ABC's of Healthcare

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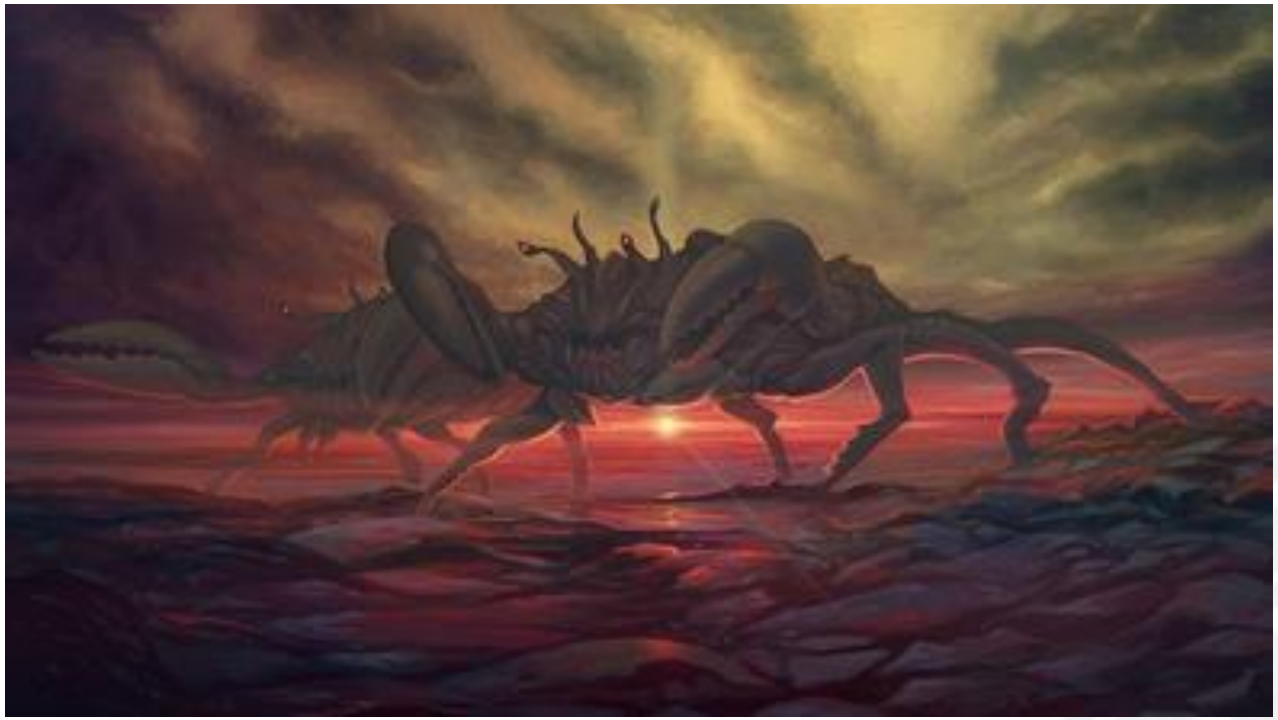
Goal

- Acronyms make up the language of our industry
- Develop a better understanding of their definitions and what they mean for your practice

Ones to know

- HHS: Health and Human Services
- OIG: Office of Inspector General
- DOJ: Department of Justice
- MA: Medicare Advantage
- APP: Advanced Practice Practitioner
  - APN, PA, Pharm D



What acronym shares the same name as this creature?

A. CRAB

B. CHIP

C. MACRA

D. ALL ACRONYMS ASSOCIATED WITH HEALTHCARE REFORM!

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MACRA

- Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act

It's an acronym within an acronym!

The MACRA Terror was the seventh story in the season 4 of the Doctor Who TV series. The MACRA, also known as the scourge of the galaxy, were gigantic crustacean race that fed on unclean gases which were poisonous to humans.

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Payment Reform

It all started with ACA – Affordable Care Act

ACO's: Accountable Care Organizations such as Pioneer and Medicare Shared Savings (MSSP)

CMMI: Centers for Medicare and Medicaid Innovation with programs such as BPCI: Bundled Payments for Care Improvement, SmartCare……

Maybe it all started with SGR: Sustainable Growth Rate!

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Triple Aim

BETTER care
SMARTER spending
HEALTHIER people

Via a focus on **3 areas**

Incentives

Care Delivery

Information Sharing

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Payment Reform

- RVU: Relative Value Unit
  - Includes GPCI (where you live), med mal, practice expense, etc.
    - GPCI: Geographic Practice Cost Index

      Work RVU (GPCI) + Practice Expense RVU (GPCI) + Malpractice RVU (GPCI) = Total RVU

      Total RVU * Conversion Factor = Medicare Fee
- Fee schedules
  - PFS: Physician Fee Schedule
    - Billed with CPT codes– (93015 = Global stress test)
      - Global and Professional
    - ICD-10 – codes you use to identify a diagnosis
  - OPPS or HOPPS: Outpatient Prospective Payment System
    - Billed with APC: ambulatory Payment Codes
    - Currently being bundled into “families”
  - IPPS: Inpatient Prospective Payment System
    - Billed with DRG’s
    - MCC’s

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Payment Reform

- APM: Alternative payment model
  - ACO: accountable care organizations (470)
    - MSSP: Medicare Shares Savings Plans (4 models)
    - Pioneer: currently 9 left
    - Next Generation ACO – 21 in 13 states
  - BPCI: Bundled Payment for Care Improvement
    - 4 models
    - 337 using 1254 episodes (3 yr. model)
  - Several models: Maryland, ESRD, CPC
- HCIA: Health Care Innovation Awards for delivery systems

This and That……

- CMI: Case Mix Index
- CCs: Complication and Comorbidities
- FFS: Fee for Service
- V2V or FFV: Volume to Value; Fee for Value
- MSPB: Medicare Spend per Beneficiary
- CJR: Comprehensive care for joint replacement
  - Mandatory bundle – 20% of all LE replacements
  - 5 yrs., 800 hospitals, 67 locales, 30% of population
  - Penalty will start in yr. 2 (target will be pre-determined)

Newest kids on he block

- QP's: qualifying APM's participants
  - Best of the best ☺
  - Not subject to MIPS + 5% lump sum
- PROM: Patient Reported Outcomes
  - Watch this one
- LAN: Health Care Payment Learning and Action
- PFPM: Physician-Focused Payment Model

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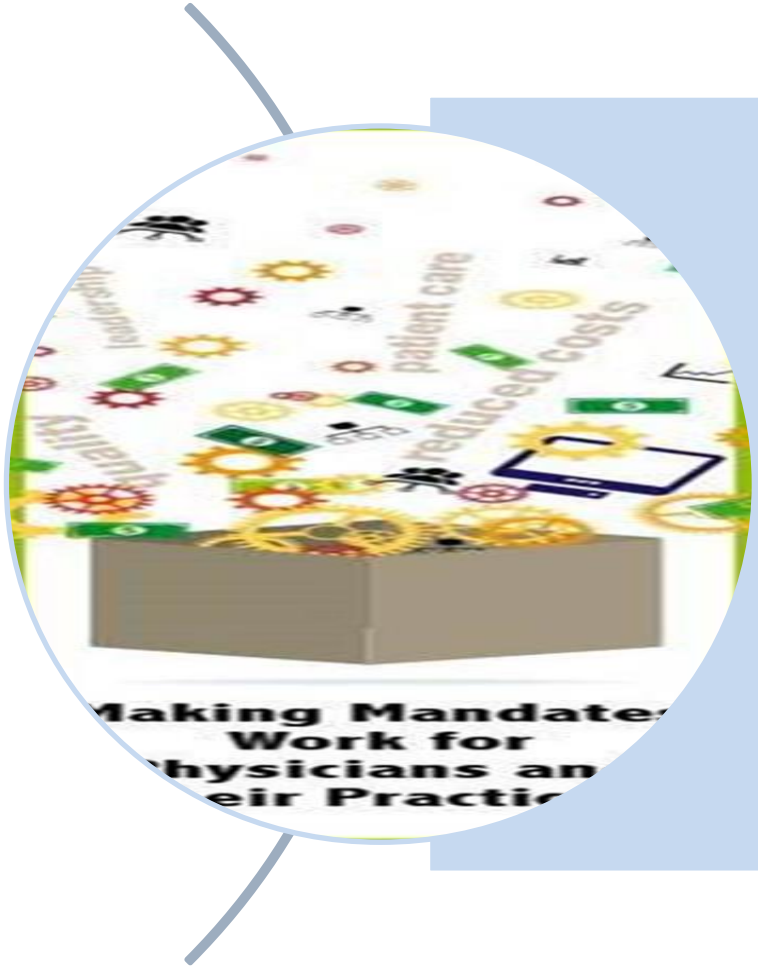
Physician Quality



PQRS: Physician Quality Reporting System

QCDR: Qualified Clinical Data Registry

EP: Eligible Provider

GPRO: Group Practice Reporting Option

MU: Meaningful Use

VM: Value modifier

QRUR: Quality & Resource Utilization Report

S-QRUR: Supplemental QRUR

MIPS: Merit-based Incentive Payment System

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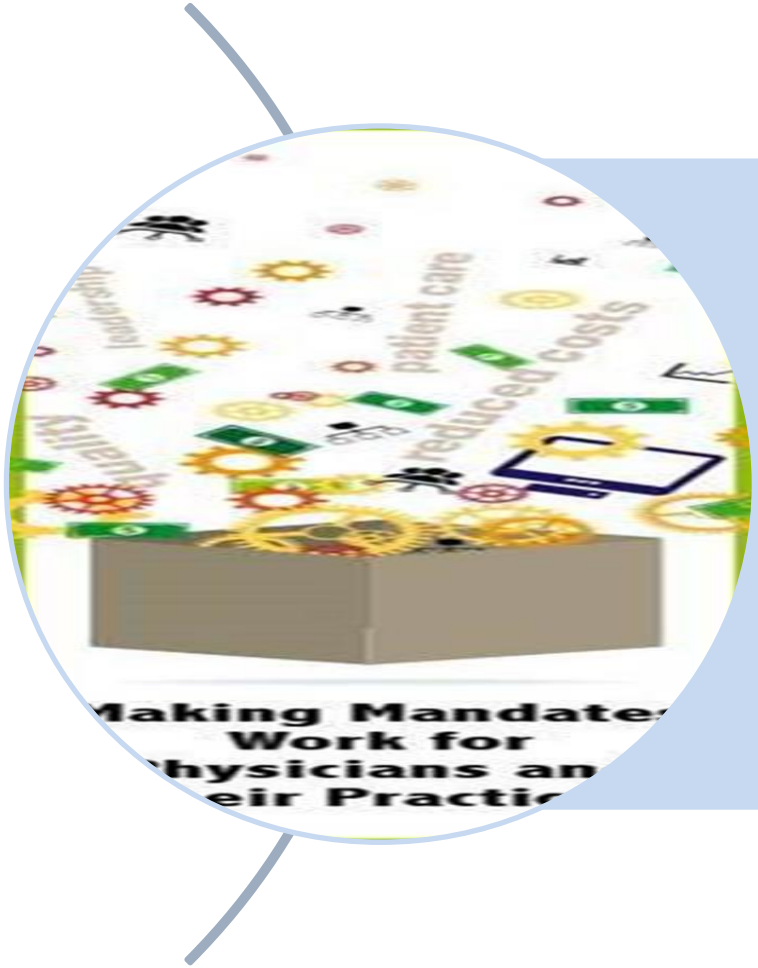
Quality

- Where do PQRS measures come from:
  - AHRQ: Agency for Healthcare Research & Quality
  - NCQA: National Committee for Quality Assurance
  - NQF: National Quality Forum
  - B2E: Bridges to Excellence

Hospital Quality



QIO: Quality Improvement Organizations

HAC: Hospital Acquired Conditions

RRP: Readmission Reduction Program

MU: Meaningful Use

IQR: Inpatient Quality Report

HVBP: Hospital Value Based Purchasing

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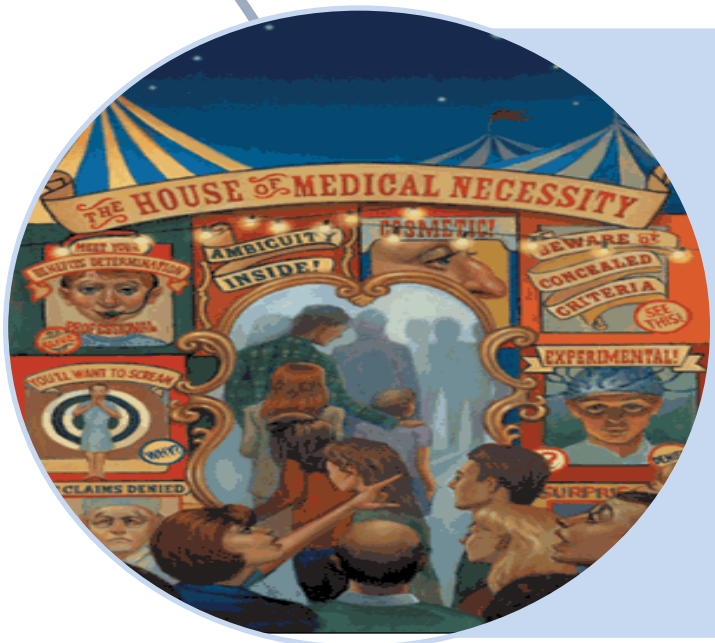
EHR/EMR/Other Names We Can't Say

- MU: Meaningful Use
  - ONC: Office of the National Coordinator
  - CEHRT: Certified Electronic Health Record Technology
- eCQM's: Electronic Clinical Quality Measures
- CPOE: Computerized Provider Order Entry

Medical Necessity



ABN – Advance Beneficiary Notice of Non-coverage

AUC – Appropriate Use Criteria

LCD – Local Coverage Determination

NCD – National Coverage Determination

TWO-MIDNIGHT RULE

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Advanced Beneficiary Notice of Non-Coverage (ABN)

- Standardized notice you or your practice must issue to a Medicare patient before providing certain Medicare Part B or Part A items or services that may be denied
- You must issue the ABN when: (1) You believe Medicare may not pay for an item or service; or (2) Medicare usually covers the item or service, however Medicare may not consider the item or service medically reasonable and necessary for this patient in this particular instance.
- GA modifier
- Is not required for services Medicare never covers

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A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

Local Coverage Determination (LCD)

- A coverage policy by your local Medicare carrier (MAC), that determines whether or not a particular item or service is covered.
- Every carrier has their own set of LCD's and are unique to Medicare Part A and Part B. Examples of local Medicare carriers include: First Coast Service Options (FSCO), Wisconsin Physicians Service Insurance (WPS), Noridian, Palmetto GBA, National Government Services (NGS), etc.

National Coverage Determination (NCD)

- A nationwide determination of whether Medicare will pay for an item or service
- Local policies are supposed to follow national guidelines, so if there are two polices for the same procedure, CMS tells us to follow the NCD

Billing and Compliance

APP – Advance Practice Provider

CCM – Chronic Care Management

TCM – Transitional Care Management

CDI – Clinical Documentation Improvement

RAC – Recovery Audit Contractor

ZPIC – Zone Program Integrity Contractor

ICD-10 – International Classification of Diseases

MLN – Medicare Learning Network

PECOS: Provider Enrollment, Chain, & Ownership

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Advanced Professional Provider (APP)

- Specially trained and licensed providers (other than physicians) who can provide medical care and billable services. Examples include audiologists, Certified Registered Nurse Anesthetists (CRNAs), midwives, nurse practitioners, occupational therapists, optometrists, physical therapists, physician assistants, psychologists, social workers and surgeon's assistants.
- Formerly known as Mid-Level Providers (MLPs) or Non-Physician Providers (NPPs)

Chronic Care Management (CCM)

- CPT code 99490 Effective Jan 1, 2015
- Non-face-to-face care coordination services provided to Medicare patients who have multiple (two or more), significant chronic conditions.
- Requirements for CCM services:
  - At least 20 min of clinical staff time per calendar month
  - 2 or more chronic conditions expected to last at least 12 months, or until the death of the patient
  - Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
  - Comprehensive care plan established, implemented, revised, or monitored

Transitional Care Management (TCM)

- TCM includes services provided to a patient during transitions in care from an inpatient hospital setting to the patient's community setting (home, domicile, rest home, or assisted living).
- It has two main codes (99495/99496) and requires:
  - Direct, iterative contact with patient within 2 business days of discharge
  - Certain non-face-to-face services (care coordination, review records, testing follow-up, etc.)
  - Face-to-face visit; either within 7 or 14 days from discharge, depending on level of service and code billed
  - Medical decision making of either high (7-days), or moderate (14-days) complexity medical decision making follow up post discharge.
- Billing cannot occur until 30 days post discharge and can only be billed by one provider.
- Somewhat complex rules and will require well-defined workflow

Clinical Documentation Improvement (CDI)

- CDI is a process primarily used in hospitals that employs specialists who review clinical documents, providing feedback and education to physicians.
- Designed to fill gaps in documentation such as questions about coding, quality measures and overall care management of a patient.
- Goal is to make sure that documentation is high quality and corresponds to care delivered as well as the diagnoses that are being made.

Recovery Audit Contractors (RAC)

- Created by Congress to help the CMS identify and correct improper payments made by Medicare and Medicaid.
- Initial demonstration (2005 – 2008) and was a huge success in that they recovered over $900 million in overpayments which was returned to the Medicare Trust Fund. $38 million in underpayments were returned to health care providers.
- RAC program became permanent as a result and is now active in all 50 states

Who are the RACs?

- Four private companies: CGI Federal, Connolly, HealthData Insights, Performant Recovery
- Contracts recently extended through 2015
- Paid on contingency basis
- New modifications to reduce provider burden, create more oversight and transparency
  - Limits on additional documentation requests (ADRs)
  - Delay auditor contingency fees until 2nd level of appeal is exhausted
  - Restrict review timeframes

Zone Program Integrity Contractors (ZPIC)

- Similar to RAC
- Covers 7 zones based on MAC jurisdictions
- Primary goal is to investigate instances of suspected fraud, waste, and abuse.
- They also identify any improper payments that are to be recouped by the MAC.
- Use statistical data sampling and extrapolation methods which allow them to recoup millions of dollars.

How is ZPIC Different From RAC?

- Do not conduct random audits
- Can make unlimited documentation requests
- Not paid on contingency basis
- Data analysis, complaints, and referrals are main triggers for ZPIC audits

Potential Outcomes From ZPIC Audit

- Suspension of payment
- Recoupment
- Referral to enforcement agencies, e.g. OIG
- Revocation of participation on Medicare

Medicare Learning Network (MLN)

- Free Medicare education and information resource
- The CMS developed MLN Matters® articles to ensure the health care professional community has immediate access to the latest changes to CMS Programs, Medicare coverage, billing and payment rules in a brief, accurate, and easy-to-understand format.
- Prepared in consultation with clinicians, billing experts, and CMS subject matter experts, MLN Matters® articles help explain critical provider information. They are tailored, by content and language, to specific provider type(s) who are affected by complex program changes. 5,100 articles since 2004.