MEDICAL ONCOLOGY CODING & REIMBURSEMENT

Annual Membership Conference
The Future of Cancer Care Delivery
November 15, 2014

Risë Marie Cleland, Oplinc Inc.
www.oaplnc.com
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MEDICARE UPDATES

New CPT, HCPCS Codes
“Incident to”
Billing for Discarded Drugs
Modifier 59

“Modifier 59 is used appropriately for two services described by timed codes provided during the same encounter only when they are performed sequentially. There is an appropriate use for modifier 59 that is applicable only to codes for which the unit of service is a measure of time (e.g., per 15 minutes, per hour). If two timed services are provided in time periods that are separate and distinct and not interspersed with each other (i.e., one service is completed before the subsequent service begins), modifier 59 may be used to identify the services.”

CMS – New HCPCs

CMS has developed the following new HCPCS as a subset of Modifier 59:

- **XE** Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter,
- **XS** Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure,
- **XP** Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner, and
- **XU** Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service.

Modifier -59 is still valid and will be recognized by Medicare, however it should not be used when a more descriptive modifier is available.

Polling Question

Q. Which modifier is most appropriately used when billing for the administration of hydration that is subsequent to chemotherapy?

Choose 1:

a. **59**, Distinct Procedural Service identifies procedures/services not normally reported together, but appropriately billable under the circumstances

b. **XE** Separate Encounter, a service that is distinct because it occurred during a separate encounter

c. **XS** Separate Structure, a service that is distinct because it was performed on a separate organ/structure

d. **XP** Separate Practitioner, a service that is distinct because it was performed by a different practitioner

e. **XU** Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service
Answer:

- **59, Distinct Procedural Service identifies procedures/services not normally reported together, but appropriately billable under the circumstances.**

*CMS is leaving it up to the Medicare Contractors to determine requirements for the use of the selective sub-set of modifiers in lieu of the general -59 modifier.
Noridian Webinar: Modifier 59 Clarification and Changes

Start Date: 12/18/14
Duration: 11:00 AM – 12:30 PM - Pacific Daylight Time
Type: Web-based Workshop

Register Online:
https://noridianmedicare.webex.com/noridianmedicare/onstage/g.php?MTID=e89d14ddf76f7dd1caec0664e6b6563db

Abstract
This workshop includes information about the National Correct Coding Initiative Manual and when to use modifier 59 and also updates and changes in 2015.
New Chronic Care Management (CCM)

CPT code, 99490, describes CCM services effective January 1, 2015. Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:

- Multiple (two 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.
CCM Services

- CMS requires that providers explain to beneficiaries the cost-sharing obligation involved in receiving CCM services and obtain their consent prior to furnishing the service.
- National unadjusted payment rate of approximately $42.60
- CMS will allow CCM and non-face-to-face portion of the TCM services provided by clinical staff incident to the services of a practitioner to be furnished under the general supervision of a physician or other practitioner.
# Incident to - Billing

<table>
<thead>
<tr>
<th>Situation</th>
<th>Performed by</th>
<th>Billing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Established patient with no new problems</td>
<td>NPP</td>
<td>If 'incident to' requirements have been met the service may be billed under the supervising physician's NPI</td>
</tr>
<tr>
<td>Established patient with new problem</td>
<td>NPP (only)</td>
<td>Must be billed under NPP's NPI</td>
</tr>
<tr>
<td>Established patient with new problem</td>
<td>NPP and Physician</td>
<td>May be billed under physician if the &quot;incident to&quot; requirements have been met. The documentation must support a face-to-face occurred with the physician (during the encounter) and that he/she has initiated the course of treatment. The physician must sign his/her entry.</td>
</tr>
</tbody>
</table>

[https://med.noridianmedicare.com/web/jeb/topics/incident-to-services](https://med.noridianmedicare.com/web/jeb/topics/incident-to-services)
## Incident to - Signatures

<table>
<thead>
<tr>
<th>Situation</th>
<th>Performed by</th>
<th>Signature Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘Incident to’</td>
<td>Ancillary Staff</td>
<td>Must be signed by supervising (billing) provider</td>
</tr>
<tr>
<td>NPP</td>
<td>NPP</td>
<td>May be signed by the NPP or the supervising (billing) physician</td>
</tr>
</tbody>
</table>

[https://med.noridianmedicare.com/web/jeb/topics/incident-to-services](https://med.noridianmedicare.com/web/jeb/topics/incident-to-services)
Noridian FAQ – “Incident To”

- Q8. Is chemotherapy instruction considered incident to by a Nurse Practitioner (NP)?
- A8. No. In the office and other outpatient setting, counseling and/or coordination of care must be provided in the presence of the patient. Face-to-face time refers to the time with the physician only. Counseling by other staff is not considered to be part of the face-to-face physician/patient encounter time; therefore, the time spent by the other staff is not considered in selecting the appropriate level of service. The service provided must be medically necessary and the service must be within the scope of practice for a non-physician practitioner in the State in which he/she practices.

“Chemotherapy Teaching”

H.R. 1661 Improving Cancer Treatment Education Act of 2013 - Amends title XVIII (Medicare) of the Social Security Act to extend Medicare coverage to comprehensive cancer patient treatment education services, including a one-hour patient treatment education session delivered, in advance of treatment, by a registered nurse to an individual diagnosed with cancer (or whose course of treatment has been materially modified).

But no movement on this bill for over a year.
Polling Question

True or False:

Q. When a NPP performs a service “incident to” a physician’s service (and the service is billed under the physician’s NPI) the supervising physician must sign the medical record documentation of the service.

a. True
b. False
Answer:

b. False, when a NPP provides the “incident to” service the medical record documentation may be signed by either the NPP or the supervising physician.
Drug Wastage

Drug wastage or discard must be documented in the patient's medical record with:

- Date
- Time
- Amount wasted
- Reason for wastage
- Total amount the vial is labeled for

Upon review, any discrepancy between amount administered to the patient and amount billed may be denied as non-rendered unless the wastage is clearly and acceptably documented. The amount billed as "wasted" must not be administered to another patient or billed again to Medicare.
Discarded Drug

If the provider must discard the remainder of a single-use vial or other package after administering the prescribed dosage of any given drug, Medicare may cover the amount of the drug discarded along with the amount administered. The following elements must be followed in order for the discarded amount to be covered:

1. The vial must be a single-use vial. Multi-use vials are not subject to payment for any discarded amounts of the drug.
2. The units billed must correspond with the smallest dose (vial) available for purchase from the manufacturer(s) that could provide the appropriate dose for the patient.
3. The left-over amount must actually be discarded and may not be used for another patient regardless of whether or not that other patient has Medicare.
Can single-dose or single-use vials be used for more than one patient?

No.

Vials that are labeled as single-dose or single-use should be used for a single patient and single case/procedure/injection. There have been multiple outbreaks resulting from healthcare personnel using single-dose or single-use vials for multiple patients.

Even if a single-dose or single-use vial appears to contain multiple doses or contains more medication than is needed for a single patient, that vial should not be used for more than one patient nor stored for future use on the same patient. To prevent unnecessary waste or the temptation to use contents from single-dose or single-use vials for more than one patient, healthcare personnel should select the smallest vial necessary for their needs when making purchasing decisions.

www.cdc.gov/injectionsafety/providers/provider_faqs_singlevials.html
Polling Question

Q. A single-dose vial of drug expired and had to be discarded, can you bill Medicare for the wasted discarded drug?

Choose 1
a. Yes
b. No
Answer

b. No, expired drug that has to be discarded would not be payable by Medicare.
E/M Services Inappropriate Payments

- OIG will review multiple E/M services associated with the same providers and beneficiaries to determine the extent to which electronic or paper medical records had documentation vulnerabilities.
- Medicare contractors have noted an increased frequency of medical records with identical documentation across services.

www.oig.hhs.gov
Cloning

- Documentation that is worded exactly like previous entries
  - ‘Copy and paste’ or ‘carry forward’,
  - Cloned documentation does not meet medical necessity, contractors will recoup payment when cloned documentation is discovered.

- Documentation must be patient and date of service specific.

- OIG reviewing multiple E/M services for the same providers and beneficiaries to identify EHR documentation practices associated with potentially improper payments.
  - May be considered fraudulent coding

Q30. What does Noridian consider to be a cloned E/M note? If a note is very similar from day to day but is accurate to what happened, is this a cloned note?

A30. In general, if only the DOS and vital signs are different, then Noridian would most likely consider it cloned. We do realize that there may not be changes day to day detail the stability of the patient but it is important to include the details in the documentation. Medical necessity is also important here. To repeat a family and social history on visits every week or two would be considered cloning or at least not reasonable and necessary.
Templates

- CMS does not prohibit the use of templates to facilitate record-keeping.
- CMS discourages the use of templates that provide limited options and/or space for the collection of information such as “check boxes,” predefined answers, and/or limited space to enter information.
- Templates focused for reimbursement purposes are often insufficient to demonstrate that all coverage and coding requirements are met.
- Medical necessity must be documented for all services provided.
MORE MEDICARE AUDITS

Recovery Audit Contractors (RAC)
Comprehensive Error Rate Testing (CERT)
Meaningful Use (MU)
Make Sure Documentation is Complete Including Orders & Signatures
CMS Instructions to Review Contractors

If the signature is illegible, ACs, MACs, PSCs, ZPICs and CERT shall consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record.

If the signature is missing from an order, ACs, MACs, PSCs, ZPICs and CERT shall disregard the order during the review of the claim.

If the signature is missing from any other medical documentation, ACs, MACs, PSCs, ZPICs and CERT shall accept a signature attestation statement from the author of a medical record.
Orders – Required Elements

- Beneficiary’s name;
- Name of drug;
- Dosage;
- Route of administration;
- Frequency of administration;
- Physician’s name;
- Physician signature and date; or
- The start date of the order, if different than the signature date.
E/M Visit on Day of Drug Administration

- When a medically necessary, significant, and separately identifiable E/M service (which meets a higher complexity level than CPT code 99211) is performed, in addition to one of these drug administration services, the appropriate E/M CPT code should be reported with modifier -25.

- Documentation must support the level of E/M service billed.

- For an E/M service provided on the same day, a different diagnosis is not required.

Leading Oncology Practice To Pay $4.1 Million To Settle False Claims Act Investigation

FOR IMMEDIATE RELEASE

Georgia Cancer Specialists Overbilled Medicare for Evaluation and Management Services

ATLANTA, GA - The United States Attorney’s Office for the Northern District of Georgia announced today that it has reached a settlement with Georgia Cancer Specialists I, PC, which agreed to pay $4.1 million to settle claims that it violated the False Claims Act by billing Medicare for evaluation and management services that were not permitted by Medicare rules. Georgia Cancer Specialists is one of the largest private oncology practices in the country with 27 offices located throughout the Atlanta metro area.

Sally Quillian Yates, United States Attorney for the Northern District of Georgia, said, “Health care providers should be on notice that if they inflate their billings, we will aggressively seek to recover not only the overcharges, but also significant penalties under the False Claims Act.”

Ricky Maxwell, Acting Special Agent in Charge, FBI Atlanta Field Office, stated: “The FBI continues to do its part in ensuring that federal funds appropriated to Medicare are spent appropriately and today’s settlement is an example of those efforts. The FBI urges anyone with information related to overbilling or fraudulent billing of our Medicare programs to contact their nearest FBI field office.”

“Today’s settlement sends a clear message to health care providers across the country that they will be held responsible if they misrepresent the services they bill to Medicare,” said Derrick L. Jackson, Special Agent in Charge of the U.S. Department of Health and Human Services, Office of Inspector General for the Atlanta region. “The Office of Inspector General will continue to work closely with our law enforcement partners to stamp out fraud, waste and abuse within the Medicare system.”

The civil settlement resolves the United States’ investigation into Georgia Cancer Specialists’ practices relating to billing for evaluation and management (E&M) services on the same day as a related procedure. Generally, providers are not permitted to bill both E&M services and a related procedure on the same day under the Medicare program’s regulations. In specific circumstances, providers can avoid this prohibition by submitting their claims marked with modifier -25, which tells Medicare to pay both the procedure and the E&M service. Here, the U.S. Attorney’s Office alleged that Georgia Cancer Specialists applied modifier -25 to claims that did not qualify for its use, leading to overpayments by Medicare.

Because of widespread abuse of the use of modifier -25, the U.S. Department of Health and Human Services, Office of Inspector General has targeted the use of modifier -25 in its yearly work plans. The yearly work plans outline the current focus areas of the OIG and lead to increased scrutiny by the OIG of
Use of Modifier 25

Complex medical review has revealed confusion over the proper billing of evaluation and management (E/M) CPT codes with modifier 25 on same date as procedures and/or drug administration codes.

- It may be appropriate to report an E/M service code when a separately identifiable, medically necessary service has been provided in addition to a procedure provided on the same date.
- The physician/NPP's documentation must indicate that on the day a procedure was performed, the patient's condition required a significant separately identifiable E/M service.
- A separately billable E&M service does not relate directly to the actual performance of the procedure.
- Commonly, the separately identifiable nature of a service is indicated by a separate diagnosis code.
- Rarely, an E&M service separate from the procedure may be associated with the same diagnosis code.

https://www.noridianmedicare.com
Inappropriate Use of Modifier 25

- An E/M with modifier 25 may not be billed for use of a room, technician time, nursing care, assessment, or monitoring.
- A routine interval evaluation, for example to assure there are no new issues when the patient presents for chemotherapy, may not be separately paid by Medicare and should not be billed.

Example: The patient arrives for chemotherapy treatment. The nurse completes an assessment including vital signs, confirms there are no new or interval issues; starts the treatment and continues to periodically monitor the patient during the treatment. A separately identifiable E/M service has not been provided and should not be billed with modifier 25.
Appropriate Use of Modifier 25

An E/M with modifier 25 may be billed on the same day as a drug administration code when documentation clearly supports a medically necessary E/M service unrelated to the chemotherapy administration. This may include physician/NPP evaluation and management of the disease process requiring the administration for the drug if an alteration of the treatment plan may be required due to symptoms/signs, adverse treatment reactions, etc.

Example: The patient arrives for chemotherapy treatment, refusing to continue home medication regimen due to side-effects. The physician/NPP evaluates the patient complaint and makes a determination on potential changes in the treatment plan. The patient also receives chemotherapy. An E/M with modifier 25 may be billed for the physician/NPP service in addition to the administration of the chemotherapy.
Polling Question

Q. Would it be appropriate to bill a routine interval evaluation, to assure there are no new issues the day before the patient presents for chemotherapy?

a. Yes
b. No
Answer:

b. No. If the E/M visit is not considered separate and significant from the chemotherapy encounter it would not be appropriate to bypass the NCCI edit by bringing the patient in the day before the procedure.
Medicare Appeals Backlog

- The Office of Medicare Hearings and Appeals (OMHA) announced a backlog of nearly 357,000 claims at the third level of appeal, the administrative law judge (ALJ).
- In response, they have suspended acting on new requests for hearings filed by hospitals, doctors and other providers for approximately 2 years.
- Appeals at this level have the best success rate with 56% of lower level denials being reversed.
- Beneficiaries appeals will continue to be processed.
- Providers still having money recouped 30 days after appeal is accelerated to ALJ.
Meaningful Use (MU) Audits

Pre and post payment MU audits performed by:

Figliozzi and Company www.figliozzi.com
Questions: Peter Figliozzi (516) 745-6400 x302 pfigliozzi@figliozzi.com
Don’t Overlook EHR Audit Letters

- Initial request letters will be sent to providers selected for an audit
- The request letter will be sent electronically by Figliozzi and Company from a CMS email address to the email address provided during registration for the EHR Incentive Program
- The initial review process will be conducted using information provided in response to the request letter
- Additional information may be needed during or after the initial review process
- Providers selected for the audits have two weeks to submit their documentation

EHR Audit Process

- On-site review at the provider’s location may follow
  - A demonstration of the EHR system may be required during the on-site review
- If the provider is found to be ineligible for an EHR incentive payment, the payment will be recouped
- Contact CMS EHR Information 888-734-6433, for questions on how to file appeals and the status of any pending appeals

Resources to Prepare for MU Audits

Documentation to support attestation data for MU objectives & clinical quality measures should be saved for 6 years post-attestation.

Remember: Not all systems allow for printing of documentation once a reporting period is closed. Talk to your vendor!

CMS Resources:
- Supporting Documentation for EHR Audits
- Sample audit request letter for EPs
- CMS FAQ with MU Audit Documentation Tips
Source Document

At minimum the summary document should include:

- The numerators & denominators for the measures
- The time period the report covers
- Evidence to support that is was generated for that EP (identified by National Provider Identifier (NPI), provider name, practice name etc.)
CMS EHR Audit Tips

- Be sure to enter accurate numbers when you attest to meaningful use of an EHR.
- Know that dated screen shots provide a good source of documentation.
- Turn on, for the entire reporting period, EHR features that track functionality issues, such as drug interaction checks and clinical decision support.
- Understand that the security risk analysis must be specific to the EHR and the practice and is required every year.
- Direct all audit questions directly to Figliozzi and Co., the certified public accountant firm selected by CMS to conduct the audits, for faster response time.

https://questions.cms.gov/faq.php?faqId=7711
MEDICARE INCENTIVE PROGRAMS - Updates

- Physician Quality Reporting System
- Value-Based Payment Modifier Program
- EHR Meaningful Use
CMS proposes to create & publish composite scores for these group measures:

- Coronary Artery Disease
- Diabetes Mellitus (DM)
- General Surgery
- **Oncology**
- Preventive Care
- Rheumatoid Arthritis
- Total Knee Replacement (TKR)

CMS says that providing composite scores and benchmarks will give consumers the tools needed to most accurately interpret the quality data published on Physician Compare and to compare performance between providers.
2017 Value-Based Payment Modifier Program

- All Physicians
  - PQRS Reporters
    - Mandatory Quality Tiering
      - Solo Practitioners & Groups of 2-9 Eligible Providers
        - Upward or No Adjustment
      - Groups of 10 or more Eligible Providers
        - Upward, Downward or No Adjustment
  - Non PQRS Reporters
    - Solo Practitioners & Groups of 2-9 Eligible Providers
      - -2% Downward Adjustment
    - Groups of 10 or more Eligible Providers
      - -4% Downward Adjustment

2015 Medicare Physician Fee Schedule Final Rule
Medicare Quality Program
Maximum Penalties

<table>
<thead>
<tr>
<th>Quality Program</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Value-based payment modifier</td>
<td>Bonus maximum +1.0x*</td>
<td>Bonus maximum +2.0x*</td>
<td>Bonus maximum +4.0x*</td>
</tr>
<tr>
<td></td>
<td>Penalty maximum -1.0%</td>
<td>Penalty maximum -2.0%</td>
<td>Penalty maximum -4.0%</td>
</tr>
<tr>
<td>PQRS (No Incentive)</td>
<td>Penalty -1.5%</td>
<td>Penalty -2.0%</td>
<td>Penalty -2.0%</td>
</tr>
<tr>
<td>EHR MU (No Incentive)</td>
<td>Penalty maximum -1.0%</td>
<td>Penalty maximum -2.0%</td>
<td>Penalty maximum -3.0%</td>
</tr>
<tr>
<td>Total maximum possible payment penalty</td>
<td>-3.5%</td>
<td>-6.0%</td>
<td>-9.0%</td>
</tr>
</tbody>
</table>

2014 Oncology Specific Qualified Clinical Data Registries (QCDRs):

- American Society of Clinical Oncology  Quality Oncology Practice Initiative (QOPI®)
- Oncology Nursing Society Quality Improvement Registry in collaboration with CECity
- Oncology Quality Improvement Collaborative (The US Oncology Network, McKesson Specialty Health, Quality in Health Care Advisory Group, LLC (QHC Advisory Group), CECity)
Provider ratings are displayed using stars, which represent performance on a measure. The actual percentage score is also listed to the right of the star display.

“This is an important first step in publicly reporting quality measures on Physician Compare. Offering a strong set of meaningful quality measures on the site will ultimately help consumers make decisions and it will encourage quality improvement among the clinician community, who shares CMS's strong commitment to the best possible patient care.”

Patrick Conway, M.D., CMS’s Chief Medical Officer and Deputy Administrator for Innovation and Quality
ARNOLD K N YEE, MD
Primary Specialty: Medical Oncology
Additional Specialties: Hematology/Oncology, Internal Medicine

Quality Programs:
- Physician Quality Reporting System (PQRS)
- Electronic Prescribing (eRx) Incentive Program
- Electronic Health Records (EHR)

View information about Medicare quality reporting programs

Gender: Male
Education: Graduated: 1988
School: TUFTS UNIVERSITY SCHOOL OF MEDICINE

Group Affiliations: HAWAII HEMATOLOGY ONCOLOGY

Hospital Affiliations: PALI MOMI MEDICAL CENTER
THE QUEENS MEDICAL CENTER
WAHIAWA GENERAL HOSPITAL

Medicare Assignment: Accepts Medicare Assignment

* Please contact the Healthcare Professional to verify information.
WENATCHEE VALLEY MEDICAL CENTER

Specialty: Multiple

Quality Programs:
- PQRS Group Practice Reporting Option (GPRO)
- Electronic Prescribing (eRx) Incentive Program

Medicare Assignment:
- Accepts Medicare Assignment

Please contact the Group Practice to verify information.
Quality of Care for Patients with Diabetes

Some group practices do a better job than others at providing care that is known to get the best results for patients with diabetes. Medicare looked at a sample of patients in the group practice to help you compare how well group practices are providing the recommended care to their patients with diabetes and helping them to control their blood sugar, blood pressure, and cholesterol. Medicare used this information to give the group practice a score on each measure. The score is presented as stars and as a percent. (more information)

More stars are better.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Score</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlling blood sugar levels in patients with diabetes.</td>
<td>★★★★☆</td>
<td>61%</td>
</tr>
<tr>
<td>Controlling blood pressure in patients with diabetes.</td>
<td>★★★★☆</td>
<td>74%</td>
</tr>
<tr>
<td>Prescribing aspirin to patients with diabetes and heart disease.</td>
<td>★★★★★</td>
<td>93%</td>
</tr>
<tr>
<td>Patients with diabetes who do not use tobacco.</td>
<td>★★★★★</td>
<td>83%</td>
</tr>
</tbody>
</table>

Quality of Care for Patients with Heart Disease
THE QUEENS MEDICAL CENTER
1301 PUNCHBOWL ST
HONOLULU, HI 96813
(808) 538-9011
Add to my Favorites
Map and Directions

General information
- Hospital type 🔄: Acute Care Hospitals
- Provides emergency services 🔄: Yes
- Participates in 🔄: Cardiac Surgery Registry, Stroke Care Registry, Nursing Care Registry, General Surgery Registry
- Able to receive lab results electronically 🔄: Yes
- Able to track patients' lab results, tests, and referrals electronically between visits 🔄: Yes
- Uses a safe surgery checklist 🔄: Yes
Patients who reported that their doctors "Always" communicated well

Why is this important?

Hide Graph

<table>
<thead>
<tr>
<th>Hospital Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Queens Medical Center</td>
<td>78.0%</td>
</tr>
<tr>
<td>Hawaii (Average for all reporting hospitals)</td>
<td>82.0%</td>
</tr>
<tr>
<td>National (Average for all reporting hospitals)</td>
<td>82.0%</td>
</tr>
</tbody>
</table>

www.medicare.gov/hospitalcompare/profile
The CY 2015 OPPS proposed rule also would require hospitals to report a modifier for services furnished in an off-campus provider-based department on both hospital and physician claims.

This is intended as a means for CMS to begin collecting data on services furnished in off-campus provider-based departments, as discussed in the CY 2014 OPPS proposed rule.
Best Practices Review

Is NOW Available
On iPad
Download Your Copy Today!

www.Oplinc.com

Sponsored By

Lilly
Resources
E/M Resources

CMS E/M Documentation Resources

CMS Distribution of E/M Services by Specialty
www.cms.gov/medicarefeeforsvcpartsAB/04_medicareutilizationforpartb.asp
RESOURCES

CMS Modifier 59 Article:
RESOURCES
Health Care Reform

- Kaiser on Health Care Reform http://kff.org/health-reform/
- U.S. Small Business Administration/Health Care http://www.sba.gov/healthcare/