Session V

The Numbers Game: Coding and Billing
Applying MACRA to Cardio-Oncology
Anita Arnold and Cathie Biga
The Numbers Game

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Lee Health System, Fort Myers Florida
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
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
Agenda

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

- Manage Population Health
- Enhance the Experience of Care
- Reduce Per Capita Cost

Ideal Care System
Where are we.....how do we get there
### How did we get to MACRA?

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997</td>
<td>Medicare Sustainable Growth Rate (SGR) implemented as part of the Balanced Budget Control Act of 1997</td>
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<tr>
<td>2002 - 2015</td>
<td>- 17 patches to avert steep cuts to Medicare</td>
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<tr>
<td></td>
<td>- House of Medicine, including the ACC, works with Congress to craft MACRA</td>
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<tr>
<td>March 24, 2015</td>
<td>H.R. 2 (Medicare Access and CHIP Reauthorization Act of 2015) introduced in the House</td>
</tr>
<tr>
<td>March 26, 2015</td>
<td>The House passed H.R. 2 (392-37)</td>
</tr>
<tr>
<td>April 14, 2015</td>
<td>The Senate passed H.R. 2 (92-8)</td>
</tr>
<tr>
<td>April 16, 2015</td>
<td>MACRA signed into law by President Barack Obama</td>
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</tbody>
</table>
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)
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
Quality Payment Program Pathways

MACRA Quality Payment Program

Merit-Based Incentive Payment System
Flexibility for:
- Solo and small practices (≤15)
- MIPS APM participants

Exempt
- First-year Medicare participants
- Low-volume threshold (<$30,000 allowed charges and <100 Medicare beneficiaries)

Advanced Alternative Payment Models
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."
Cathie Biga
President/ CEO
Cardiovascular Management of Illinois
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

<table>
<thead>
<tr>
<th>Required Measures</th>
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<tr>
<td>Security Risk Analysis</td>
</tr>
<tr>
<td>E-Prescribing</td>
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<td>Send Summary of Care</td>
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<td>Request/Accept Summary of Care</td>
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</table>
Clinical Practice Improvement (15%)

Full Credit

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

<table>
<thead>
<tr>
<th>Activity</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation in MOC Part IV</td>
<td>Medium</td>
</tr>
<tr>
<td>Participation in CMMI Models such as the Million Hearts Risk Reduction Model</td>
<td>Medium</td>
</tr>
<tr>
<td>Use of QCDR data for ongoing practice assessment and improvements</td>
<td>Medium</td>
</tr>
<tr>
<td>Use of decision support and standardized treatment protocols</td>
<td>Medium</td>
</tr>
<tr>
<td>Participation in a systematic anticoagulation program</td>
<td>High</td>
</tr>
<tr>
<td>Participating in CAHPS or other supplemental questionnaire</td>
<td>High</td>
</tr>
</tbody>
</table>
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?”

- 1 Quality Measure
- OR
- 1 Improvement Activity
- OR
- 4 or 5 Required Advancing Care Information Measures
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
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
The Moment of Truth

• We don’t always get paid for what we do
• But we can maximize efforts
• Medicare vs private payers
• Let's talk coding and documentation
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
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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>C3490</td>
<td>Malignant neoplasm of unsp part of unsp bronchus or lung</td>
<td>0.973</td>
</tr>
<tr>
<td>C679</td>
<td>Malignant neoplasm of bladder, unspecified</td>
<td>0.317</td>
</tr>
<tr>
<td>C7412</td>
<td>Malignant neoplasm of medulla of left adrenal gland</td>
<td>0.154</td>
</tr>
<tr>
<td>C779</td>
<td>Secondary and unsp malignant neoplasm of lymph node, unsp</td>
<td>0.672</td>
</tr>
<tr>
<td>C799</td>
<td>Secondary malignant neoplasm of unspecified site</td>
<td>2.484</td>
</tr>
<tr>
<td>Z4889</td>
<td>Encounter for other specified surgical aftercare</td>
<td>.</td>
</tr>
<tr>
<td>Z5111</td>
<td>Encounter for antineoplastic chemotherapy</td>
<td>.</td>
</tr>
<tr>
<td>Z5112</td>
<td>Encounter for antineoplastic immunotherapy</td>
<td>.</td>
</tr>
<tr>
<td>Z5189</td>
<td>Encounter for other specified aftercare</td>
<td>.</td>
</tr>
</tbody>
</table>
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."
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
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
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
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
Thank you

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