will close on **December 1, 2017**
- Call the QPP line for all needed assistance: **QualityNet Help Desk** 1-866-288-8912 Qnetsupport@hcqis.org Week days - 7:00 am - 7:00pm





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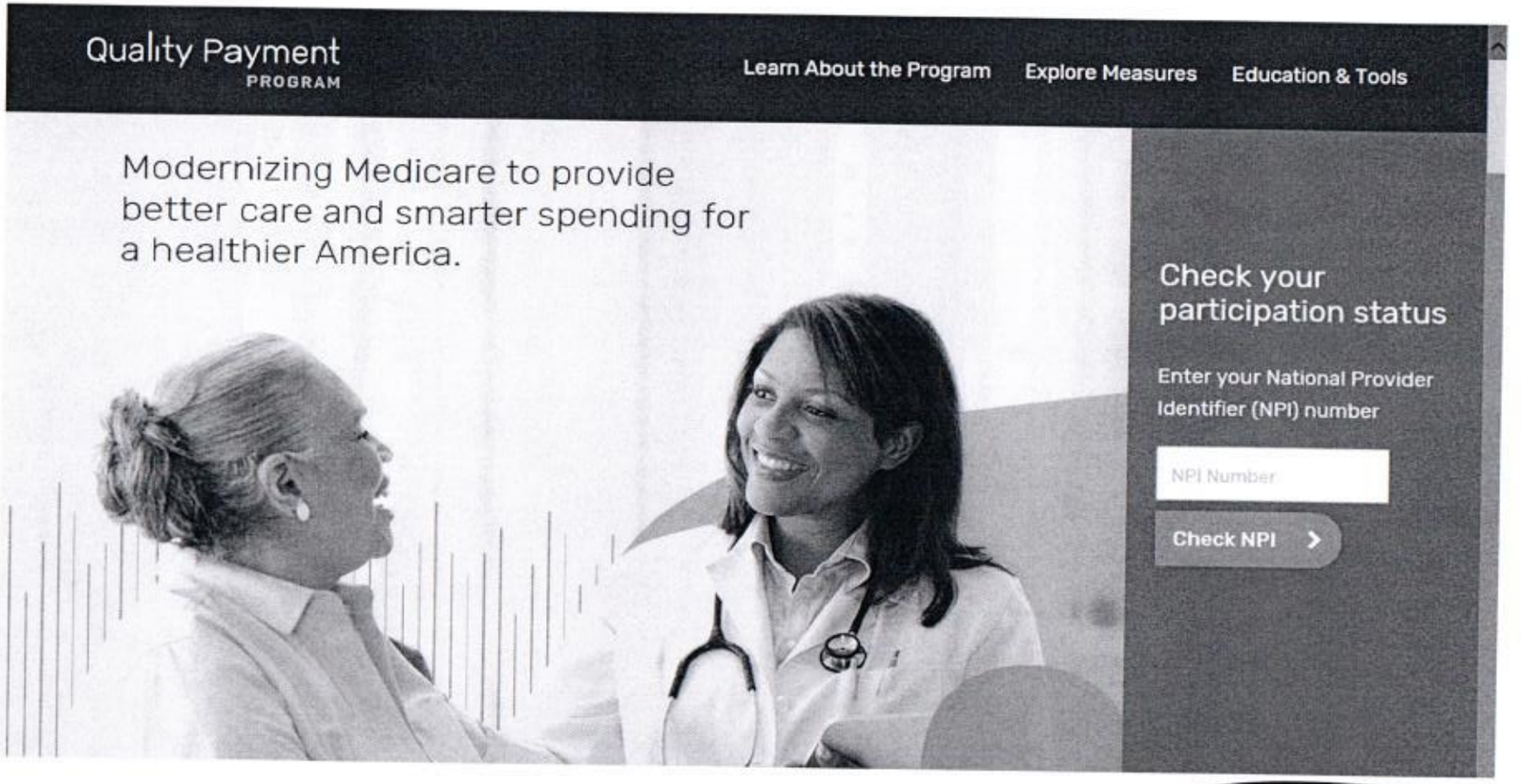
# Quality Payment Program - QPP

Home web page – https://qpp.cms.gov/





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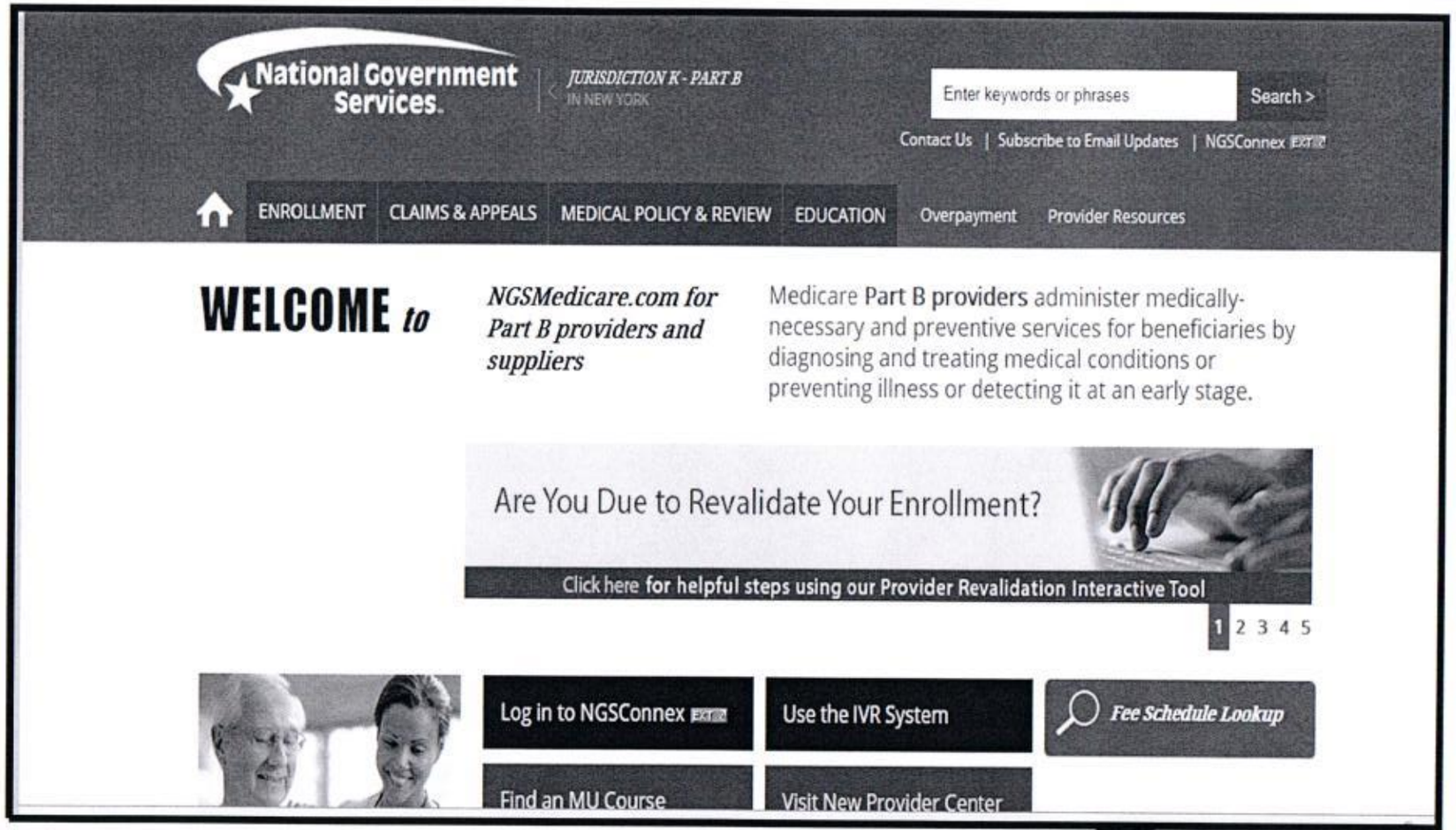
# Take Advantage of NGS educational programs





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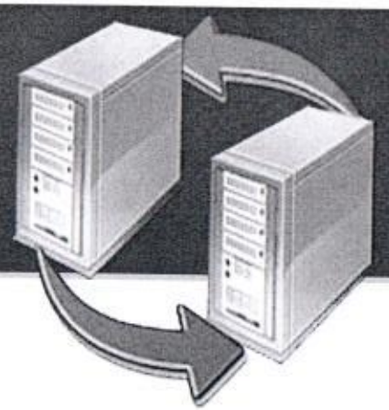
# Connex is new and approved!



**New and Improved NGSConnex is Now Available**

## What isn't changing?

- Functionality

## What will you see?

- Refreshed visual design
- Simplified and consistent navigation
- Revised logout process
- For detailed instructions on the new and improved NGSConnex, visit the NGSConnex home page in the **Provider Resources** section of our website.





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# Connex is the solution for your practice!

Access Needed:

- **Internet access and email**

Provides:

Submit claims - new features added

- Claim status
- Beneficiary eligibility/therapy caps - New Medicare Card!!!
- Financial data/Provider demographics
- Ability to order/download duplicate remittances
- Redeterminations/ Reopenings
- Inquiries
- Submission of medical records (ADR request) Part B only





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*Thank you for your support and sharing this information with your members.*

*Your questions!*





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# JK MAC
# CERT UPDATE

# Improper Payment Rates and Projected Improper Payments by Claim Type and Over/Under Payments (Dollars in Billions)

| Claim Type | Overall Improper Payments | | | Overpayments | | Underpayments | |
|---|---|---|---|---|---|---|---|
| | Total Amount Paid | Improper Payment Amount | Improper Payment Rate | Improper Payment Amount | Improper Payment Rate | Improper Payment Amount | Improper Payment Rate |
| Part A (Total) | $272.3 | $27.2 | 10.0% | $26.5 | 9.7% | $0.7 | 0.3% |
| Part A (Excluding Hospital IPPS) | $157.5 | $22.0 | 14.0% | $22.0 | 13.9% | $0.0 | 0.0% |
| Part A (Hospital IPPS) | $114.8 | $5.2 | 4.5% | $4.5 | 3.9% | $0.7 | 0.6% |
| Part B | $93.3 | $10.9 | 11.7% | $10.4 | 11.2% | $0.5 | 0.6% |
| DMEPOS | $8.1 | $3.7 | 46.3% | $3.7 | 46.1% | $0.0 | 0.1% |
| **Total** | **$373.7** | **$41.8** | **11.2%** | **$40.6** | **10.9%** | **$1.2** | **0.3%** |

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/MedicareFeeforService2016ImproperPaymentsReport.pdf

# Projected Improper Payments, Overpayments and Underpayments by Top 10 States (Dollars in Millions)

| State | Overall | | Overpayments | | Underpayments | |
|---|---|---|---|---|---|---|
| | Improper Payment Amount | Improper Payment Rate | Improper Payment Amount | Improper Payment Rate | Improper Payment Amount | Improper Payment Rate |
| CA | $4.790.9 | 13.6% | $4.662.1 | 13.2% | $128.8 | 0.4% |
| TX | $4.383.2 | 17.5% | $4.284.1 | 17.1% | $99.1 | 0.4% |
| FL | $3.417.2 | 12.9% | $3.331.2 | 12.6% | $86.1 | 0.3% |
| PA | $2.215.0 | 12.9% | $2.179.0 | 12.7% | $36.0 | 0.2% |
| IL | $1.949.9 | 13.1% | $1.906.5 | 12.8% | $43.5 | 0.3% |
| OH | $1.595.4 | 12.4% | $1.489.5 | 11.5% | $105.9 | 0.8% |
| NJ | $1.587.8 | 12.7% | $1.537.2 | 12.3% | $50.6 | 0.4% |
| NY | $1.501.6 | 6.3% | $1.387.4 | 5.9% | $114.2 | 0.5% |
| NC | $1.445.0 | 11.8% | $1.400.4 | 11.5% | $44.6 | 0.4% |
| GA | $1.390.9 | 13.6% | $1.372.2 | 13.5% | $18.7 | 0.2% |
| **Overall** | **$41,826.2** | **11.2%** | **$40,586.4** | **10.9%** | **$1,239.7** | **0.3%** |

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/MedicareFeeforService2016ImproperPaymentsReport.pdf

# Service-Specific Underpayment Rates: Part B

| Part B Services (HCPCS) | Projected Dollars Underpaid | Underpayment Rate |
|---|---|---|
| Office/outpatient visit est (99213) | $226,020,284 | 4.1% |
| Office/outpatient visit est (99212) | $79,576,743 | 15.7% |
| Office/outpatient visit est (99214) | $53,439,083 | 0.7% |
| Subsequent hospital care (99231) | $35,354,944 | 12.2% |
| All Codes With Less Than 30 Claims | $27,154,261 | 0.1% |
| Office/outpatient visit new (99203) | $21,559,909 | 2.4% |
| Emergency dept visit (99283) | $15,940,094 | 9.9% |
| Nursing fac care subseq (99308) | $13,182,878 | 2.4% |
| Therapeutic exercises (97110) | $6,860,756 | 0.6% |
| Nursing fac care subseq (99307) | $5,253,623 | 4.7% |
| Office/outpatient visit new (99202) | $5,202,612 | 3.1% |
| Initial hospital care (99222) | $4,967,343 | 0.7% |
| Subsequent hospital care (99232) | $4,793,865 | 0.2% |
| Emergency dept visit (99284) | $3,877,239 | 0.8% |
| BLS (A0428) | $3,014,364 | 0.3% |
| Chiropract manj 1-2 regions (98940) | $2,793,587 | 1.9% |
| Rituximab injection (J9310) | $2,534,781 | 0.6% |
| Office/outpatient visit new (99204) | $1,705,138 | 0.1% |
| Office/outpatient visit est (99211) | $1,388,035 | 2.0% |
| Psytx pt&/family 45 minutes (90834) | $1,213,864 | 0.4% |
| **Combined** | **$520,758,056** | **0.6%** |

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/AppendicesMedicareFee-for-Service2016ImproperPaymentsReport.pdf

# Service-Specific Underpayment Rates: Part A Excluding Hospital IPPS

| Part A Excluding Hospital IPPS Services (TOB) | Projected Dollars Underpaid | Underpayment Rate |
|---|---|---|
| SNF Inpatient | $18,006,473 | 0.1% |
| Hospital Outpatient | $12,092,580 | 0.0% |
| Critical Access Hospital | $7,945,701 | 0.2% |
| SNF Inpatient Part B | $4,489,796 | 0.2% |
| Home Health | $4,100,714 | 0.0% |
| Hospital Other Part B | $2,952,847 | 0.4% |
| All Other Codes | $0 | 0.0% |
| **Combined** | **$49,588,111** | **0.0%** |

https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/AppendicesMedicareFee-for-Service2016ImproperPaymentsReport.pdf

# Service-Specific Underpayment Rates: Part A Hospital IPPS

| Part A Hospital IPPS Services (MS DRGs) | Projected Dollars Underpaid | Underpayment Rate |
|---|---|---|
| All Codes With Less Than 30 Claims | $312,262,982 | 1.0% |
| Major Joint Replacement Or Reattachment Of Lower Extremity W/O Mcc (470) | $83,730,259 | 1.4% |
| Simple Pneumonia & Pleurisy W Mcc (193) | $21,651,703 | 1.4% |
| Misc Disorders Of Nutrition, metabolism, fluids/Electrolytes W/O Mcc (641) | $13,789,229 | 2.0% |
| Heart Failure & Shock W Cc (292) | $11,548,700 | 0.8% |
| Chronic Obstructive Pulmonary Disease W/O Cc/Mcc (192) | $10,217,027 | 3.2% |
| Pulmonary Edema & Respiratory Failure (189) | $9,613,545 | 0.9% |
| Signs & Symptoms W/O Mcc (948) | $8,976,820 | 4.5% |
| Cardiac Arrhythmia & Conduction Disorders W/O Cc/Mcc (310) | $8,902,599 | 2.9% |
| Simple Pneumonia & Pleurisy W/O Cc/Mcc (195) | $8,371,940 | 2.9% |
| Kidney & Urinary Tract Infections W/O Mcc (690) | $8,323,549 | 1.0% |
| Heart Failure & Shock W Mcc (291) | $8,322,617 | 0.4% |
| Heart Failure & Shock W/O Cc/Mcc (293) | $8,296,796 | 2.7% |
| Esophagitis, Gastroent & Misc Digest Disorders W/O Mcc (392) | $7,976,235 | 0.8% |
| Perc Cardiovasc Proc W Drug-Eluting Stent W Mcc Or 4+ Vessels/Stents (246) | $6,832,542 | 1.1% |
| Cellulitis W/O Mcc (603) | $6,203,482 | 0.8% |
| Intracranial Hemorrhage Or Cerebral Infarction W Cc Or TPA In 24 Hrs (065) | $5,665,941 | 0.7% |
| Perc Cardiovasc Proc W Drug-Eluting Stent W/O Mcc (247) | $5,200,805 | 0.5% |
| Renal Failure W Cc (683) | $5,015,261 | 0.6% |
| Chronic Obstructive Pulmonary Disease W Cc (191) | $4,643,959 | 0.6% |
| All Other Codes | $103,794,584 | 0.2% |
| **Combined** | **$659,340,575** | 0.6% |

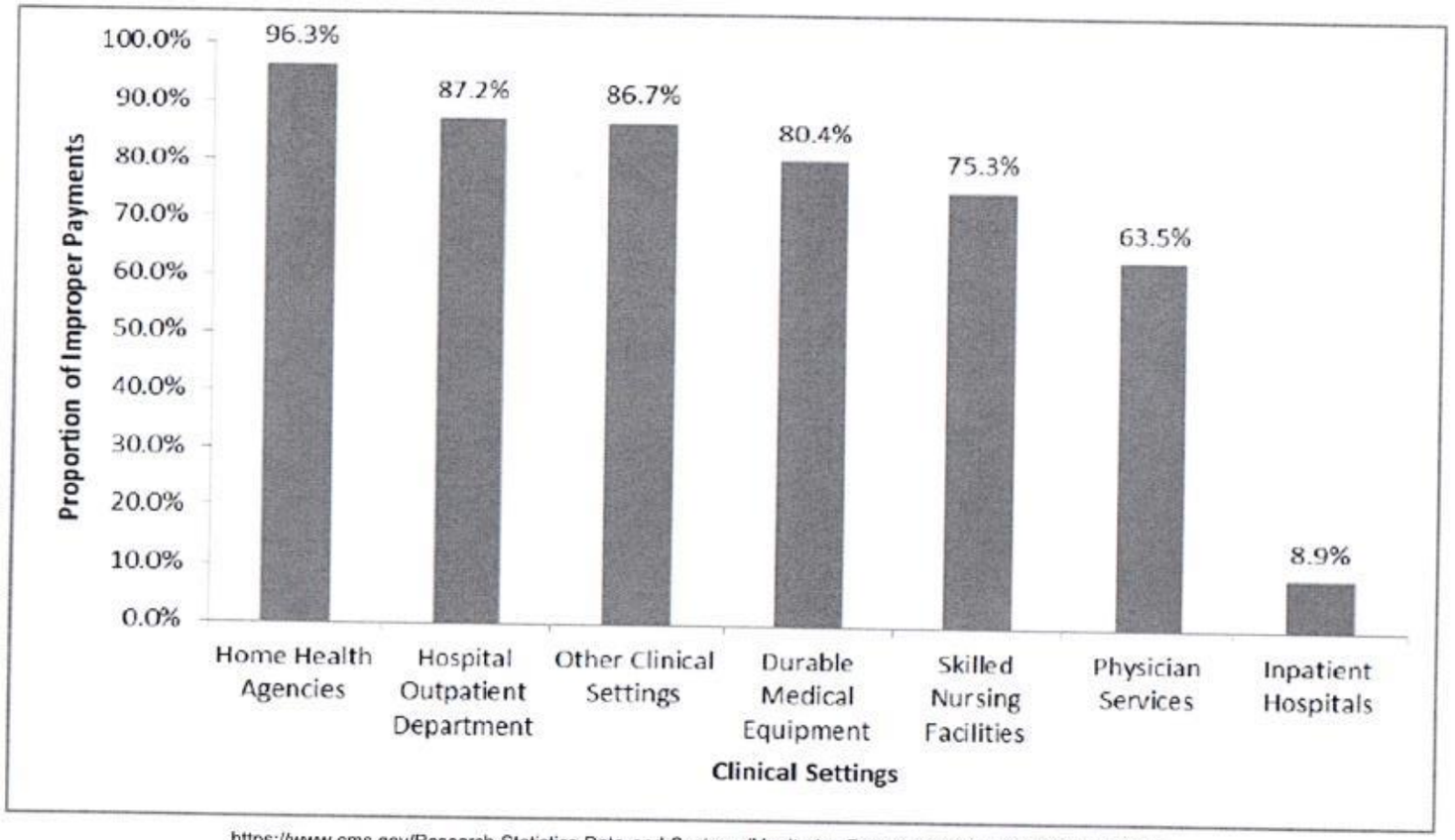
https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/AppendicesMedicareFee-for-Service2016ImproperPaymentsReport.pdf

# Medicare Fee-For-Service 2016 Improper Payments Report

**released 7/27/17**

**Figure 1: Proportion of Improper Payments Attributed to Insufficient Documentation in 2016, by Clinical Setting**

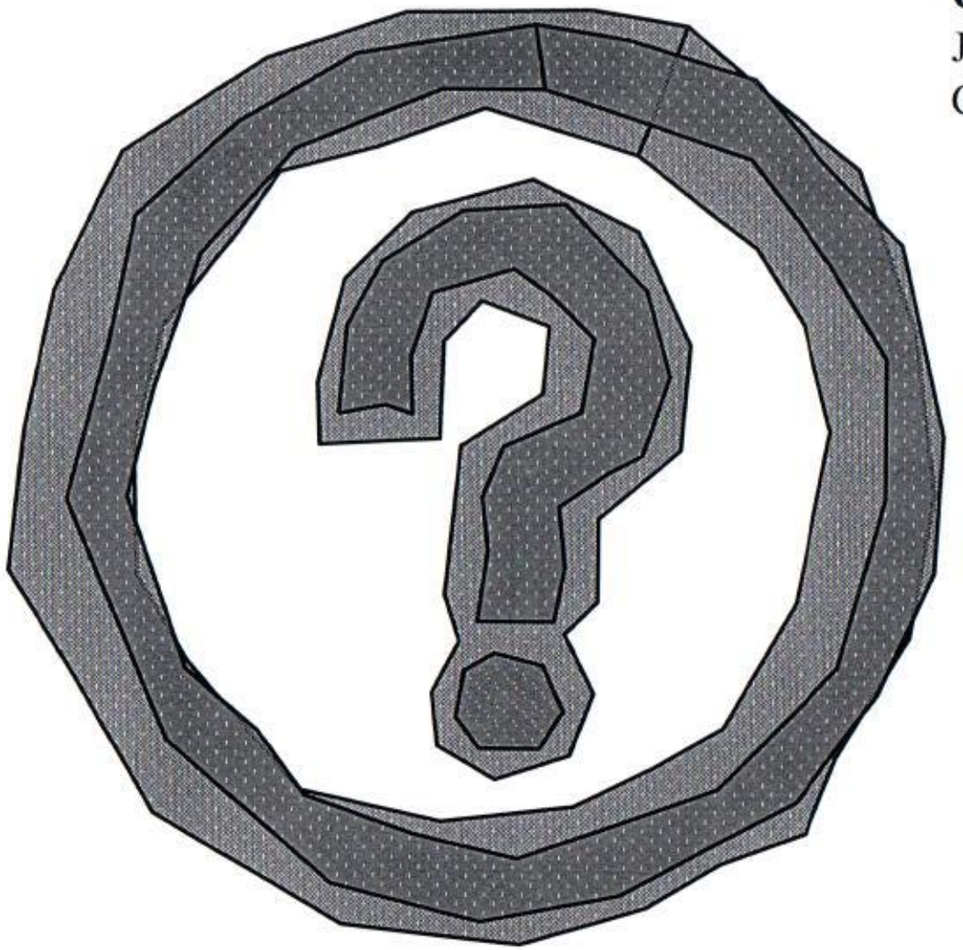
Insufficient documentation errors accounted for the greatest proportion of improper payments during the 2016 report period.




https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/MedicareFeeforService2016ImproperPaymentsReport.pdf

“80 percent of success is showing up" – Woody Allen

# Questions…



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National Government Services

# NEXT MEETING

## February 26, 2018

National Government Services