

FALL/WINTER EDITION 2016

Medicare

SAVE THE DATE: SOLVING THE THIRD-PARTY PAYER PUZZLE SEMINAR – WEDNESDAY, MAY 4, 2016 – SEE REGISTRATION INFORMATION INSIDE THIS ISSUE

CMS Announces Submission Timeframes for 2015 PQRS Data

The Centers for Medicare & Medicaid Services (CMS) recently released the timeframes for submitting 2015 Physician Quality Reporting System (PQRS) data. If physicians are not reporting through claims, GPRO Web Interface or EHR Direct, the American Medical Association recommends physicians reach out to their registry or electronic health record (EHR) vendor to coordinate submission.

Eligible professionals who do not satisfactorily report quality measure data to meet the 2015 PQRS requirements will be subject to a negative PQRS payment adjustment on all Medicare Part B Physician Fee Schedule (PFS) services rendered in 2017.

- EHR Direct or Data Submission Vendor (QRDA I or III): Jan. 1–Feb. 29
- Qualified Clinical Data Registries (QCDRs) (QRDA III): Jan. 1–Feb. 29
- Group Practice Reporting Option (GPRO) Web Interface: Jan. 18–March 11
- Qualified registries (Registry XML): Jan. 1–March 31
- QCDRs (QCDR XML): Jan. 1–March 31
- Claims: Due Feb. 28 (Last day that 2015 claims will be processed to be counted for PQRS reporting to determine the 2017 payment adjustment)

Submission ends at **8 p.m. Eastern time** on the end date listed. An Enterprise Identity Management (EIDM) account with the “submitter role” is required for these PQRS data submission methods. See the [EIDM System Toolkit](#) for additional information.

For questions, contact the QualityNet Help Desk at (866) 288-8912, or via email at Qnetsupport@hcqis.org.

Payment Adjustments & Hardship Information

Payment Adjustments

In the American Recovery and Reinvestment Act of 2009 (ARRA), Congress mandated that payment adjustments should be applied to Medicare eligible professionals (EPs), eligible hospitals (EHs) and critical

access hospitals (CAHs) that are not meaningful users of Certified Electronic Health Record (EHR) Technology under the Medicare EHR Incentive Program.

If a provider is eligible to participate in the Medicare EHR Incentive Program, they must demonstrate meaningful use in either the Medicare EHR Incentive Program or Medicaid EHR Incentive Program, to avoid a payment adjustment. Medicaid providers who are only eligible to participate in the Medicaid EHR Incentive Program are not subject to these payment adjustments.

Eligible Professional Reconsideration Form

[Instructions](#)

[Application \(Single EPs\)](#)

[Application \(Multiple EPs\)](#)

The deadline for EPs to submit Reconsideration forms for the 2016 payment adjustment, based on the 2014 EHR reporting period, is February 29, 2016. Only apply if you received a letter from Medicare indicating that you are subject to the 2016 payment adjustment. (For inquiries about the Reconsideration Application, please email pareconsideration@provider-resources.com.)

Hardship Information

Please review the applicable hardship tip sheet for more information on hardship categories. Some categories require the submission of a hardship exception application. If approved, the hardship exception is valid for 1 payment year only. A new application must be submitted if the hardship continues for the following payment year. In no case may a provider be granted an exception for more than 5 years.

Critical Access Hospital Hardship Exception Application

[Instructions \(CAH\)](#)

[Application \(CAH\)](#)

The deadline for CAHs to submit hardship applications for the 2015 payment adjustment, based on the 2015 EHR reporting period, is February 29, 2016. For more information see the [CAH tip sheet](#).

Eligible Hospital Hardship Exception Application

The deadline for EHs to submit hardship applications for the 2017 payment adjustment, based on the 2015 EHR reporting period, is July 1, 2016. For more information see the [EH tip sheet](#).

Eligible Professional Hardship Exception Application

The deadline for EPs to submit hardship applications for the 2017 payment adjustment, based on the 2015 EHR reporting period is July 1, 2016. For more information see the [EP tip sheet](#).

New Resources Available at myCGS

CGS has introduced a new web page, [myCGS Brochures/Resources](#). This page includes myCGS brochures, which focus on each of the functions available through myCGS, and the benefits physicians can experience as a myCGS user. In addition, this page includes Job Aids that provide detailed instructions to assist myCGS users with certain functions.

If you are not already registered to use myCGS, enrollment instructions are located in [Chapter 1 of the myCGS User Manual](#). The [myCGS User Manual](#) is also an excellent resource, with detailed information about accessing and obtaining information from the myCGS web portal.

ICD-10 Support

The Centers for Medicare & Medicaid Services (CMS) is prepared to solve problems that may come up when using the new ICD-10 code set. Because this is a major transition, CMS will be monitoring the transition in real time, watching their systems and addressing any issues that come into the ICD-10 Coordination Center.

CMS is also offering support for physicians and their staff in the following four ways:

1. If you need general ICD-10 information, CMS has many free resources at our [Road to 10](#) web page and on cms.gov/ICD10 that can help, such as the ICD-10 quick-start guide, customized ICD-10 action plans, videos, and Frequently Asked Questions.
2. Your first line for help for Medicare claims questions is to contact your Medicare Administrative Contractor (MAC). They'll offer their regular customer service support and respond quickly. The link to the Ohio MAC is <http://cgsmedicare.com/>
3. You can email the CMS [ICD-10 Coordination Center](#), and they will respond to your questions.
4. You can contact the [ICD-10 Ombudsman](#). This resource is intended to be an impartial advocate for providers, focused on understanding and resolving concerns.

CMS has been working to help physicians move to ICD-10 by offering resources and flexibility, but if you aren't ready for the transition, you still have [options](#) that will enable you to continue to provide care and be paid for your services. CMS recommends that you check with other payers to learn about their available claims submission alternatives.

MORE ICD-10 Information from the American Medical Association

The AMA has revised its [online ICD-10 information and resources](#). If physicians experience any problems with the processing of their claims or other administrative transactions, they should take the following steps.

- **Medicare**

The AMA has created an [ICD-10 complaint form](#) that is available on the AMA ICD-10 web page to report problems with Medicare claims.

Please note: Forms will be forwarded to the Centers for Medicare & Medicaid Services (CMS). The American Medical Association will not provide individual responses to each complaint.

Physicians can also contact their Medicare Administrative Contractor (MAC) or monitor their MAC's website for information on problems with ICD-10.

You may also contact CMS directly by emailing the ICD-10 ombudsman Dr. William Rodgers, whose contact email is ICD10_Ombudsman@cms.hhs.gov

- **Medicaid**

Check the state Medicaid website for information about ICD-10 implementation and a method of contact for issues.

- **Commercial Payers**

Check the payer’s website for information about ICD-10 implementation and a method of contact for issues.

- For UnitedHealthcare Group, physicians can use the following email address: ICD10questions@uhc.com
- For Humana, physicians can use the following email address: ICD10Inquiries@humana.com
- For Anthem, physicians should contact the Provider Service Call Center for the locality and line of business involved (telephone numbers can be found on Anthem.com).

- **Vendors**

Any issues with practice management systems, electronic health records, billing vendors or clearinghouses should be directed to the company.

Physicians should also contact their state or specialty medical society for advice on handling problems and to find out if other practices are experiencing similar issues.

Medicare Advance Payment

CMS has announced that MACs will issue advance payments in situations where the MAC is unable to process claims within established time limits because of administrative problems, such as contractor system malfunction or implementation problems. An advanced payment is a conditional partial payment and will require repayment.

To apply for an advance payment, the physician will be required to submit the request to their appropriate MAC. Should there be Medicare systems issues that interfere with claims processing, CMS and the MACs will post information on how to access advance payments. CMS does not have the authority to make advance payments in the case where a physician is unable to submit a valid claim for services rendered.

UPDATED CLARIFYING QUESTIONS AND ANSWERS FOR CMS ICD-10 FLEXIBILITIES

On September 22, CMS released an updated “[Clarifying Questions and Answers Related to the July 6, 2015 CMS/AMA Joint Announcement and Guidance Regarding ICD-10 Flexibilities](#).” Information added includes the naming of the CMS ICD-10 Ombudsman, Dr. William Rodgers (his contact email is ICD10_Ombudsman@cms.hhs.gov), and additional information about prior authorizations, Medicare Advantage plans, application to other provider types, Medicare advance payments, cross-over claims, and audits.

Checking Your Medicare FFS Claim Status

With the recent transition to ICD-10, you may wonder how soon you will know whether your Medicare fee-for-service (FFS) claim was paid. Generally speaking, Medicare FFS claims take several days to be processed and must also—by law—wait 2 weeks before payment is issued.

You can check your Medicare FFS claim status by:

1. **Interactive Voice Response (IVR):** IVR gives providers access to Medicare claims information through a toll-free telephone number. Visit your [Medicare Administrative Contractor \(MAC\)](#) website for information on the Provider Contact Center and IVR user guide.
2. **Customer Service Representative (CSR):** Visit your [MAC](#) website for information on the Provider Contact Center only if you are unable to access claims information via IVR.
3. **MAC portal:** Visit your [MAC](#) website for portal features and access.
4. **Direct Data Entry (DDE):** Providers that bill institutional claims are also permitted to submit claims electronically via DDE screens. Visit your [MAC](#) website for more information.

5. **ASC X12:** The ASC X12 Health Care Claim Status Request and Response (276/277) is a pair of electronic transactions you can use to request the status of claims (via the 276) and receive a response (via the 277). Visit your [MAC](#) website for more information.

Keep up to date on ICD-10. Visit the CMS [ICD-10 website](#) and [Roadto10.org](#) for the latest news and resources, including the [ICD-10 Quick Start Guide](#).

2015-2016 Influenza Resources for Healthcare Professionals

- Take advantage of each office visit as an opportunity to encourage your patients to protect themselves from the flu and serious complications by getting a flu shot.
- Continue to provide the flu shot as long as you have vaccine available, even after the new year.
- Remember to immunize yourself and your staff.

You can read more here: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1523.pdf>

The CGS Administrators Newsletter is Available for Review on the AMCNO Website

The August 2015 edition of the CGS Administrators J15 newsletter is posted to the AMCNO website for review. This newsletter is provided to the AMCNO by CGS on a regular basis. The newsletter contains a wealth of information from CGS for providers and their staff. To view the newsletter, go to http://www.amcno.org/pdf/NewsSet_Autumn2015b.pdf



*News from Other
Third-Party Payers*

Medicaid

Study Committee Recommends Graduate Medical Education Reforms

As a result of the budget enacted in June, a legislative study committee reviewed why the 30-year-old Medicaid funding formula for graduate medical education (GME) generates dramatically different results for hospitals that provide similar medical training. Some hospitals receive up to \$385,000 per resident or intern trained, while others receive nothing at all. The committee submitted a report in December that outlines a strategy to make the GME formula more fair and promote state health policy priorities, including recruiting and retaining more physicians into primary care and specialties with shortages. Ohio Medicaid will use the committee's report as its starting point when it initiates consideration of Medicaid GME reforms in 2016.

[Read the report](#)

First Medicaid Managed Care Report Cards are Released

The Ohio Department of Medicaid also released a new Medicaid Managed Care Consumer Report Card that rates Ohio's five contracted health plans on topics such as "getting care," "keeping kids healthy," and "doctors' communication and service." The goal is to provide greater transparency around Medicaid care and services,

encourage competition among the five health plans, and help Medicaid beneficiaries learn more about the managed care plans available to them.

[Read the Report Card](#)

Health Transformation Year in Review

After several years of intense work, the Ohio Office of Health Transformation is beginning to see significant signs of improvement. In 2015, Ohio's uninsured rate was cut in half, fewer infant deaths were reported than at any point in at least 75 years, and Ohio Medicaid led the nation in prosecuting fraud and transitioning individuals out of institutions. The Kasich Administration will leverage these gains to address the challenges that remain; for example, reduce the number of black infant deaths and continue the fight against drug abuse.

To view the 2015 Year in Review go to [2015 Health Transformation Year in Review](#)

Anthem

[Anthem December Network update](#)

UnitedHealthcare

[UnitedHealthcare January bulletin](#)

Medical Mutual

[Medical Mutual Mutual News/Providers](#)

Bureau of Workers' Compensation (BWC)

ICD-10

BWC asks providers to please send the most specific ICD-10 codes when filing FROIs and requests for additional allowances. BWC may contact you for clarification if the:

- Diagnosis is not clearly stated in the medical information,
- Diagnosis code you provided is on the list of ICD-10 codes that are not appropriate for claim allowances,
- Medical documentation conflicts with the diagnosis code(s) provided, and
- Existing claims are without associated ICD-10 codes.

When requesting treatment or providing care for a condition where the ICD-10 code is not yet associated in the claim, it is important to include the ICD-10 code that corresponds to the allowed existing narrative description you are treating. If you are not sure about the specific code(s), use your conversion resources, a professional coder or the new BWC resource lists on the Web to assist you. For questions about ICD-10, providers may email BWC provider relations.

For more information on ICD-10 from the Ohio Bureau of Worker's Compensation [click here](#).

Moving Ahead to Stage 3 Meaningful Use

By Cathy Costello, JD, Director of CliniSyncPLUS

Many providers have heard that new regulations were released in 2015 that define Meaningful Use (MU) from 2015 on. But few providers understand whether the regulations pertain to them. The important message is that ALL providers that bill the Centers for Medicare & Medicaid Services (CMS) for services are affected by the new regulations whether or not they are still eligible for MU incentive payments. MU has been incorporated into every new payment mechanism CMS has created. So how MU will change over the next few years is important for you to understand.

Meaningful Use in 2015 – 2017

A. Measures Removed from Attestation in 2015

The MU incentive program was significantly restructured starting with the 2015 reporting year. There are many measures that were successfully being attested to by physicians and hospitals in earlier years at a rate of over 90%, such as demographics, vital signs and smoking status. These measures are considered “topped out” and have been removed from MU attestation starting in 2015. *However, you should continue to track all the removed measures since they are necessary for the successful reporting of quality measures.* A complete list of all removed measures is listed below:

MU Measures Not Being Attested to Separately Starting in 2015

Meaningful Use EP/EH Measures Removed from Attestation	Additional EH Measures Removed from Attestation
Demographics	eMAR
Vital Signs	Advanced Directives
Smoking Status	Electronic Notes
Clinical Summaries	Imaging Results
Structured Lab Results	Family Health History
Patient Lists	Lab Results to Providers
Patient Reminders	
Summary of Care	

B. Measures Required for Attestation in 2015 - 2017

The remaining measures that will be tracked and attested for MU in 2015 – 2017 include measures that currently appear in Stage 1 and Stage 2. The measures have been pulled together into one short list; there are no longer “core” and “menu” measures. These new “blended” measures represent areas that CMS wants to continue to emphasize. These blended measures become the basis for Stage 3. All Eligible Professionals (EPs) and Eligible Hospitals (EHs) will attest to the same measures regardless of their Stage of MU. There are exclusions for providers that might have been at Stage 1 MU in 2015 if they had not been planning to attest to certain measures. By 2016, all providers will be responsible for meeting the same measures and the same threshold percent. *Although the reporting period for MU in 2015 is 90 days, by 2016 the reporting period returns to a full year reporting.* The measures that will be attested to are the following:

2015 – 2017 MU Measures for Attestation	
1	Protect Electronic Health Information
2	Clinical Decision Support (CDS)
3	Computerized Electronic Order Entry (CPOE)
4	Electronic Prescribing (eRx)
5	Health Information Exchange (HIE)
6	Patient-Specific Education
7	Medication Reconciliation
8	Patient Electronic Access (Patient Portal)
9	EP Secure Messaging
10	Public Health Reporting (PH Reporting)

Stage 3 Meaningful Use Beginning Either 2017 or 2018

The option is yours which year you want to begin attesting to Stage 3 MU: 2017 or 2018. CMS has built some incentives into the 2017 Stage 3 reporting, though, by lowering some of the reporting thresholds and shortening the reporting period. By 2018, however, all providers will have to attest using Stage 3 and will be required to have the Stage 3 upgrade to their EHR systems, called 2015 edition CEHRT (i.e., 2015 ed.). There are several advantages to beginning Stage 3 in 2017. If you attest to the blended Stage 2 measures in 2017 (the same ones used in 2016), your reporting period is 365 days. If you move to Stage 3 in 2017, your reporting period is reduced to 90 days. Also, by beginning Stage 3 in 2017, there are lower thresholds for some of the measures. If you wait until 2018 to begin Stage 3, you will be required to meet the higher thresholds for all measures. Below is the comparison between beginning Stage 3 in 2017 or 2018:

Selecting a Year to Begin Reporting Stage 3

#	Measure or Attestation Information	2017	2018
	Reporting Period	90 days	1 year
	Certification criteria for CEHRT	Any combination of 2014, 2015 Edition CEHRT	2015 Edition CEHRT
1	Protect Electronic Health Information	Conduct security review in calendar reporting year prior to attestation	Conduct security review in calendar reporting year
2	Electronic Prescribing (eRx)	>60%	>60%
3	Clinical Decision Support	5 related to 4 CQMs	5 related to 4 CQMs
4	Computerized Provider Order Entry (CPOE)	Med orders: >60% Lab orders: >60% Imaging orders: >60%	Med orders: >60% Lab orders: >60% Imaging orders: >60%
5	Patient Electronic Access	<u>Must meet both measures</u> Patient Access: >80% unique patients to portal & API Patient Education: >35% unique pts.	<u>Must meet both measures</u> Patient Access: >80% unique patients to portal & API Patient Education: >35% unique pts.
6	Coordination of Care through Patient Engagement	<u>Must meet 2 out of 3 measures</u> 1) Patient portal VDT/API: 5% 2) Secure message sent: 5% 3) Health data incorporated: 5%	<u>Must meet 2 out of 3 measures</u> 1) Patient portal VDT/API: 10% 2) Secure message sent: 25% 3) Health data incorporated: 5%
7	Health Information Exchange	<u>Must meet 2 out of 3 measures</u> 1) Electronic summary of care sent: 50% 2) Incorporation of summary of care into record: 40%	<u>Must meet 2 out of 3 measures</u> 1) Electronic summary of care sent: 50% 2) Incorporation of summary of care into record: 40% 3) Perform clinical information

		3) Perform clinical information reconciliation for meds, med allergies and current problems for new patients: 80%	reconciliation for meds, med allergies and current problems for new patients: 80%
8	Public Health & Clinical Data Registry Reporting	<u>Clinical Data Registry reporting and Case reporting options added to current options for both EPs and EHs</u> EPs: 2 (syndromic no longer available except for urgent care) EHs: 4	<u>Clinical Data Registry reporting and Case reporting options added to current options for both EPs and EHs</u> EPs: 2 (syndromic no longer available except for urgent care) EHs: 4
	CQM Reporting	2016 Annual Update; attestation or eCQM reporting; 365 day reporting period	2017 Annual Update; eCQM reporting; 365 day reporting period

Deciding When to Begin Stage 3: Working with Your Vendor

When trying to decide which year will be best to begin Stage 3, you will have to talk to your vendor. The timing of your EHR's system's upgrade to Stage 3 will determine whether you can meet Stage 3 in 2017. It will be easier to meet Stage 3 in 2017, so make sure you get on your vendor's implementation list early in 2017 for the upgrade. The earlier you can receive the 2015 ed. CEHRT version for your system, the sooner you can begin establishing the new workflows you will need to meet Stage 3. If you decide to wait until 2018 to begin Stage 3, you will still need to have the 2015 ed. upgrade installed before the end of 2017 to allow for a full year of reporting in 2018. Some of the new Stage 3 measures require additional functionality, so the vendor will have to tell you how it is planning to meet that measure. Plan on talking to your vendor about the API ("Application Programming Interface") that your EHR system will need to have as an option to the patient portal. If you want, you can still use the portal to post patient information. Your vendor, though, will have to offer to the patient a method called the API to access that information through a smart phone or other means that can combine information from different portals and different providers. Either the portal or the API or both can be used by your practice to meet the "Patient Electronic Access" measure.

Changes in Workflow Required to Meet New Stage 3 Measures

Some of the Stage 3 measures will be the same ones you are attesting to now, just with higher thresholds (e-prescribing—with or without controlled substances prescriptions—your choice, CPOE, patient education, patient portal). Some are the same (security review and clinical decision support). There are several, though, that are totally new. These are ones you will have to work with your staff members to determine how to best meet the measures. Stage 3 is also the first time that CMS has created options as to which MU measures you want to attest to, so you will need to sit down and decide as a group what your target measures will be.

A. "Coordination of Care through Patient Engagement"

This new measure has 3 parts: 1) View/Download/ Transmit for patient portal or API; 2) Secure messaging to patients from the practice; and 3) Incorporating clinical data from non-EP or non-EH sources into the patient's record. You will need to meet 2 out of 3 of the parts to meet MU for Stage 3. This measure replaces the old View/Download/Transmit measure for the patient portal and the secure messaging measure from Stage 2. If you begin Stage 3 in 2017, you will need to have 5% of your patients viewing their records in the patient portal (**Part 1**). If you begin in 2018, then the number of patients viewing rises to 10%. For secure messaging (**Part 2**), rather than asking your patients to email you, your practice will be tracked for emailing the patient. You will need to send to 25% of your patients that are seen an email related to their clinical care (not billing or a reminder of a scheduled appointment). There is also a new part to the measure that says a provider needs to add information from a non-EP or non-EH source to the patient's clinical record for 5% of the patients seen (**Part 3**). Items that you might add to the record would include such things as physical therapy notes, home

healthcare notes, behavioral health reports, reports gathered through a wearable monitoring device (such as a cardiac monitor), or information from a home health or fitness device.

B. Health Information Exchange

The health information exchange measure expands the Stage 2 measures for transitions of care and medication reconciliation. There are 3 parts and you will need to meet the threshold for 2 of them: 1) provide an electronic summary of care record for patient's being referred to another provider (**Part 1**); 2) retrieve a summary of care record from the HIE or a DIRECT email exchange for new patients (**Part 2**); and 3) incorporate the summary of care document into the patient's record including performing a "clinical information reconciliation" on information being added to the record (**Part 3**). This measure is designed to make sure that for new patients any information that is available on the patient from previously treating providers is reviewed and, if important, added to the record. The measure is summarized in this chart:



Health Information Exchange Measures (Must meet 2 out of 3):

- 1) Patients being referred elsewhere for care: Summary of care record sent for **50% of cases** (exclusion for < 100 referrals in reporting period).
- 2) New patients seen: Summary of care records sought through DIRECT email from another provider or from the HIE for **40% of new patients**.
- 3) New patients seen: Information received on meds, med allergies and problem list are reconciled for **80% of new patients**.

C. Public Health/Clinical Data Registry Reporting

Public health reporting changes in different ways with Stage 3. EPs will need to report on 2 public health/clinical data registry measures while EAs will increase to report on 4 measures. In 2015 and 2016 these measures have focused on reporting to public health agencies, such as the Ohio Department of Health (ODH) for immunization reporting, syndromic surveillance reporting or cancer registry reporting for EPs. Whenever you choose to start Stage 3 (either 2017 or 2018), your reporting options will change. You will no longer have the option to do syndromic surveillance reporting unless you work in an urgent care or emergency department. Immunization and cancer registry reporting options will remain for EPs. For Stage 3, EPs will also be allowed to count reporting to private clinical data registries to meet this measure, such as specialty registries for cardiology reporting, orthopedic reporting or surgical reporting run by the specialty societies. CMS will publish every year a directory of registries that are ready to receive registrations and can meet the technical requirements for the data transmission for that year. If a registry does not give at least 6 months' notice of its readiness to accept data, it will not be included in the directory for that year. EPs can also report to case registries but these standards are still being developed.

Steps to Take to Prepare for Stage 3

You need to plan to be successful for Stage 3. Many of the measures for Stage 3 represent best practices that you are already using. You and your staff should understand how to capture those practices in a way that will meet the MU requirements. Talk to your vendor, talk to the staff at the CliniSync HIE, talk to the data

registries, but most importantly, talk to your practice and the other practices you refer to. With a little bit of planning, you will be able to glide into Stage 3 with very little effort.

Centers for Medicare & Medicaid Services Convenes Region V Medical Society Meeting

In September, staff from the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) participated in the Centers for Medicare & Medicaid Services (CMS) Region V State Medical Society quarterly meeting. Also attending this meeting were representatives from state medical associations representing Ohio, Michigan, Indiana, and Illinois. Some of the topics covered were the ICD-10 roll out, two-midnight rule, and Medicare Access and CHIP Reauthorization Act (MACRA).

CMS representatives discussed the roll out of ICD-10-CM, stating that ICD-10 should be used by all providers in every healthcare setting and claims for dates of service on or after October 1, 2015, must be coded in ICD-10. No claim can contain both ICD-9 and ICD-10 codes. CMS has provided guidance on how to handle claims that span the October 1 transition date. CMS has also established an ombudsman department to address problems and issues with the new coding set. They have a full office dedicated to questions and these queries will be tracked and followed until completion. They are also working on other resources that will be made available soon. It is important to remember that Medicare claims take a couple of days to process, and it may take a couple of weeks before they are paid. If physicians want to check the status of a claim they can go to their MAC portal.

CMS presenters also encouraged the medical society representatives in attendance to have their members go to the Road to ICD-10 website for more information. This website was developed by CMS with the help and input from practicing physicians. The website was developed because physicians asked for a “one-stop shop” to get their questions answered. The website includes provider-inspired fact sheets, the top 25 codes by specialty, information on how to contact the new CMS ombudsman department, quick start guides and other information. The website is <https://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html>.

CMS representatives discussed the two-midnight rule, noting that the rule includes the need to have documentation to justify the stay. In addition, the benchmark applies to the admitting practitioner, and the benchmark is when a physician orders an inpatient admission if the patient is *expected* to need hospital care (outpatient and inpatient) for at least two midnights. The presumption applies to the medical reviewer. Inpatient stays longer than the two midnights will be presumed medically necessary, absent evidence of gaming or fraud and abuse. Special circumstances include patient death, transfer or left against medical advice. CMS has heard from both the hospital and physician community that on many instances CMS removed physician judgment in these circumstances; therefore, in the proposed rule, they are providing more of a role for physician judgment. Further changes to the rule have been proposed for 2016, such as stays expected to last less than two midnights: exception based on the judgment of the physician rather than national guidance, and still rare and unusual for an inpatient admission for a minor surgical procedure or treatment expected in the hospital for only a few hours and not overnight. For stays expected to last more than or equal to two midnights: no change. Medical review: The first review will be done by the quality improvement organization, and there will be a referral to the recovery audit contractors where there is repeated non-compliance with the rule. Comments are being sent in on the proposed rule and the final rule will be out by November 2015.

The presentation regarding MACRA covered an overview of the new law. There will be a lot of rules and information developed in the next couple of years to implement the law. As previously reported in the AMCNO's *Northern Ohio Physician*, MACRA repealed the 1997 Sustainable Growth Rate Physician Fee Schedule (PFS) update and will change the Medicaid PFS payments to a merit-based incentive payment system (MIPS), with incentives to participate in an alternate payment model (APM). This is under comment through a request for information through November 2015. MIPS and APMs will drive payment from 2019 onward.

Separate application of payment adjustments under PQRS, value modifiers and electronic health records/meaningful use will sunset as of 12/31/2018. Beginning January 2019, MIPS and APM payments will begin, and eligible providers (EPs) can participate in MIPS or meet requirements to be a qualifying APM participant. MIPS participants can receive positive, negative or zero payment adjustment, and if criteria are met, APM participants can receive 5% incentive payments for 6 years. CMS will propose the initial policies for the MIPS in CY2017 PFS Rule Making, with the proposed rule to be published in June 2016. As part of MIPS, CMS must make available timely confidential feedback reports to each MIPS-eligible provider by July 1, 2017. Information about the performance of MIPS EPs must also be made available on the Physician Compare website.

APM model incentive payments will begin in 2019 and for 6 years there will be a 5% incentive payment for EPs or groups of EPs who participate in certain types of APMs and meet specified payment thresholds. Payments will be made in a lump sum on an annual basis, and EPs or groups of EPs who meet the criteria to receive APM incentive payments are excluded from the MIPS requirements.

There was a lot of information contained in the MACRA law and even the CMS representatives noted that patients and providers alike will need assistance in order to implement the law. An item contained in MACRA that will impact Medicare beneficiaries is that the new Medicare cards will not display Social Security numbers (SSNs). For more than a decade the Department of Health and Human Services has recommended taking the SSNs off of Medicare cards to reduce the potential for identify theft, and MACRA includes funding and instructions for HHS to consult with the Social Security Administration to establish cost-effective procedures to modernize Medicare cards.

There will be more information on MIPS and APMs and the entire MACRA law from CMS in the coming months. The information will be available through the CMS website, the Medicare Learning Network and other resources. CMS representatives will also make materials available to the medical societies, including the AMCNO, for dissemination to our members.

ICD-10 Has Arrived...Now What?

By Tamiya Williams, CMPE, Senior Manager, Medic Management Group, LLC

The long-awaited transition from ICD-9 to ICD-10 finally took place October 1, 2015, and you may be wondering as a provider or administrator what you should now be doing in your practice. In the months leading up to the transition date you were probably informed to do the following: Crosswalk your top 25-50 diagnosis codes, take steps to improve clinical documentation, make sure revenue cycle staff has adequate training, make sure you have enough cash on hand to cover expenses, and, most importantly, make sure that your billing software and clearinghouse are ICD-10 ready. If you have taken the time to do all of those things, you probably consider your practice to be in pretty good shape, and you probably are. With all those things being said, however, there is still more work to be done.

There is probably a sense of relief among providers, clinical support staff and revenue cycle staff everywhere, but we are still in the land of the unknown. We should all keep focused on the following:

- Am I doing everything in my power to help cash flow?
- Is my documentation and coding to the highest specificity possible?
- Will I understand and know how to process the various denial reasons?
- Is there a delay in the processing of claims?
- Should I be conducting ongoing chart audits?

Surviving the last quarter of 2015 may not be an easy task for some practices as it pertains to cash flow. It is important that the patient registration process is ironclad. Obtaining complete and accurate demographic information, along with complete and accurate insurance information, is important. It is very beneficial for a practice to verify insurance prior to the patient's appointment time so the front desk staff can be prepared to collect copays, deductible amounts and any outstanding balances owed. It will also be beneficial for practices to avoid huge cash expenditures during the last quarter of 2015 to help maintain cash flow.

Before claims are sent out the door it is a good idea to have a coder take a second look to see if there is any missing documentation and the claim is coded using the highest specificity. CMS announced that claims will not be denied for level of specificity for 12 months after the ICD-10 transition date, but that does not mean other payers won't. Coders and providers should have open lines of communication during this time so that there is not a delay in the billing process. It may also be advantageous for a practice to nominate a "Physician Champion" for ICD-10 for peer-to-peer education.

Denial management is another key component that practices should pay attention to. It is important to do thorough research when a claim is denied for ICD-10. If the denial reason is not clear, it is imperative that someone from your billing department calls the payer to get clarification on what is needed in order to correct the claim. Denials can be used to train physicians and clinical support staff on documentation and coding requirements. It also important to look at the big picture when it comes to denials to see if trends and root causes can be identified. All denials should be addressed immediately to prevent future denials that can and will impact cash flow.

Accounts Receivable management should also be a focus point for your practice's billing department. Once claims submission has taken place, it is important to confirm that the number of claims you submitted were accepted by the clearinghouse and the payer. If a claim falls out and does not go through the submission process successfully, it should be due to a claims edit that was created and should be reviewed immediately. Claim acceptance can be verified by using the EDI report (Claim Status), which can be obtained from your clearinghouse. Ohio has a prompt-pay law, meaning you should know if a claim is being denied or paid within 15-30 days. Best practice is for the A/R team to start calling on claims between 20-30 days. This practice will also serve as a double check to confirm that the payer has the claim on file, which, in turn, will help the practice avoid timely filing denials.

It is also important for practices to perform ongoing chart audits to ensure that all billing providers are using the correct ICD-10 codes. All chart audits should be performed by a Certified Professional Coder that has had ICD-10 training. Feedback and education should always be a part of the audit process. Documentation of the audit findings and provider education should be kept on file for reference in the future.

The world of health care is ever-changing, or I should say the requirements placed on providers by CMS and the government are ever-changing. With all of the new healthcare requirements and guidelines, it is imperative that physicians and support staff form a partnership with one goal in mind—to provide the best patient care possible while meeting CMS requirements. ICD-10 requires a more collaborative effort with patients due to the level of detail that we need to obtain from them. At the beginning this will require patient education on why this type of detailed information is needed. The one thing that will never change is that this world will always need physicians to facilitate and guide patients through their medical journey and on to a healthier life. Welcome to the world of ICD-10.

Ohio Department of Insurance Requires Health Insurers to Update Directories on a Regular Basis

Beginning in January 2016, health insurance plans must comply with new requirements to ensure network information is accessible.

Beginning in 2016, Ohio's health insurance companies must meet new expectations regarding their provider directories. The Ohio Department of Insurance will now require health insurers to update their directories of healthcare providers at least every 3 months.

Another provision of this rule mandates that insurance companies must update their directory to reflect the change within 15 days of a doctor or other provider leaving their network, and they must also notify any of their customers who have received care from that provider in the previous year of the change as well.

As of right now, there are no official fines or penalties for violations of the new rule; however, if the directories are not kept current, insurers will not be permitted to pass on additional costs of an out-of-network provider if the provider is listed in their directory as "in-network."

The insurance directory must also show whether providers are accepting new patients, and it has to include locations where a doctor or provider's care would be considered in-network. The directory also has to include a statement about how an in-network hospital might employ out-of-network providers and specialists, such as anesthesiologists, radiologists and laboratories.

To view the ODI rule, [click here](#).

Board of Pharmacy Announces New Website

The State of Ohio Board of Pharmacy has launched a redesigned website for the state's prescription monitoring program, known as the Ohio Automated Rx Reporting System (OARRS). A **fresh design, new features and improved navigation** offers visitors a better user experience. The [website](#) is more user-friendly, with content that helps OARRS account holders maximize the information contained in the system.

This new content includes an updated **frequently-asked-questions section, guidance documents and three new training videos** that take users through the process of registering for an account, running a patient report and reviewing the information contained within an OARRS report. Additionally, the site contains a **new statistics feature** that allows anyone to create custom county reports and view maps based on aggregate data collected in OARRS.

Established in 2006, OARRS is the only statewide database that collects information on all prescriptions for controlled substances that are dispensed by pharmacies and personally furnished by licensed prescribers in Ohio. **OARRS data is available to prescribers when they treat patients, pharmacists when presented with prescriptions from patients and law enforcement officers only during active investigations.**

Governor Kasich Announces Integration of OARRS into EMRs

Recently, Gov. John Kasich announced an investment of up to \$1.5 million a year to integrate the Ohio Automated Rx Reporting System (OARRS) directly into electronic medical records and pharmacy dispensing systems across the state, allowing instant access for prescribers and pharmacists.

Use the following resources to learn more about this important initiative to address prescription drug abuse in Ohio:

- [Frequently Asked Questions - OARRS Integration](#)
- [Integration Request Form](#)

- [OARRS Integration Fact Sheet](#)

If you have any additional questions regarding OARRS integration, please email the Pharmacy Board at info@pharmacy.ohio.gov.

SMBO Develops List of “Red Flag” Signs of Prescription Drug Abuse

The State Medical Board of Ohio has developed a list of “**Red Flag**” signs of prescription drug abuse as a reference tool for prescribers. View this “[Red Flag Signs of Prescription Drug Abuse](#)” link to find out how you can often identify signs of potential drug-seeking behavior. The Medical Board encourages you to share this information with your staff and post it in your office. The document is also available in the “News” section of the Board’s website, which you can access at www.med.ohio.gov.

Discounted Classes at Tri-C for AMCNO Members

AMCNO Discounted Tri-C Classes for the Center for Health Industry

Do you or your staff need information on the upcoming changeover to ICD-10? Does your staff need to learn more about the essentials of electronic health records?

AMCNO members and their staff can receive discounted rates on classes at Tri-C covering these topics and much more.

For the 2016 winter curriculum, [click here](#).

To take advantage of the member fee listed, you must obtain a member course number from the AMCNO. *Please contact the AMCNO at 216-520-1000 for exclusive AMCNO member course numbers to register and obtain a discounted price. Or email Abby Bell for more information at abell@amcno.org.*

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO)

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