15TH ANNUAL CAC-PIAC

16th Annual Joint National Podiatric CAC-PIAC Representatives' Meeting

November 3-5, 2016
Baltimore, Maryland

APMA
American Podiatric Medical Association

Medicare Policy Issues for DPMs

- Important Takeaways:

Nothing major…….only …THE BIGGEST CHANGE IN MEDICARE SINCE INCEPTION

Also known as **Advanced Alternative Payment Model(APMs) and MIPS**.

- MIPS - Based on low volume threshold: MC Part B billers >$30,000 and > 100 MC pts/yr.
- Replaces PQRS and Quality Portion of the Value Modifier.

(continued)

- Who is excluded from MIPS ?

- 1. Newly enrolled providers
- 2. Low volume threshold
- 3. Significantly participating in Advanced APMs

MIPS

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SGR Repealed

- Quality Payment Program
- 2 Paths
- MIPS or APMs
- MIPS combines MU, PQRS, and VM

MACRA

Quality Payment Program

MIPS

APM

MIPS Score

0-100

Positive or negative or neutral payment adjustment to fee schedule based on MIPS score

Penalties

- Payment reductions (and bonuses!) still come 2 years after the reporting period
- Meaningful Use lives in 2016!
- MIPS negative (and positive!) adjustments begin in 2019 based on…….

MIPS Year 1

- Going to get positive, negative, or no adjustment to Medicare part B payments
- Mostly budget neutral
- Penalty no more than 4%
- Most positive adjustments no more that 4%
  …positive moved based on budget neutrality

MIPS

- Maximum negative adjustments:
- 2019: 4% (based on 2017 score)
- 2020: 5% (based on 2018 score)
- 2021: 7% (based on 2019 score)
- 2022 : 9% (based on 2020 score)

MIPS

- MIPS reporting not limited to just Medicare patients

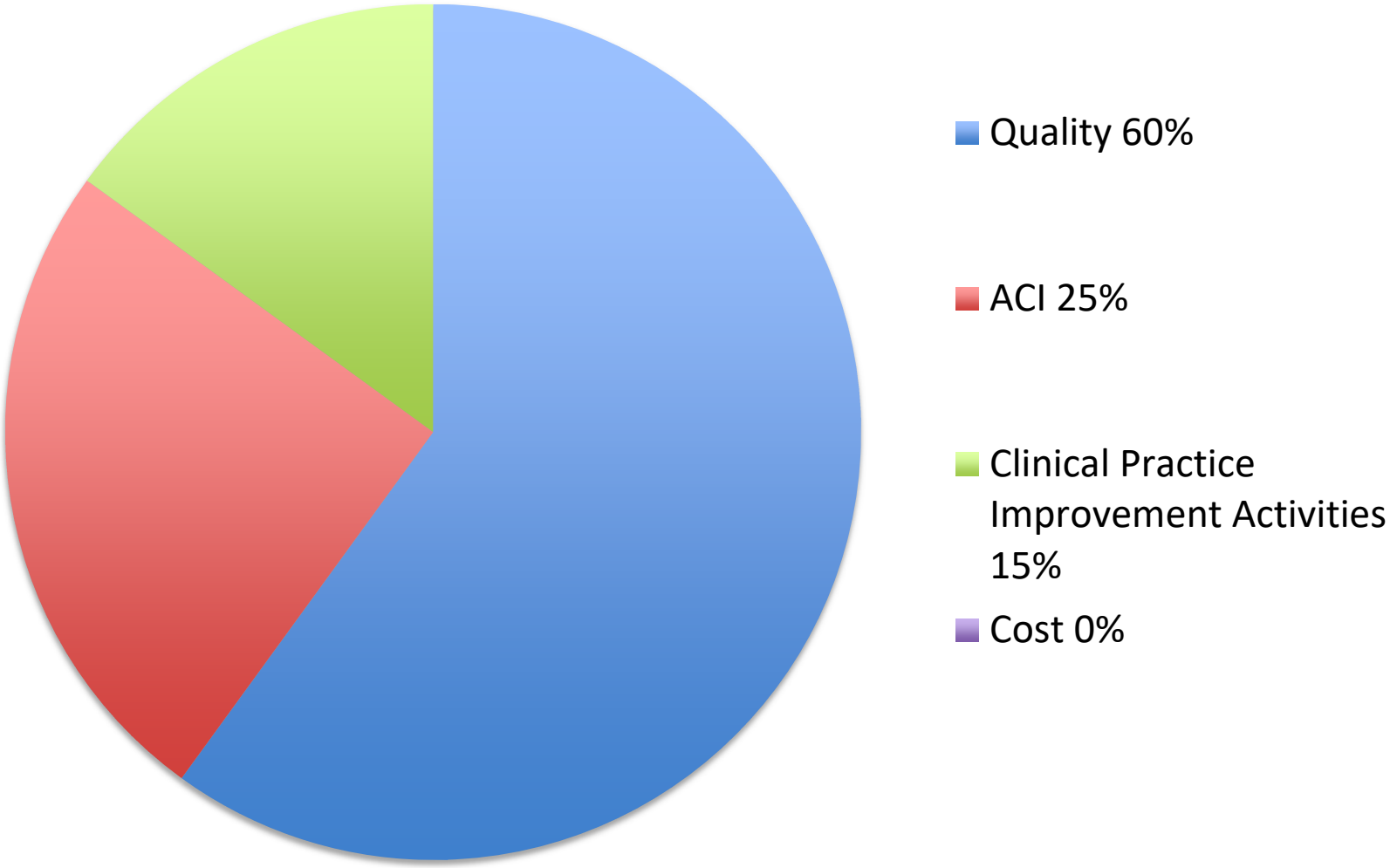
MIPS

- Exempt from MIPS payment adjustment if:
  - Newly enrolled in Medicare
  - Less than 30K in Medicare charges or less than 100 Medicare patients
  - Significantly participating in APM
  - Certain Partially Qualifying APM

MIPS Score Year 1

- Quality (Replaces PQRS)
  60%
- Advancing Care Information (Replaces MU)
  25%
- Clinical Practice Improvement Activities
  15%
- Cost (Resource Use)
  0%

MIPS Score


Quality 60%
ACI 25%
Clinical Practice Improvement Activities 15%
Cost 0%

MIPS Year 1

- Quality (Replaces PQRS) 60%
  - Choose 6 measures instead of 9
- ACI (Replaces MU) EHR use 25%
  - Emphasis on interoperability and information exchange
- Clinical Practice Improvement Activities 15%
  - Activities that focus on care coordination
  - Patient engagement
  - Patient safety
  - Over 90 options
- Cost - based on MC claims data, no reporting 0%

Pick Your Pace!!

- First Option: Test the Quality Payment Program.
  - Report one quality measure or one clinical practice activity or report the 5 ACI measures
  - Avoid negative adjustment
  - No bonus

Pick Your Pace!!

- Second Option: Participate for Part of the Calendar Year.
  - Minimum of 90 days
  - Report more than one quality measure or more than one clinical practice improvement activity, or more than 5 measures of ACI
  - Avoid a negative payment adjustment and possibly qualify for a small positive payment adjustment.

Pick Your Pace!!

- Third Option: Full Participation
  - 90 days to one year
  - 6 Quality Measures
  - 2 or 4 CPIA
  - 5 ACI Measures

APMs

- Exempt from MIPS payment adjustments
- Successful participation = 5% bonus and no MIPS adjustment
- Have to receive certain amount of payments or see certain number of patients through APM

APMs

- No change in how APMs currently reward value
- Just creates extra incentive
- 2019 – 2024 if clinician meets standards for Advanced APM participation = excluded from MIPS adjustments and receives a 5 percent Medicare Part B incentive payment.

Advanced APM

- Advanced APMs are those in which clinicians accept risk for providing coordinated, high- quality care.

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- PICK YOUR PACE - 2017 4 ways to participate
- 1. Choosing to test: Submit a minimum amount of 2017 data to MC. (i.e. submit one measure). 62% participation currently in PQRS of MC providers / 74%
- 2. Partial Participation: Submit 90 days of data - earn neutral or small positive payment adjustment. Could earn full positive adjustment with 90 days of reporting.
- 3. Full Participation: May earn a moderate positive payment adjustment.
- 4. Participate in an APM.

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Other Medicare issues

- Transition for Traditional X-ray imaging to Digital : FX modifier is going to be required for traditional X-ray codes starting 1/1/17

BMAD

- Important Takeaways: David Freedman, DPM, Former Chair, CAC
  - 99214 continues to be low in frequency for DPM compared to other specialties and appears to have decreased in the data. 99212, 99213 and 99203 has remained the same
  - 79% clean claims average
  - 11720 + 11719 or G0127 = average $44 above the average for 11721
  - 64450 - podiatry #1 biller for this code as well as 64640 (this is a problem still, as DPMs haven't converted the neurolytic injections)
  - 2011-2014 : amputation codes are increasing
  - DM shoe trends - 2010-2014 $41 million / 33.9% allowed charge $67. DPMs continue to rank as #1 provider but total dollars decreased across all providers
  - DME L4360 may be over-utilized. Suggested newer code to use is L4361

BMAD Data

- 2 yrs in a row of decreased charges. Podiatry comprises 1.6% of total CMS claims. 2.16 billion dollars allowed to DPMs in 2016
- L3000/L3020 - > 5 million paid in 2015 by CMS. Continued usage of KX-modifier that needs to be discontinued.
- Request BMAD data for your states from CMS – For example - Top 25 codes.

DME Developments

- Important Takeaways: Paul Kesselman, DPM, Coordinator, DME Workgroup
  - The DME MACs did not finalize a problematic draft LCD on lower limb prostheses (LLP) that would have eliminated DPMs' ability to perform an in-person functional assessment for beneficiaries requiring an LLP when referred to by a physician colleague for this assessment.
  - DME MAC Jurisdictions B and C have instituted educational review programs for therapeutic shoes for patients with diabetes. Jurisdiction A is in testing stage.
  - Therapeutic shoe audits continue with DPMs and others leaving the program.
  - DME - L4361 is correct code for pneumatic IM boots. Not L4360.
  - DM SHOES - Ensure that documentation is in note that shoe / insert fit was appropriately fitted to foot structure.

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Guidewell is holding company that is contracted with Florida BCBS and is exhibiting enlarging presence throughout the country as a contracted quality review entity.

- DME Recertification - Remind members about site inspection that is required. APMA website has suggested documents on website.

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CAC Discussion Session Recap

- **High priority –**
  1. Routine/at-risk-foot care LCDs
  2. Scope of practice issues (e.g. HBOT, PCD)
  3. ICD-10 new codes effective 10/1/2016
  4. Coordination of CAC representatives' advocacy efforts
- Specific issues –
  1. WPS – wound debridement, RFC, injection codes
  2. Palmetto – strapping codes
  3. Novitas – mycotic nails
  4. Noridian – retired LCDs with no ICD-10 replacements
  5. Cahaba – wound debridement, wound care, and RFC

Local Medicare Issues

- Late signatures are becoming a greater focus. CMS expects records to be validated at the time of the visit or no more than 1-2 days following. If the records are being transcribed, a reasonable amount of time will be allowed, but certainly no more than 1-2 weeks at maximum. We strongly recommend that when documenting in the EHR you close the visit out at the time of the visit. Additional information such as diagnostic findings may be added later as an addendum. This will avoid late signature denials in the future.

- **<u>Retired Policies</u>**:

- –L34053: Application of Cellular and/or Tissue Based Products (CTPs) for Wounds of Lower Extremities

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- **New Policies**
- – DL36690: Wound Application of Cellular and/or Tissue Based Products (CTPs), Lower Extremities . For services performed on or after 10/10/2016
- Will replace current policy L34053 (Application of Cellular and/or Tissue Based Products (CTPs) for Wounds of Lower Extremities).
- New format and updated information concerning skin substitutes.
- New products added as covered HCPCS codes Q4105, Q4127, Q4128, Q4137, C9349, Q4117, and Q4147

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- Repeat use of surgical preparation services (CPT codes *15002, 15003, 15004,* and *15005)* in conjunction with CTP application codes will be considered not reasonable and necessary. It is expected that each wound will require the use of appropriate wound preparation code at least once at initiation of care prior to placement of the CTP graft.

- CTP grafts will be allowed for the episode of wound care in compliance with FDA guidelines for the specific product (see utilization guidelines) not to exceed 10 applications or treatments. In situations where more than one specific product is used, it is expected that the number of applications or treatments will still not exceed 10