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Session V

The Numbers Game: Coding and Billing

Applying MACRA to Cardio-Oncology

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The Numbers Game

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The Numbers Game: FACTS

- You are physicians and health care providers, NOT certified coders
- Your goal is to provide expert care to cardio-oncology patients
- However…
- YOU are responsible for coding appropriately

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The Numbers Game: FACTS

- If your program is not financially viable you cannot provide those services
- Increasing pressures are brought to bear on the entire health care system: MACRA, Coding, and payment reform are just the beginning

Goals

- To give you an overview of recent changes in healthcare: MACRA
- Coding Strategies to help keep your program viable
- Future issues, how to get involved with ACC Health Affairs and Cardio-Oncology Councils

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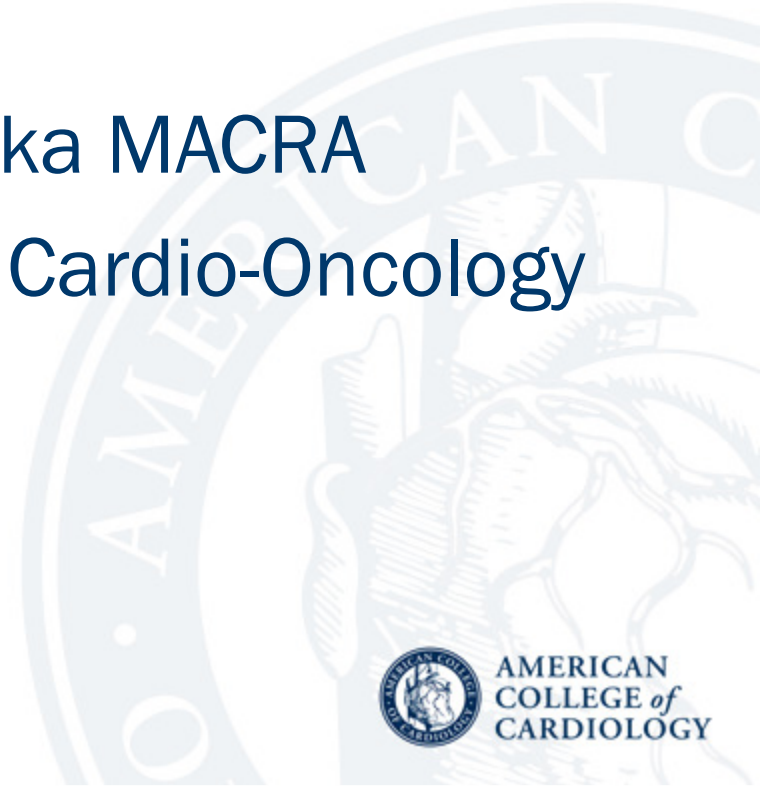
Agenda

- Environmental Trends
- Quality Payment Program aka MACRA
- Fee For Service vs Value in Cardio-Oncology
- Case studies
- Future Advocacy



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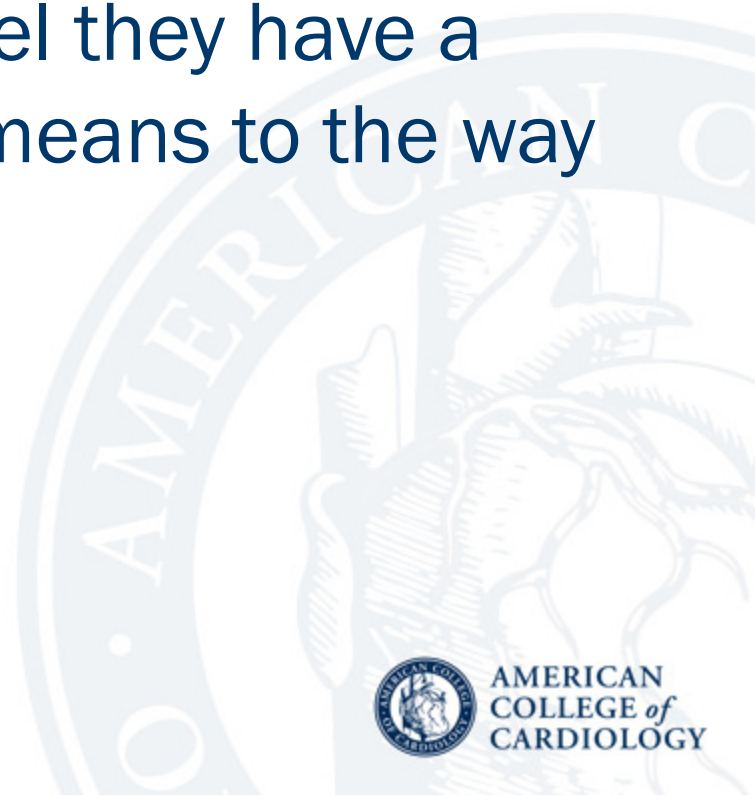
Question 1

How many in the audience feel they have a grasp of MACRA and what it means to the way they practice medicine?

A) I totally get it

B) I think I get it

C) What?



Question 2:

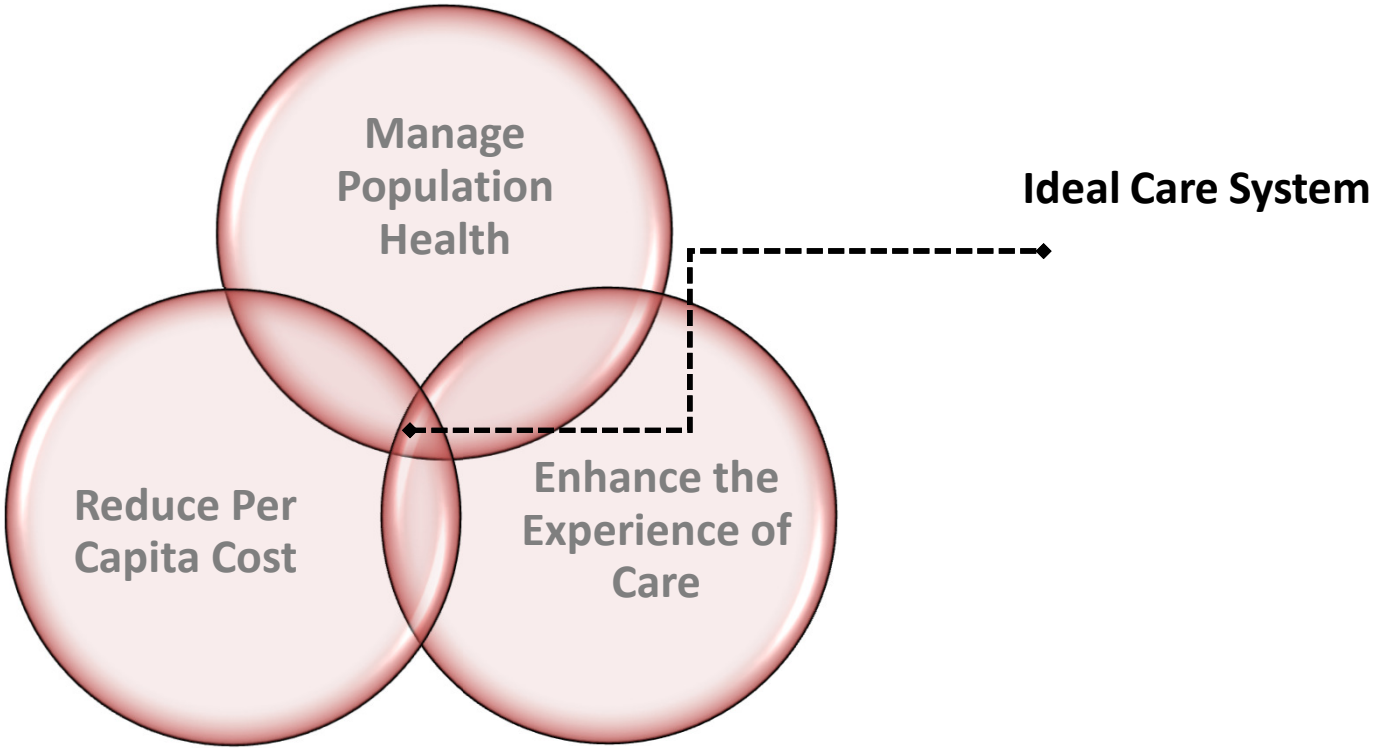
Have you implemented changes in practice management due to MACRA as of 2017?

a) YES

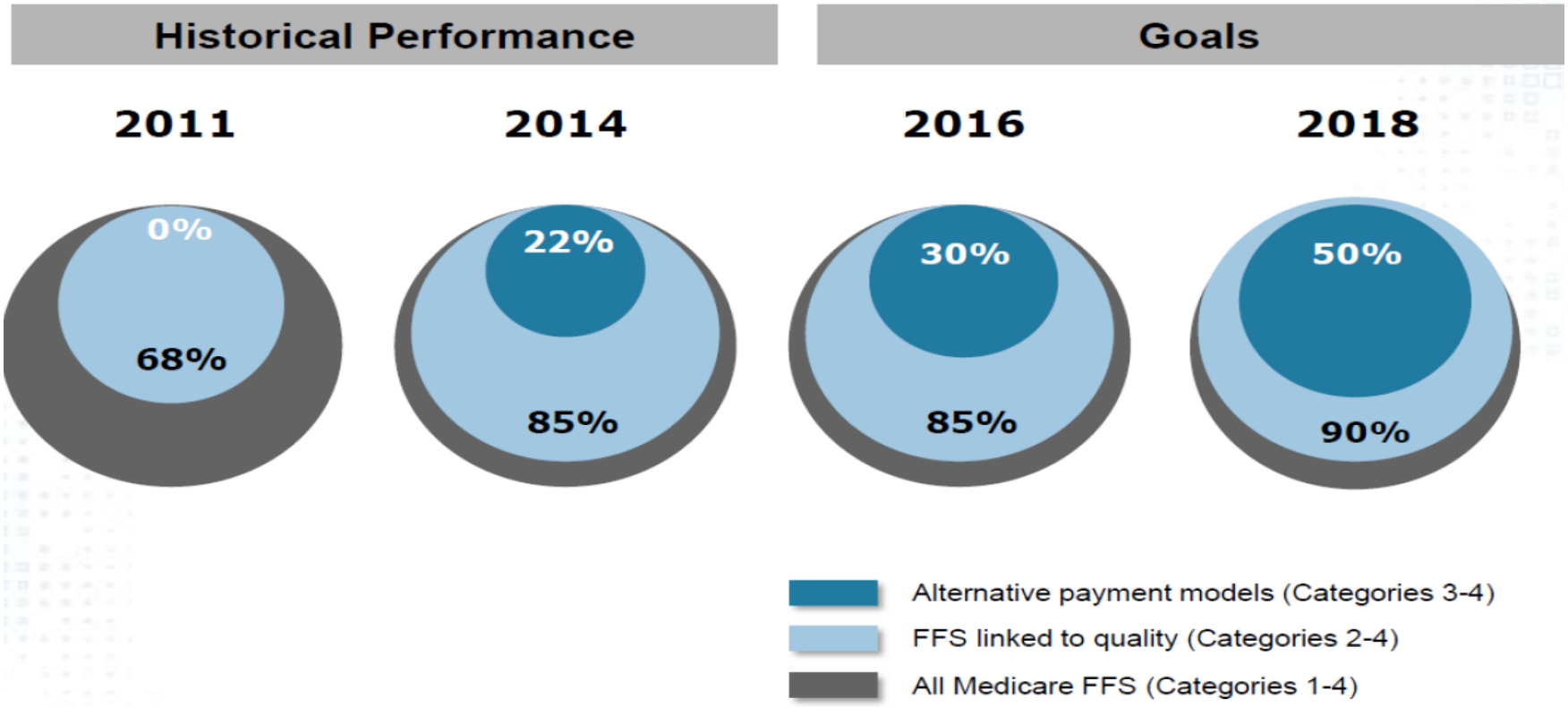
b) NO

c) Not sure what has been done

Triple Aim of Reform



Where are we…..how do we get there



How did we get to MACRA?

1997

- **Medicare Sustainable Growth Rate (SGR)** implemented as part of the Balanced Budget Control Act of 1997

2002 - 2015

- **17 patches to avert steep cuts to Medicare**
- House of Medicine, including the ACC, works with Congress to craft **MACRA**

March 24, 2015

- H.R. 2 (**Medicare Access and CHIP Reauthorization Act of 2015**) introduced in the House

March 26, 2015

- The House passed H.R. 2 (392-37)

April 14, 2015

- The Senate passed H.R. 2 (92-8)

April 16, 2015

- **MACRA** signed into law by President Barack Obama

The Basics of MACRA

- Eliminated SGR move to VALUE programs
- Effective 1/1/19 – using data from 2017
- Two arms of Quality Payment Program/MACRA
  - APM (alternate payment models)
  - MIPS (merit based incentive payment system)

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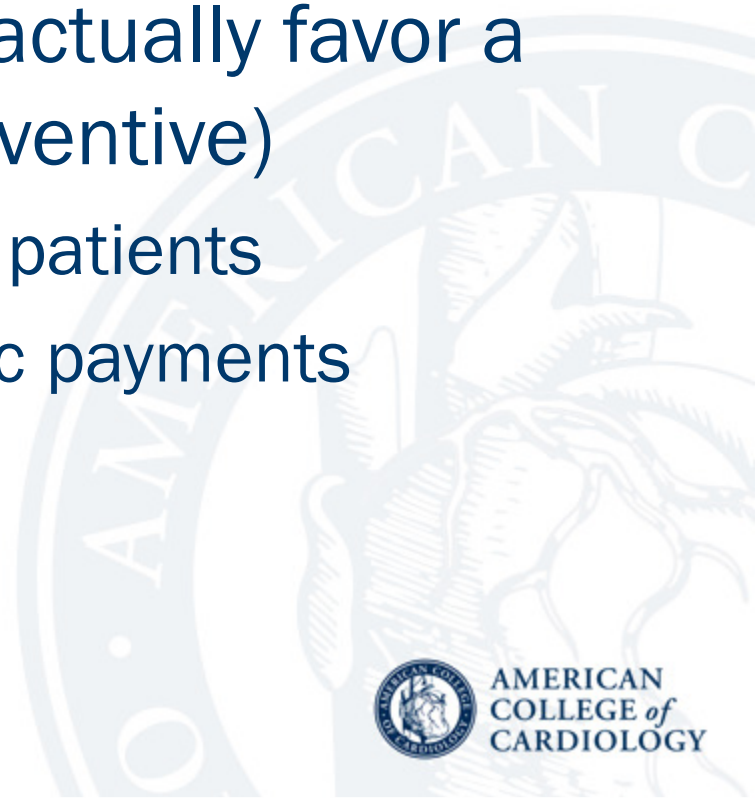
Opportunities

Newer payment models may actually favor a cardio-oncology program (preventive)

- Access to care and value for patients
- Bundled payments / episodic payments
- Medical homes
- Coordinated care models



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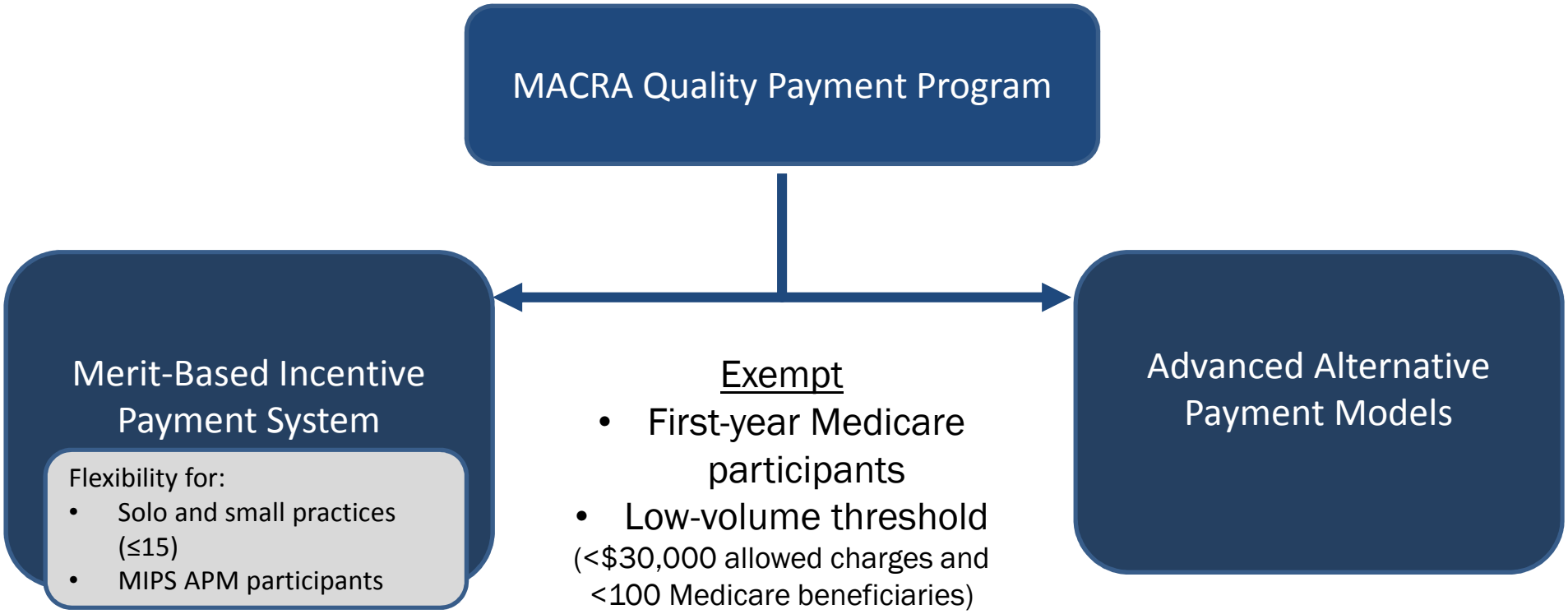
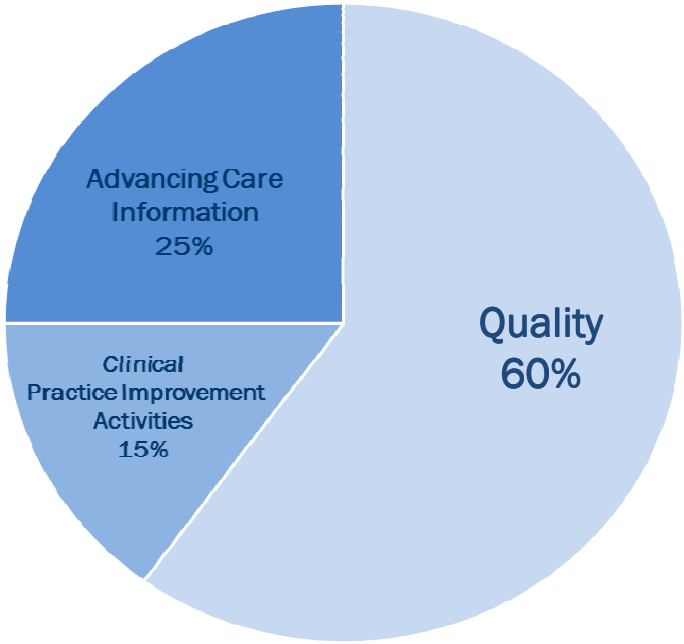
Quality Payment Program Pathways



2019 MIPS Composite Weighting

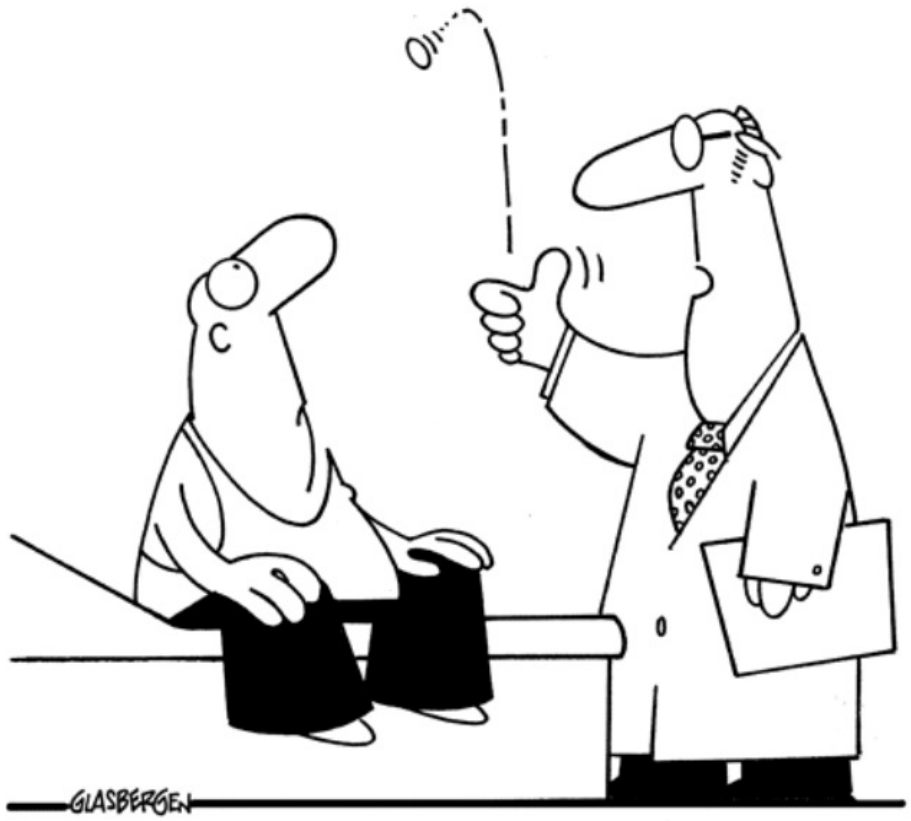
Advancing Care Information
- Security Risk Analysis
- E-Prescribing
- Provide Patient Access
- Send Summary of Care
- Request/Accept Summary of Care
- Bonus: Registry Reporting

Clinical Practice Improvement
- Expanded Practice Access
- Population Management
- Care Coordination
- Beneficiary Engagement
- Patient Safety
- Practice Assessment (ex. MOC)
- Patient-Centered Medical Home or specialty APM



Quality
- Most PQRS measures
- QCDR (non-MIPS) measures
- Bonus: "High-priority measures"
  - Outcome, appropriate use, patient safety, efficiency, patient experience, care coordination

Resource Use (0%) will be incorporated into the MIPS score starting with the 2018 performance period



**"Heads, you get a quadruple bypass.
Tails, you take a baby aspirin."**

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Cathie Biga
President/ CEO
Cardiovascular Management of Illinois

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2019 MIPS Weighting
Quality (60%)

Full Credit

- 6 quality measures, including 1 outcome measure or one specialty measure set
- Points will be allocated based on performance against prior year benchmarks
- QCDRs approved for group and individual level reporting

Bonus Points

- "High Priority Measures"
  - Outcome, appropriate use, patient safety, efficiency, patient experience, care coordination

MIPS APM participants will report the quality measure requirements of their program

Advancing Care Information (25%)

Full Credit

- Report 4 or 5 of the required measures for at least 90 days

Bonus Points

- Submit up to 7 or 9 additional measures for at least 90 days
  - Clinical Data Registry Reporting

Required Measures
Security Risk Analysis
E-Prescribing
Provide Patient Access
Send Summary of Care
Request/Accept Summary of Care

Clinical Practice Improvement (15%)

Full Credit

- 4 medium-weighted activities or 2 high-weighted activities
- I high and 2 medium
- At least 90 days of participation in each activity
- Cardio-oncology activities

Activity	Weight
Participation in MOC Part IV	Medium
Participation in CMMI Models such as the Million Hearts Risk Reduction Model	Medium
Use of QCDR data for ongoing practice assessment and improvements	Medium
Use of decision support and standardized treatment protocols	Medium

Activity	Weight
Participation in a systematic anticoagulation program	High
Participating in CAHPS or other supplemental questionnaire	High

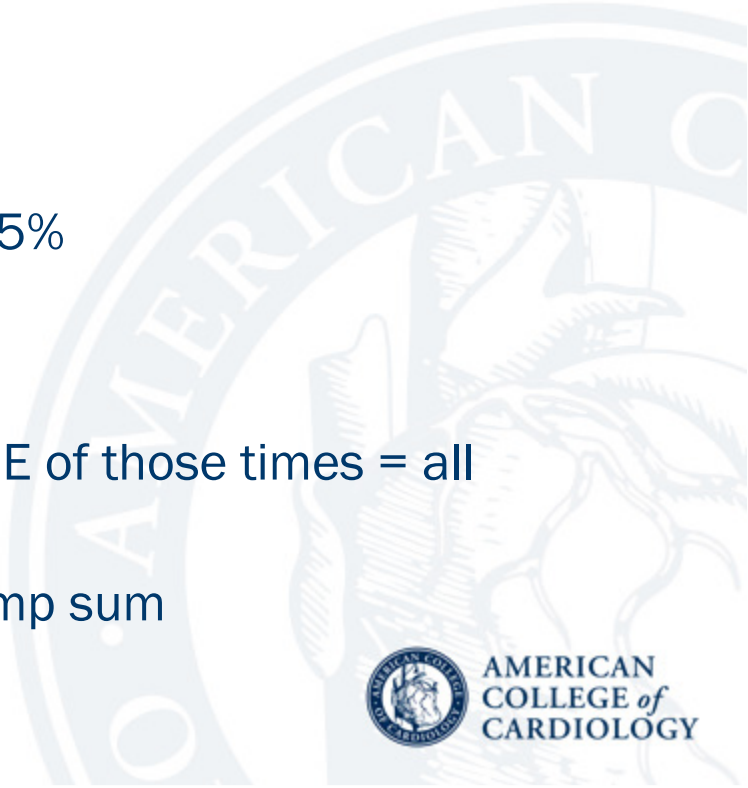
Pick Your Pace in 2017

- Submit minimum amount of 2017 data to Medicare
- Avoid a downward adjustment

You Have Asked: *"What is a minimum amount of data?"*

Alternate Payment Models

- List of Qualifying APM's final
- Advanced APM's will be expanded in 2018
  - MSSP Track 1+
- Qualifying criteria remains the same 20%/25%
  - Designations will occur 3 times
    - 3/31, 6/30, and 8/31
    - If you are designated a QP at any ONE of those times = all clinicians in the entity will be QP's
  - Partial QP's – forego MIPS but no 5% lump sum



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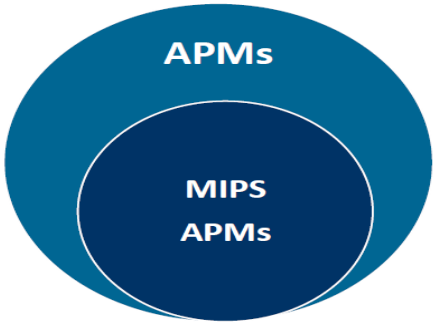
MIPS and APM



- Not in a qualifying ACO
- Not a Qualifying provider
  - You will receive preferential scoring ☺
  - Full credit for CPIA
  - Quality thru your ACO
  - Meaningful use thru your ACO

Getting ready for MIPS

- Know your current program results: go to ACC MACRA hub
- Participate
  - Submit something
- Decide if you will report as a group or as individuals
- 90 day continuous reporting
  - Each category can be a DIFFERENT 90 day time frame
  - Start anytime between 1/1/17 thru 10/2/17
  - Submit by 3/31/18

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The Moment of Truth

- We don’t always get paid for what we do
- But we can maximize efforts
- Medicare vs private payers
- Lets talk coding and documentation

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Cardio-Oncology

Comprehensive CV Care

- Risk assessment prior to treatment
- Care for Cancer patient with pre-existing CV disease
- Monitoring early cardiac complications from Cancer therapy

Long Term CV Care

- Assessment of Long-term Cardiac sequelae in Cancer Survivors
- Assessment of New Chemotherapies and CV risk
- Research

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Begin with Documentation

- Do not use unspecified codes
- List as many ICD10 codes per visit that are warranted
  - Ensure billing system is “Open”: as many dx as possible
  - Billing codes are the only way the insurer knows the patients co-morbidities

Cardio-Onc and MIPS

- Have you found your Quality resource and utilization report…..do you know what QRUR is? ☺
- Risk scores are critical
  - You need to document so the payer UNDERSTANDS the status of the patient
  - Malignant neoplasm “qualifies” for HCC coding
    - Z codes do not
    - Bill BOTH

Here you Go

C3490: Malignant neoplasm of unsp part of unsp bronchus or lung	0.973
C679: Malignant neoplasm of bladder, unspecified	0.317
C7412: Malignant neoplasm of medulla of left adrenal gland	0.154
C779: Secondary and unsp malignant neoplasm of lymph node, unsp	0.672
C799: Secondary malignant neoplasm of unspecified site	2.484
Z4889: Encounter for other specified surgical aftercare	.
Z5111: Encounter for antineoplastic chemotherapy	.
Z5112: Encounter for antineoplastic immunotherapy	.
Z5189: Encounter for other specified aftercare	.

Work with your payer

- Initial visit is most problematic
- Add V codes to echo LCD (local coverage determination) for payment
- Documentation is critical

Fee Schedules and Cardio Oncology

- When using the Physician Fee schedule
  - You can add the CPT codes to your bill
  - You need to use appropriate diagnosis
  - You may need to work with your MAC or Private payer
- When using Ambulatory procedure codes in hospital out patient world
  - Know the difference between on campus and off campus setting
  - Know if you are grandfathered or not
  - Understand that CPT codes are often bundled into 1 reimbursement rate called an APC

"I want you to find a bold and innovative way to do everything exactly the same way it's been done for 25 years."

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Case 1:

- An oncology patient is sent to you for CV evaluation prior to starting cardio-toxic drugs.

- They are otherwise healthy, no risk factors for CAD.

Case 1:

- You do a full consult and order an echo with strain to assess LV function.
- How do you code and bill for this encounter and for the ECHO?
- Can strain be paid for?

Possible scenarios

- Bill Encounter pre-chemotherapy
- Baseline echo (add any sx at all): may NOT get paid
- Strain as a T code- not currently on Fee Schedule aka no $$$

Strain: Not paid now but counts in future

- +0399T Myocardial strain imaging : **not currently on Fee Schedule aka no $$$**
  - Quantitative assessment of myocardial function
  - Mechanics using image-based analysis of local myocardial dynamics

- List separately in addition to code for primary procedure
- Report with Surface Echo Codes : 93303, 93304, 93306, 93307, 93308
- Report with TEE Codes: 93312, 93314, 93315, 93317
- Report with Stress Echo Codes: 93350, 93351, 93355

Case 2:

- Hodgkin's survivor referred to you for a prior history of cardio-toxic drugs and XRT to the chest, is now in surveillance mode, 10 years.
- They are asymptomatic
- You consult and order a stress test to access ischemia, and aerobic capacity and an ECHO

Case 2:

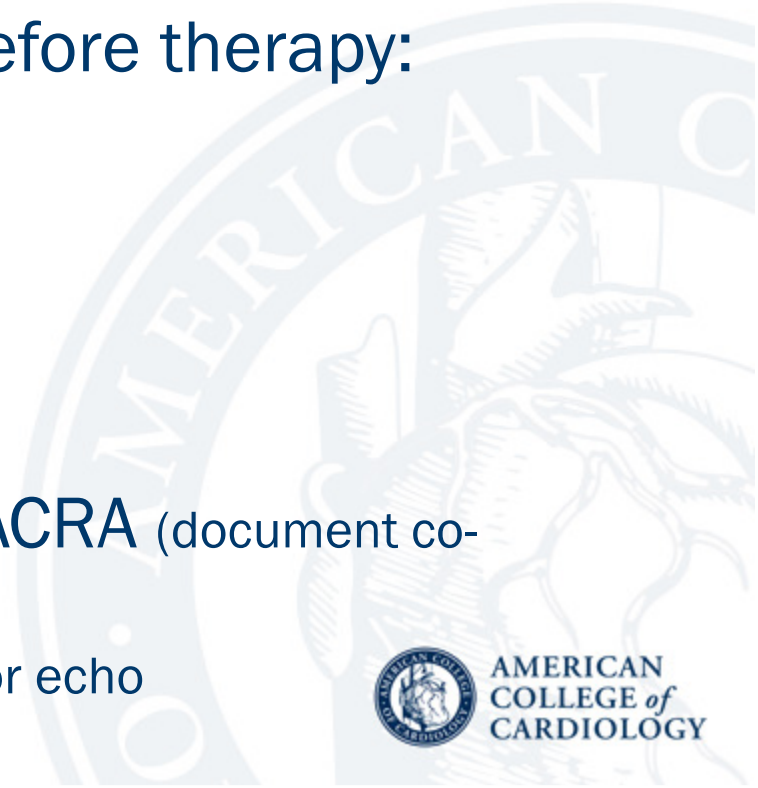
- What are the best codes to use for this patient for the consult and the subsequent testing?

- Are they truly asymptomatic?

Can use symptoms as diagnoses

always document the cancer

- Documentation compared to before therapy:
  - SOB
  - Fatigue
  - Decreased exercise capacity
  - Tachycardia
- New risk factors: remember MACRA (document co-morbidities)
  - HTN, DM, HLD, obesity, abnormal EKG or echo



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Z-Codes: payment ??

Can be added to supplement the dx:

We will have to work to get these paid eventually

- Z 92.21 hx of antineoplastic chemotherapy
- Z 92.3 hx of radiation therapy
- Z 91.89 At risk for cardiomyopathy

Case 3

- A young healthy woman with triple negative breast cancer (aggressive) is being monitored several times during chemo for CMY.

- She does not manifest any non-cancer symptoms

Case 3

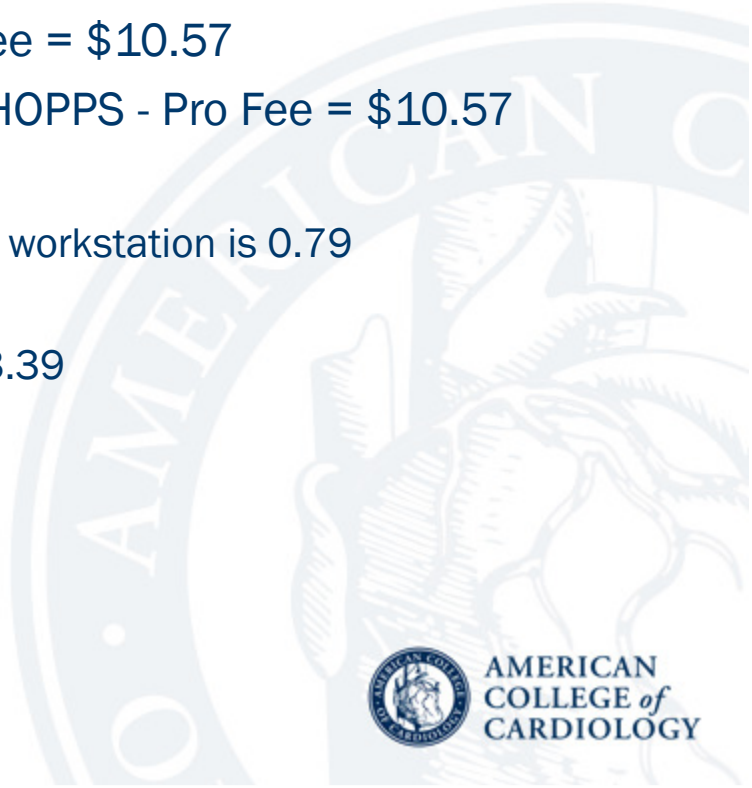
- How do you bill for multiple echoes?
- What is the best dx to use?
- Should you always include Z codes?
  - MAY be paid
  - If denied: be aggressive (pvt and CMS carriers)

Best scenarios

- Multiple echoes: Use Z codes Plus cancer dx
- Any Symptoms you can document
- Always include Z codes
- Make sure you document co-morbidities
- ABN: advanced beneficiary notice: PROBLEM

Comment: 3D- ECHO

- wRVU for 3D that does not require independent workstation is 0.20
- – CPT Code 76376
- – Physician Fee Schedule Reimbursement Pro fee = $10.57
  - – Technical fee is $14.46 -Global is $25.04 HOPPS - Pro Fee = $10.57
- The technical is bundled in the APC
- wRVU for 3D requiring post-processing on independent workstation is 0.79
- – CPT Code 76377
- Physician Fee Schedule Reimbursement Pro Fee = $43.39
  - – Technical is $33.05
  - – Global is $76.44 (2.35 wRVU's)
  - – HOPPS – Pro Fee is $43.39
- Technical is bundled into the APC



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Future Directions

- Adding cardio-oncology as a payable dx for cardiac rehab
- Educating lawmakers about Cardio-Oncology in general and the benefit it provides for patients

Future Directions

- National level: Work with the HAC to educate legislators about Cardio-Oncology
  - Legislative Conference in 2017
- State level: joining your chapter's Advocacy efforts: relationships are everything

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Thank you

"Your insurance won't pay for an expensive procedure, so I'll be doing your colonoscopy with my cell phone camera."

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