• **Call to order**

• **Introduction of Members and Guests** –
  - Dr. Arthur Lurvey, Dr. Roger Kimura

• **Meeting Notes from June 3, 2016**

• **Centers for Medicare and Medicaid Services (CMS)**

• **Comprehensive Error Rate Testing (CERT)**
  - Marion DeMoss, RN ([Marion.DeMoss@noridian.com](mailto:Marion.DeMoss@noridian.com)) – (701) 282-1981
  - Patty Holton, RN ([Patty.Holton@noridian.com](mailto:Patty.Holton@noridian.com)) – (701) 433-5969

• **Old Business:**
  - Finalizing LCDs (in notice):
  - Benign Skin Lesion Removal (Excludes Actinic Keratosis, and Mohs)
  - MoIDX: HLA-DQB1*06:02 Testing for Narcolepsy – effective 10/1/2016
  - Total Hip Arthroplasty – effective 9/7/2016
  - Total Knee Arthroplasty – effective 9/7/2016

• **New Business:**  **Draft LCDs for October**
# DRAFT POLICIES

**DRAFT LCDS FOR OCTOBER CACs: JE/JF B Meeting October 6, 2016**

**Comment Period October 6 to December 16**

2. Injections - Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton's Neuroma - Combined for JE/JF A AND B
3. Polysomnography and Other Sleep Studies - Combined for JE/JF A AND B
4. Diagnostic and Therapeutic Colonoscopy – Combined for JE/JF A AND B
5. Trigger Point Injections - Combined for JE/JF A AND B
7. MolDX: Percepta Bronchial Genomic Classifier New LCD
9. Measurement of Salivary Hormones - New
10. Cardiovascular Stress Testing, Including Exercise and/or Pharmacological Stress and Stress Echocardiography - COMBINED FOR JE/JF A AND B
11. MolDX-CDD: Oncotype DX Breast Cancer for DCIS (Genomic Health - New LCD for JE/JF A and B– Comment period ends Dec. 30
CHEST X-RAY DL43417

• 70 Pages of ICD-10-CM codes including some deleted and some new for 2017

• Combines JE A and B; and JF A and B
INJECTIONS-TENDON, LIGAMENT, GANGLION CYST, TUNNEL SYNDROMES AND MORTON’S NEUROMA DL 34218

• Combines JE A and B; and JF A and B
• Addresses indications for injection of chemical substances, (local anesthetics, steroids, sclerosing agents and/or neurolytic agents) into ganglion cysts, tendon sheaths, tendon origins/insertions, ligaments or near nerves of the feet (e.g., Morton's neuroma) to affect therapy for a pathological condition
• Discusses medical necessity and frequency of treatments as well as latest CPT and ICD-10-CM codes
POLYSOMNOGRAPHY AND OTHER SLEEP STUDIES DL36861

- Combines JE A and B; and JF A and B
- Refers to continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep furnished in sleep laboratory
- Diagnose a variety of sleep disorders and evaluate patient’s response to therapies such as CPAP. PSG is distinguished from sleep studies by the inclusion of sleep staging.
- Defines criteria for coverage & medical conditions covered, types of tests (I-IV) in or out of sleep lab
- Defines type of sleep testing and credentials of technicians and professional readers
DIAGNOSTIC AND THERAPEUTIC COLONOSCOPY DL34213

• Combines JE A and B; and JF A and B

• Indications diagnostic colonoscopy:
  – Abnormalities in BE, in DNA of fecal screening
  – Unexplained GI bleeding, Fe def. anemia, diarrhea
  – Acute bowel ischemia; or inflammatory bowel disease
  – Surveillance of colonic neoplasm
  – Intraoperative lesion detection

• Indications for therapeutic colonoscopy
  – Bleeding lesions such as vascular anomalies, ulceration, neoplasia, etc.
  – Balloon dilation of a stenotic lesion,
  – Decompression of sigmoid volvulus and/or acute non-toxic megacolon
  – Removal of foreign body and/ or colon polyps
TRIGGER POINT INJECTIONS DL 34211

• Combines JE A and B; and JF A and B

• Defines trigger points:
  – Myofascial trigger points are "small, circum-scribed, hyperirritable foci in muscles and fascia"
  – No lab or imaging test for establishing the diagnosis of trigger points—depends on H&P

• Major and minor coverage criteria given for injection

• Also lists accompanying management of pain
  – Identify cause or underlying reason
  – PT, OT, non-steroidal / anti-inflammatory drugs
  – Pain medicine consultation

• CPT and newest ICD 10-CM Codes given
MOLDX APC and APC MUTYH GENE TESTING DL36882

• For JE A and B; and JF A and B-NEW

• Indications
  – Individuals suspected to have Familial Adenomatous Polyposis (FAP), Attenuated FAP (AFAP) or MYH-associated polyposis (MAP)..and
  – Personal history of ≥20 adenomas over a lifetime

• Discusses:
  – Colorectal cancer risks
  – Additional clinical findings
  – Mutations and therapy
  – Coding
MOLDX: PERCEPTA BRONCHIAL GENOMIC CLASSIFIER DL36886

• For JE A and B; and JF A and B-NEW

• Indications:
  – Limited coverage to identify patients with clinical low- or intermediate-risk of malignancy,
  – After a non-diagnostic bronchoscopy, who may be followed with CT surveillance in lieu of further invasive biopsies or surgery.
  – Percepta BGC is a messenger-RNA assay measuring gene expression of 23 lung cancer associated genes and patient age. Assay performed on cytology brushings of bronchial epithelial cells collected during a bronchoscopy from the main stem bronchus and stored in an RNA preservative at 4°C immediately after collection
  – Can detect cancer with a high sensitivity exceeding the performance of bronchoscopy alone
CARDIOVASCULAR STRESS TESTING INCLUDING EXERCISE AND/OR PHARMA-COLOGICAL STRESS AND STRESS ECHOCARDIOGRAPHY DL34324

- Combines JE A and B; and JF A and B-NEW

- **General Indications for Cardiac Stress Test:**
  - Signs and symptoms of CAD
  - Metabolic disorders known to cause CAD
  - Abnormal EKG consistent with CAD
  - Evaluation for progression of CAD & pre op with hx of CAD

- **Indications for Stress Echocardiography:**
  - Electrical stress test not diagnostic for stated reasons
  - Evaluate valvular heart disease and ischemia
  - Diagnose, evaluate or differentiate cardiomyopathy
  - Pre op for high risk CAD

- **Information on documentation required on chart**
GLYCOMARK TESTING FOR GLYCEMIC CONTROL DL36864

• For JE A and B; and JF A and B-NEW

• Non-coverage policy for the GlycoMark® assay (aka 1,5-anhydroglucitol [1,5-AG]; developed by Nippon Kayaku, Co., Ltd).
  – Data to support the use of this test is based on showing correlations over short periods with other early glycemic markers (A1C, fructosamine, or glycated albumin) but is not specific to the intended use population
  – Comparative studies do not show that 1,5-AG is as good as a 2-hour post prandial blood glucose, or alternative biomarker
  – Long-term prospective studies are lacking, and large cohort studies are warranted to determine whether alternative biomarkers have potential utility for early diagnosis, management of diabetes, and prevention of diabetic complications.
MEASURING OF SALIVARY HORMONES DL36846

• For JE A and B; and JF A and B-NEW

• Traditionally endocrine hormones are measured in serum, plasma, or urine
  – Measurements of hormones at certain times of the day, or after attempts at suppression or stimulation can be used for diagnoses of endocrine diseases

• Salivary hormones testing
  – Material collected from saliva & sent to a lab
  – Accuracy of measurement and lack of standardization makes most hormone values determined still investigational.
  – Salivary cortisol collected in the evening for diagnosis of Cushing’s syndrome is only salivary hormone test covered
  – All other salivary hormones and tests are considered investigation and therefore not covered.
MOLDX-CDD: ONCOTYPE DX BREAST CANCER TEST FOR DCIS DL36941

• For JE A and B; and JF A and B-NEW

• Indications
  – Oncotype DX® DCIS assay (Genomic Health, Inc., Redwood City, CA) for women diagnosed with DCIS who are planning on breast conserving surgery and considering adjuvant radiation Rx.
  – RNA based assay measuring the expression of five proliferation genes, progesterone receptor (PR), GSTM1 and five reference genes (Figure 1) with results reported as a numerical score along with accompanying interpretive information. The assay is performed on formalin fixed paraffin-embedded (FFPE) tissue blocks containing DCIS
  – An algorithm was developed using scaling and category cut-points based on the analysis of the DCIS “Score” which can help guide treatment decisions
• **New Business, Continued**

• **Noridian Education Report:**
  - Jean Matsushita, CPC

• **Medicare Part A/B Administrative report**
  - Arthur Lurvey, MD

• **Other Noridian Meetings:**
  - Next HI Contractor Advisory Committee Meeting: Friday, February 24, 2017
  - Open Public Meeting Notification: Wednesday, February 8, 2017 11 a.m.-12 p.m. MT
  - The next Ask the Contractor Teleconference October 19, 2016; 1:00 p.m., CT
  - Toll Free Call-in Number: 1-800-553-5275

• **Open mike: any personal comments**
Contractor Advisory Committee (CAC) Meeting

Medicare Part B
Provider Outreach and Education (POE)
October 2016
ICD-10-CM Update

- Effective October 1, 2016
  - “In the correct family” no longer acceptable
    - Diagnosis appropriate based on documentation
    - Does not change current system edits or LCD/NCD policy covered diagnosis(es)
    - MAC stricter about covered diagnosis(es)

- CMS published FAQ resources on ICD-10
Enrollment Reminder

• Medicare providers must revalidate enrollment every three to five years
• On-Demand training available
  • https://med.noridianmedicare.com/web/jfb/enrollment/potential-providers/medicare-part-b-specialties
• Revalidation due dates
  • Last day of month (e.g. July 31, 2016)
• Due Dates posted on
  • https://data.cms.gov/revalidation
Revalidation Website

- Name/NPI
- Lookup Tool
- Provides due date
Enrollment Deactivation

- Clinic Providers
  - Retired
  - Left the practice
- 855R application
  - Close provider applications
  - Prevent fraudulent activities
  - Prevent unnecessary correspondence for revalidation
EDI Support Services (EDISS) Gateway

• Gateway transition began May 23, 2016, and continues throughout 2016
  – No more Legacy gateway
• Vendor transition period
  – June 20 – October 3, 2016
• Direct submitter transition
  – August 29 – TBD, 2016
• Final Clean-Up TBD
Flu Resources for 2016-2017

- MLN Matters® Number: SE1622
- Deductible and coinsurance waived
- CPT code and effective dates posted
- Payment allowances – CR9758

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/VaccinesPricing.html
Medical Review (MR) Findings

• MR Non-Complex Review Notifications
  – Critical Care (99291-99292)
  – Hospital Discharge (99239 >30 mins.)

• Top reasons for focus:
  – Insufficient Documentation
  – Physician Signatures

• Cross recovery for provider claims when institutional claims denied
  – Facet injections 64493 – 64495; 64635, 64636
Quality Reporting Reminder

- Eligible physicians reimbursed by Medicare
  - Not applied to Medicaid, hospitals or SNFs
- Payment adjustments combined under Merit-Based Incentive Payment (MIPS)
  - Starts January 2017 for 2019 reporting
- PQRS, VM and EHR-MU ends Dec. 31, 2018
- EPs participate in MIPS or qualifying APM
  - MIPS~positive, negative or zero adjustment
  - APM~receive 5% incentive payment for 6 years
# Educational Schedule of Events

The Schedule of Events includes Noridian Education web-based workshops, in-person workshops, and Ask the Contractor Teleconferences (ACTs) as well as some partner events. Providers are encouraged to learn more about the web-based workshop registration process, confirmation emails, instructions for printing presentations and related materials, Continuing Education Units (CEUs) offered, as well as the computer and telephone technical requirements necessary to participate in web-based workshops.

- Select an event title below to view its agenda and register.
- The registration process can be completed using a desktop or laptop computer. Event registration cannot be completed using a mobile device.
- View events in a "List" or "Calendar" view.
- Each event time is offered using the Central Time Zone.

**Last Updated Feb 24, 2016**

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Title</th>
<th>Type</th>
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<tbody>
<tr>
<td>10/27/16</td>
<td>1:00 PM – 2:30 PM CDT</td>
<td>Critical Care</td>
<td>Web-based Workshop</td>
</tr>
<tr>
<td>10/27/16</td>
<td>3:00 PM – 6:00 PM CDT</td>
<td>Chiropractic Care - Tempe, AZ</td>
<td>In-Person Event</td>
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<td>11/15/16</td>
<td>1:00 PM – 2:00 PM CST</td>
<td>Basic E and M Avoiding Common Errors</td>
<td>Web-based Workshop</td>
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<td>11/15/16</td>
<td>1:00 PM – 2:00 PM CST</td>
<td>Ordered, Referred and Prescribed Services</td>
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<td>11/29/16</td>
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<td>Web-based Workshop</td>
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<td>Preventive and Screening Services</td>
<td>Web-based Workshop</td>
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<tr>
<td>12/16/16</td>
<td>11:00 AM – 12:00 PM CST</td>
<td>Understanding National and Local Coverage Determinations</td>
<td>Web-based Workshop</td>
</tr>
</tbody>
</table>
Thank you!
DOCUMENTATION POINTS

• Office templates/forms OK, but must be individualized for each visit

• Patient name, date, time, and ID of who documented chart is necessary

• Computerized notes fine if specific for patient and visit, but medical necessity still rules on review

• Cloning EHR is a no-no!!!

• Require time when service time related (e.g. face to face time, critical care time)

• For offices using paper claims: If poorly legible, or not properly signed--we must reject the claim

Greatest amount of Medicare denials is due to insufficient, incorrect or unreadable documentation!!!
RESPONDING TO ANY REQUEST FOR RECORDS

• Have a set office process for dealing with all ADRs (Additional Record Requests)
• Have one individual responsible for sending all records as part of the set office process
  – Experienced office person, or clinical person, or both
• Have a check off sheet that involves
  – Legibility (can add typed / printed addendum)
  – Correct name, date, physician listed in request
  – Signature (signature sheet or attestation if needed)
  – Correct address to send records
  – Timeliness of records being sent
• Know how and where to get hospital records
• Send by certified mail (or equivalent)
MANY GOVERNMENT CHANGES

• ICD-10-CM required 10/01/15
  – Initially grace period with flexibility
  – Full coding (to 7 digits) required 10/01/16

• MACRA law ended SGR hassles...and
  – Funded many other programs 2-3 years
  – Created new incentive program: Quality Payment Program....starts collecting data 2017
  – Medicare payment in 2019 (with data collection starting in 2017) will be incentive based---Private insurance likely to follow same course
  – Most physicians will either report data for Merit Incentive Program (MIPs) or for Advanced Alternative Payment Models (APMs)
  – Old incentive programs end (PQRS, Meaningful use, VBP) and incorporated into Quality program
HOW DOES MEDICARE PART B PAY ME NOW?

Fee schedule plus 3 potential incentive programs that enhance or reduce overall payment

- Physician Quality Reporting System (PQRS)
- Meaningful Use Electronic Health Records Incentive Program (MU)
- Value Based Modifier (VBM)

Adapted From ASCO
FUTURE PAYMENT INCENTIVES
MIPS Performance Categories

A single MIPS composite performance score will factor in performance in 4 weighted performance categories on a 0-100 point scale:

- Quality
- Resource use
- Clinical practice improvement activities
- Advancing care information

MIPS Composite Performance Score (CPS)
Examples of Process Improvement

• Provide 24/7 access to MIPS eligible clinicians, High Access eligible groups, or care teams for advice about urgent and emergent care

• Use of alternatives to increase access to care team by MIPS eligible clinicians and MIPS eligible groups, such as e-visits, phone visits, group visits, home visits and alternate locations

• Provision of same-day or next-day access to a consistent MIPS eligible clinician, group or care team when needed for urgent care or transition management

• Population Participation in a systematic anti-coagulation program

• For rural or remote patient, patients are managed using remote monitoring or telehealth options that involve systematic and coordinated care,

• Population For outpatient Medicare beneficiaries with diabetes High Management and who are prescribed antidiabetic agents (e.g., insulin, sulfonylureas), MIPS eligible clinicians and MIPS eligible clinician groups must attest to having: For the first performance period, at least 60 percent of medical records with documentation of an individualized glycemic treatment goal

• Use of a Qualified Clinical Data Registry
HOW WILL MEDICARE PAYMENT CHANGE IN 2019

The Merit Based Incentive Payment System (MIPS)

TODAY
Physician Quality Reporting System (PQRS)
Meaningful Use (MU)
Value Based Modifier (VBM)

SUNSETS DEC 2018

JAN 2019
CPIA (2019)
Adds Clinical Practice Improvement Activity (CPIA)
Consolidates penalties
Increases incentives
Ranks peers nationally
Reports publicly

Adapted From ASCO
WHO IS AFFECTED BY MIPS

- **Exceptions From MIPS:**
  - New Physicians billing Part B first year
  - Low Volume Doctors: Billing <$10,000/year or seeing <100 Medicare patients/year
  - APM (Alternate Payment Model) Qualified Participant
This distribution of physicians the first year or so—may change with time as they form larger groups.
DEFINITION OF ALTERNATE PAYMENT MODEL

APMs are **new approaches to paying for medical care through Medicare that incentivize quality and value.**

As defined by MACRA, APMs include:

- CMS Innovation Center model (under section 1115A, other than a Health Care Innovation Award)
- MSSP (Medicare Shared Savings Program)
- Demonstration under the Health Care Quality Demonstration Program
- Demonstration required by federal law

Adapted from CMA
DEFINITION OF ALTERNATE PAYMENT MODEL

Advanced APMs meet certain criteria

As defined by MACRA, Advanced APMs must meet the following criteria:

- **Use Certified EHR Technology**
- **Uses Quality Measures**
- **Bears financial risk or Medical Home Model Under DMMI**
CURENTLY QUALIFIED ADVANCED APMs

- Shared Savings Program
- Next Generation ACO
- Comprehensive ESRD
- Comprehensive Primary Care Plus
- Oncology Care Model (2 sided risk available in 2018)
- Others to be determined
CMS SLIDES ON MIPS

✓ MIPS is a new program
  • Streamlines 3 currently independent programs to work as one and to ease clinician burden.
  • Adds a fourth component to promote ongoing improvement and innovation to clinical activities.

✓ MIPS provides clinicians the flexibility to choose the activities and measures that are most meaningful to their practice to demonstrate performance.

Adapted from CMS
Year 1 Performance Category Weights for MIPS

- Quality: 50%
- Advancing Care Information: 25%
- Clinical Practice Improvement Activities: 15%
- Cost: 10%

Start collecting data in 2017

Adapted from CMS
COMPOSITE PERFORMANCE SCORES OVER NEXT FEW YEARS

<table>
<thead>
<tr>
<th>Year</th>
<th>Quality Measures</th>
<th>Resource Use</th>
<th>Clinical Practice Improvement Activities</th>
<th>Advancing Care Information</th>
<th>MIPS Adjustment Factor (+/-)</th>
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</thead>
<tbody>
<tr>
<td>2019</td>
<td>50%</td>
<td>10%</td>
<td>15%</td>
<td>25%</td>
<td>+/- 4%</td>
</tr>
<tr>
<td>2020</td>
<td>45%</td>
<td>15%</td>
<td>15%</td>
<td>25%</td>
<td>+/- 5%</td>
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<tr>
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<td>30%</td>
<td>30%</td>
<td>15%</td>
<td>25%</td>
<td>+/- 7%</td>
</tr>
<tr>
<td>2022 beyond</td>
<td>30%</td>
<td>30%</td>
<td>15%</td>
<td>25%</td>
<td>+/- 9%</td>
</tr>
</tbody>
</table>

- The composite performance score will range from 0-100
- The MIPS composite performance score will factor in performance in 4 weighted categories:
  - EPs receive positive adjustment factor if score above performance threshold or negative adjustment if below threshold

Adapted from CMA
SMALL PRACTICE SUPPORT

• **$100 million over 5 years in technical assistance:**
  – Legislation provides technical assistance via organizations such as Quality Improvement Organizations and Regional Extension Centers to MIPS eligible clinicians in practices with 15 or fewer clinicians.
  – The assistance will focus on small practices in rural and health professional shortage areas (HPSA).

• **Transforming Clinical Practice Initiative:**
  – This Initiative supports implementation of the Quality Payment Program among medical group practices, regional health care systems, regional extension centers, and national medical professional association networks.
  – In September 2015, CMS awarded **$685 million** to 39 national and regional health care networks and supporting organizations to provide technical assistance support to help equip more than an estimated 140,000 clinicians with the tools and support needed to improve quality of care, increase patients’ access to information, and spend dollars more wisely.
Transforming Clinical Practice

Initiative: Two Components

- **Twenty-nine Practice Transformation Networks** will provide technical assistance and peer-level support to assist clinicians in delivering care in a patient-centric and efficient manner. Examples include providing dedicated coaches to help practices better manage chronic diseases, supporting improved patient access to practitioners through e-mails and other information technology applications, and helping to advance improved access to remote and virtual care.

- **Ten Support and Alignment Networks** will focus on such initiatives as creating a collaborative for emergency clinicians to address appropriate utilization of tests and procedures and forming collaboratives between psychiatry and primary care providers so patients can receive basic mental health care from their primary care providers. These will especially support practices serving small, rural, and medically underserved communities and play an active role in the alignment of new learning.
SEVEN WAYS TO PREPARE FOR MACRA
(adapted from CMA)

- Learn the basics of MACRA (and MIPS or APMS). Remember these are proposed—learn the final rules when available
- Are you exempt from MIPS
  - Low volume, <$10,000 and <100 Medicare patients per year
  - First year in practice
  - HPSA or non-patient facing exceptions
- Participate in PQRS for 2016 to learn quality reporting issues
- Understand QRUR (Quality & Resource Use Reports); learn your quality & cost assessment data; available from CMS
- Review proposed quality measures & how to report and consider participation in a qualified clinical data registry
- Evaluate your EMR, your vendor and its support for MIPS data
- Which clinical practice improvement activities (CPIA) is your practice already doing and consider ways your practice can report at least one unique patient for each Advancing Care Information (ACI) measure
FLEXIBILITY IN MIPS / APM

(As reported by ACP)

• Sept. 8. CMS announced the final MACRA / MIPS regulation will exempt physicians from any risk of penalties if they choose one of three distinct MIPS reporting options in 2017, in addition to the option of participating in an advanced APM:
  – Full-year reporting that begins on January 1;
  – Partial year reporting for a reduced number of days; and
  – A "test" option under which physicians can report minimal amounts of data.

• Physicians who report in 2017 may be eligible for bonus payments in 2019, depending on which option they choose.
  – Those who opt for full-year reporting will be eligible to receive a "modest positive payment adjustment;"
  – Those who choose partial year reporting will be eligible for a “small positive payment adjustment."
  – Physicians who choose the "test" option will not be subject to any payment adjustments.
  – Qualified participants in advanced APMs will be eligible for 5 percent incentive payments in 2019.
MORE INFORMATION ON MIPS

• **For the full slide deck:**

• **For the full Quality Initiatives site:**

• **CFR site:**