TIPS FROM OUR CONSULTANT

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As any physician or non-physician practitioner enrolled in Medicare knows, things can change overnight! This article includes some reminders and updates we believe are pertinent to osteopathic physicians.

Primary Care Incentive Payment Program (PCIP)

§5501(a) of the Affordable Care Act authorized a quarterly incentive payment program to augment the Medicare payment for primary care services when furnished by primary care practitioners beginning January 1, 2011 and ending December 31, 2015. The incentive payment is available to primary care providers who have a Medicare specialty designation of family medicine, geriatric medicine, pediatric medicine, internal medicine, nurse practitioner, clinical nurse specialist, or physician assistant for *CPT* codes 99201-99215 and 99304-99350 if these codes account for at least 60 percent of the provider's total allowed charges under the physician fee schedule in the qualifying calendar year.

In order to be eligible for the PCIP, physician assistants, clinical nurse specialists, and nurse practitioners must be billing for their services under their own National Provider Identifier (NPI) and not furnishing services incident to a physician's service.

The Centers for Medicare & Medicaid Services (CMS) uses Medicare claims data from the calendar year that is 2 years prior to the PCIP incentive payment year to calculate the payment. Incentive payments are equal to **10 percent** of the **Medicare paid amount** for **primary care services**. Incentive payments are made quarterly to individual physicians, non-physician practitioners, group practices and Method II critical access hospitals billing for practitioners.

CMS provides contractors with a list of the eligible primary care physicians and non-physician practitioners, based on their NPI, each year to use in calculating and issuing the quarterly incentive payment. 2015 PCIP is based on 2013 data and is the last year for the PCIP.

WPS posted the list of the Indiana physicians/non-physician providers eligible for the 2015 PCIP at http://www.wpsmedicare.com/j8macpartb/fees/incentive-programs/pcip-program.shtml

2015 Medicare Physician Fee Schedule

Instead of "ding, dong the witch is dead," physicians are singing "ding, dong SGR is dead!"

On April 16, 2015, President Obama signed the "Medicare Access and CHIP Reauthorization Act of 2015," which permanently repealed the Sustainable Growth Rate (SGR) payment formula. This law eliminates the 21.2 percent negative update to the 2015 fee schedule that was scheduled to take effect with dates of service on and after April 1, 2015.

The new law, known as "MACRA," also makes significant changes to the way Medicare will pay physicians in the future. There will be a strong emphasis on quality, value, and physicians/providers taking more financial risk by continuing with the Physician Quality Reporting System and Value-Based Modifier. Most of these changes will not take effect until 2019. In the meantime, it is largely business as usual.

Medicare claims submitted for dates of service January 1, 2015 through June 30, 2015 will continue under the current fee schedule. Under MACRA services for dates of service July 1, 2015 through December 31, 2015 will receive a positive update of 0.5%. The law also provides for a positive 0.5% update each year for 2016, 2017 and 2018.

In an effort to minimize financial effects on providers, on April 1, CMS instituted a 10-business day processing hold for all impacted claims with dates of service April 1, 2015, and later. Although the Medicare Administrative Contractors (MACs) were instructed to implement the rates in the legislation, a small volume of claims were processed at the reduced rate based on the negative update amount. The MACs will automatically reprocess the claims paid at the reduced rate with the new payment rate.

No action is necessary from providers who have already submitted claims for the impacted dates of service.

ICD-10 Effective October 1, 2015

October 1st will be here before you know it!

The transition to *ICD-10* is required for all physicians, providers, suppliers, insurers and other entities subject to code sets required by the Health Insurance Portability Accountability Act (HIPAA). When we transition to this code set, in most cases, physicians/non-physician providers will need to document detailed diagnostic statements in medical records in order to determine the appropriate *ICD-10* to report on the claim.

Because *ICD-10* is expanded and has up to seven digits of specificity, physicians and other providers need to assess whether their current documentation will support *ICD-10* by the compliance date of October 1, 2015.

CMS Timeline

CMS will implement *ICD-10* effective with dates of service on or after 10/1/2015.

WPS recommended the following implementation timeline. Are you ready?

- By April 30, 2015
  - Seek resources from CMS and professional and membership organizations to help with the transition
  - Appoint an *ICD-10* coordination manager or lead.
  - Raise awareness of *ICD-10* requirements.
  - Make a list of staff members who need *ICD-10* resources and training, such as billing and coding staff, clinicians, management, and IT staff.
  - Plan a comprehensive and realistic budget
  - Identify systems, procedures and technologies requiring upgrade
  - Request a timeline and cost estimate
  - Ask your vendors how they will support you in the transition to *ICD-10*

- By May 30, 2015
  - Perform formal training for all applicable staff. Educate your staff about upcoming changes and documentation requirements. Prioritize training needed if applicable
  - For example, train the coders who will need additional time to learn and practice *ICD-10* coding changes
  - Identify the all *CPT, HCPCS,* and *ICD-9* codes that impact your office
  - Prioritize the CPT, HCPCS, and *ICD-9* lists based on the financial impact to your office. Learning these first may help to keep a steady revenue to your office during the implementation process
  - Prepare practice claims for cross walking purposes
  - Begin cross walking the priority *CPT, HCPCS,* and *ICD-9* codes to learn how to become familiar with the process

- By June 30, 2015
  - Upgrade systems, procedures and technologies.
  - Get ready for testing. *ICD-10* codes must work in all aspects of your organization.
  - Medical practices need to start internal testing as soon as new systems and upgrades are installed
  - Conduct internal testing within your clinical practice
  - Resolve any issues or concerns
  - Request a testing plan to schedule from your vendor for external testing

- By July 30, 2015
  - Conduct external testing with payers and other external business partners. Test your systems to see if they can accept and process *ICD-10* codes
  - Continue internal testing within your clinical practice as well
  - Continue *ICD-10* cross walking activities on your priority *CPT, HCPCS* and *ICD-9* codes
  - Conduct any additional training needed

- By August 30, 2015
  - Conduct internal testing within your clinical practice as well external testing with payers and other external business partners after you have completed the planning stages
  - Educate staff on resolutions and corrective actions
  - Implement corrective actions
  - Prepare a backup plan for any unresolved issues or training

- By Sept. 30, 2015:
  - Continue external testing and validation. Test your transactions and medical claims with your vendor
  - Resolve any issues
  - Educate staff on resolutions and corrective actions
  - Implement your backup plan for any unresolved issues or training

- October 1, 2015 - Implementation day!