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2016 First Quarterly Newsletter

Meaningful Use of Stage II EHR and Forward to Stage III Implementation

The addition of EHR to a physician practice is no longer a luxury or an incentive as it was over ten years ago. The adoption and correct implementation of this software is necessary for a doctor's office or any healthcare entity that provides services that plan to survive in the long term. A program that motivated health care professionals in its early years by the choice of one incentive program (Medicare or Medicaid, depending on the provider's patient demographic or other factors) is now a mandate in order to receive full reimbursement from Medicare for covered services within the scope of practice. The penalty for providers who do not successfully meet the requirements of meaningful use (whether by failure to report required information, or for not having requested a hardship exemption to indicate why they could not meet specific criteria) will be 2% of Medicare receivables for every calendar year that attestation does not meet CMS guidelines.

Presently, stage II is the current phase of implementation for eligible physicians and hospitals to meet reporting measures of particular sets of data in order to satisfy the requirements for meaningful use. In light of stage III measures that will be introduced in 2018 by CMS, a final rule has been published which modifies the criteria for all entities who provide healthcare services to eliminate redundancies, reduce ineffective or "topped-out" measures, and to ease the transition of stage three implementation in a couple of years. Currently, providers are expected to meet all of the objectives listed below:

- Protect Patient Health Information
- Medication Reconciliation
- Patient Electronic Access
- Secure Electronic Messaging
- Public Health Reporting
- Patient Specific Education
- Clinical Decision Support
- Computerized Provider Order Entry
- Electronic Prescribing
- Health Information Exchange

Since there are still providers who would have been at stage I when the final rule was published, there are modified criteria that exist that will lower the thresholds of patients that are needed to successfully meet the requirements of a measure. For providers who are newly enrolled in the program (or if a practice makes a decision to adopt stage three standards early for the 2017 reporting year), the reporting period is any continuous 90 days within the calendar year. In all other cases, the reporting period throughout the board for all providers currently in stage II is the entire calendar year, with the deadline to attest data being in February of the following year. For stage I and II, EHRs that have been certified as 2014 editions will still be valid. In order to be compliant with stage three, an EMR will have to be certified as a 2015 edition in order to meet meaningful use standards.

While the objectives of stage three requirements are still being discussed at this time, information has been published regarding discussions about possible areas where objectives and measures could be modified:

- Improved coordination of preventive care and management of chronic health conditions
- Potential safeguards against excessive or inappropriate referrals for labs, radiology, and medication management
- Standardization of the contents of an acceptable progress note
- Reconciliation of results from labs from the ordering provider and notifications of any abnormal results from the EMR
- Use of an FDA assigned Unique Device Identifier for any implantable devices
- Wider adoption of patients accessing health information online after being reviewed by an eligible professional

As always, it is strongly encouraged that your office has an open dialogue with the software vendor that provides your EMR software to make sure that it is compliant in order to be successful in attesting to meaningful use, all requirements are being met with ease, and that the vendor is proactive with any changes that will affect individual compliance with mandates from CMS.

PQRS Participation

PQRS (Physician Quality Reporting System, also known as PQRI and Physician Quality Reporting Initiative), works in conjunction with EHR as a required reporting measure for physicians on multiple components of patient care. Like EHR, these reporting features were initially optional to report with Medicare part B claims, but have now become mandatory in reporting (through CEHRT or another reporting method, which may vary on the measures selected by a practice). Providers who are not currently compliant in attesting this information will be subject to a 2% payment reduction in their payments from CMS until they have met satisfactory reporting requirements. Note that this adjustment is specific to an individual practitioner - if there is more than one provider linked to an EIN or TIN and NPI, the adjustment will only affect doctors that have not been compliant, not the group as a whole. In order to determine if a single provider's claims are being penalized due to not meeting the reporting requirements outlined by PQRS, look for the following claim and remark adjustment codes on your Medicare EOBs:

CARC CO-237 (*Legislated/Regulatory Penalty*)
RARC N699 (*Payment adjusted based on the Physician Quality Reporting System (PQRS) Incentive Program*)

To ensure compliance with PQRS reporting measures, providers need to review the current listing issued by CMS (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html). The list must be reviewed annually, because certain measures can be retired or have their definitions changed from year to year. In addition, depending on the specialty, CMS may already provide a list of recommended measures that should be used in order to satisfy minimum reporting requirements. From the six NQS domains that are published by CMS, a provider must report a minimum of three measures from at least three of the six domains to avoid a reduction in Medicare payment. In addition to reporting at least nine unique measures for Medicare beneficiaries, at least one of the reported measures must be considered a "cost cutting measure", which must be reported on each face to face encounter. Each PQRS code has different requirements where providers must report a particular CPT code (such as an E&M code, minor surgery, radiology service, etc.) in order for the measure to be counted. There may also be a diagnosis limitation dependent on the code reported. Be sure to review the documentation published by CMS which outlines the definitions, qualifications, and particular exceptions for a measure in order to bill the PQRS code, and different scenarios where an alternate CPT-II code has to be reported if a patient does not fully meet the reporting criteria outlined by CMS for the specific PQRS measure. Providers need to take precautions to make sure this information can be reported through your EHR and clearinghouse when submitting claims to Medicare - part B carriers will not allow providers to correct claims if a PQRS measure was not reported due to an error. Note that all measures cannot be reported on a Medicare part B claim, so if the information needs to be transmitted from your EHR or to a registry to be processed, the information must be submitted within the reporting period. In addition, if a claim reported with PQRS measures was denied (for coding, invalid beneficiary information, missing data, etc.), be sure to include the appropriate PQRS codes on the resubmitted claim or they will not be counted. To validate if the measure was successfully received, PQRS codes outlined on the Medicare EOB should have the following codes:

CARC CO-246 (*This non-payable code is for required reporting only*)
RARC N620 (*This procedure code is for quality reporting/informational purposes only*.)

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Medicare Part B Deductibles

Medicare Deductible for 2016: As a reminder, the part B deductible, which all Medicare beneficiaries are subject to, whether they are enrolled in traditional Medicare or a Medicare advantage plan, is $166 for the current year. This amount must be paid (either by the patient or their secondary insurance) before the Medicare plan makes any payments towards covered services. This form of patient responsibility must be collected from all patients in your practice- when submitting claims for the first weeks of 2016, be aware of the following billing scenarios:

- If a patient does not have any secondary insurance, the Medicare deductible must be collected from the patient once the claim has been processed
- If a patient is enrolled in traditional Medicare and has a Medicare supplement plan (also known as MediGap), these secondary plans do not cover the part B deductible a majority of the time and the balance will be billed to the patient once the primary and secondary claims have been processed
- If Medicare applied the entire allowed amount to the patient's part B deductible (or a portion), Medicaid will pay as secondary only up to their allowed amount
- If Medicare applies a balance to the part B deductible that is not on the NY Medicaid fee schedule, the balance will have to be adjusted as a contractual write off since the patient may not be balance billed
- Medicaid will typically not cover the Medicare co-insurance because the amount paid by Medicare is greater than the Medicaid allowed amount
- If the patient has a Medicare advantage plan or commercial insurance primary to Medicaid, the same rules apply with reimbursement of the annual deductible
- If the patient has a Medicare advantage plan or commercial insurance primary to Medicaid with a high specialist co-pay, a portion of that balance may be payable by Medicaid up to their allowed amount
- If the patient has a Medicare advantage plan or commercial insurance primary to Medicaid with a low co-pay or co-insurance, the balance will be adjusted as a contractual adjustment since the amount paid by the primary insurance payment is greater than the Medicaid allowed amount

Remember if the patient is enrolled with Medicaid at the time of service and has benefits for major medical coverage, they cannot be held responsible for any portion of the balance.

Value Based Modifier

Value Based Modifier The Value-Based Payment Modifier Program adjusts Medicare Physician Fee Schedule (PFS) payments to a physician or group of physicians (as identified by their Taxpayer Identification Number [TIN]), based on the quality and cost of care furnished to their Medicare Fee-for-Service (FFS) beneficiaries. It provides for differential payment under the Medicare PFS to a physician or group of physicians based upon the quality of care compared to the cost of care furnished to Medicare FFS beneficiaries during a performance period. The value based modifier (which has nothing to do with coding of claims) has been in a phased approach since 2015 and has or will go through the following steps:

- Providers who are in a group of 100+ providers (excluding NPs, CRNAs, CNAs, etc.) are subject to possible payment increases or adjustments starting in 2015
- Providers who are in a group of 10-99 providers (excluding NPs, CRNAs, CNAs, etc.) are subject to possible payment increases or adjustments starting in 2016
- Solo providers or groups of 2-9 providers (excluding NPs, CRNAs, CNAs, etc.) are subject to possible payment increases or adjustments starting in 2017
- Non physician practitioners (NPs, CRNAs, CNAs, etc.) are subject to possible payment increases or adjustments starting in 2018

PQRS and the value based modifier are aligned because they will determine additional payment adjustments if a provider does not meet reporting criteria for 2015. Failure to attest successfully will mean an additional 2% reduction in Medicare receivables, in addition to the 2% for failure to meet guidelines with PQRS, and an additional 3% penalty if the practice does not achieve meaningful use with EHR. For solo providers and small groups, there will be no performance penalties (a reduction of up to 2%) to allow providers to adjust to this new requirement that will work in tandem with EHR and PQRS reporting requirements. Moving forward, based on the services and measures that are reported for 2018 and beyond, payments will be subject to a possible bonus or reduction based on performance by provider based on metrics that will be issued by Medicare on an annual basis that should be reviewed by all practices. Solo providers and small groups could see no change in their Medicare reimbursement, can receive a 2% bonus, or possibly a 2% reduction (medium and large group practices are subject up to a 4% bonus or penalty based on their performance).