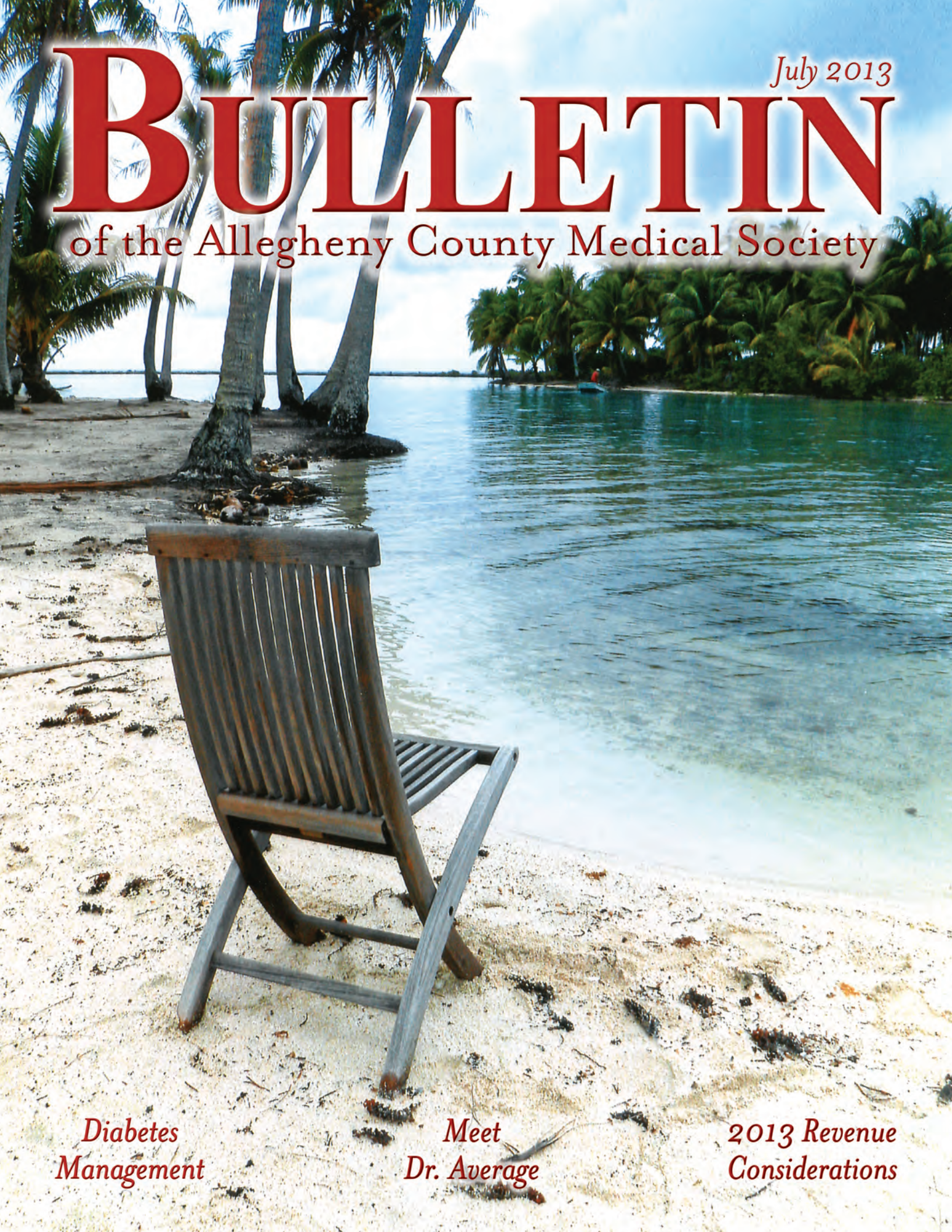

July 2013

# BULLETIN

## of the Allegheny County Medical Society

*Diabetes Management*

*Meet Dr. Average*

*2013 Revenue Considerations*

# Sequestration and Other 2013 Revenue Considerations

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At the onset of each new calendar year, we who focus on managing physicians' revenue cycle usually begin by identifying all anticipated changes—in International Classification of Diseases (ICD), Current Procedural Terminology (CPT) and/or reimbursement—then analyze the anticipated effect upon cash flow to the practice. These estimates equip practices with the data they need to shape their hiring, purchasing and investing decisions for the upcoming year.

Analyses for 2013 have been especially interesting because of three such changes, one adverse and two that are helpful, which we have found to have significant financial impact on the practices that we support:

1. Congress' mandatory 2 percent Centers for Medicare and Medicaid Services (CMS) payment reduction under sequestration;
2. The Pennsylvania Medical Assistance program fee increase for select primary care services;
3. Two new categories of Evaluation & Management CPT codes for:
   a. complex chronic care coordination services; and
   b. transitional care management services.

**The 2 percent sequestration adjustment—bad news**

In a *Provider Bulletin* issued on March 11, 2013, CMS announced this payment reduction to be effective with date-of-service or date-of-discharge April 1, 2013 (*not date-of-claim*).

From a cash flow perspective, the simplistic approach was to forecast 2013 Medicare revenue by reducing the 2012 payments by 2 percent. We quickly came to realize that the operational impact has been and continues to be more complex.

Although CMS published *Sequestration News & Updates* via the Novitas website, it was not until we processed our first ERA (Electronic Remittance Advice) at the end of April that we fully understood exactly how the reduction was calculated. And, we needed to re-program our information system software to appropriately capture the amount of the sequestration reduction for each claim.

We recommend posting the sequestration adjustment separately so that each practice and physician has an accurate understanding of and accounting for the exact impact on cash flow. Hopefully by now all practices have discovered and

| Count | Insurance Plan Name | Announced Sequestration Details | Effective as of DOS | Re-processing Claims Retrospectively | Adjustment Code on EOB |
|---|---|---|---|---|---|
| 1 | CMS Novitas | 03.11.13 | 04.01.13 | n/a | 223 |
| 2 | United HC MCR Adv | 05.04.13 | 04.01.13 | Y | Unknown |
| 3 | Aetna | 05.10.13 | 04.01.13 | Unknown | ?? |
| 4 | Gateway MCR Assured | 05.30.13 | 05.01.13 | Y | Unknown |
| 5 | UPMC for Life | 05.17.13 | 07.01.13 | n/a | 1M |
| 6 | Highmark MCR Blues | | | | |
| 7 | Bravo | | | | |
| 8 | CIGNA | | | | |
| 9 | Advantra | | | | |
| 10 | Humana | | | | |

implemented the operational workflow that will accurately report this reduction.

The complexity continues, however, because the Medicare advantage plans are rolling out their sequestration programs differently from CMS. For example, Gateway Medicare Assured and UPMC Health Plan Medicare Advantage are using effective dates later than April 1. Gateway Medicare Assured announced this on April 30, and therefore will be taking back monies for April claims that were paid between April 1 and April 30.

Such anomalies will make it difficult for some practices to audit reimbursements to ensure that claims are appropriately paid. Not only is the practice bearing the 2 percent reduction, but it is also bearing the additional cost of billing personnel needed to perform such audits, appealing claims that may be paid incorrectly or posting offsets.

As of this writing, of the ten most frequently billed Medicare advantage plans here in the Pittsburgh area, we still await written explanation from five companies about how they are handling sequestration. The table above illustrates our current understanding of the sequestration implementation by insurance companies. Blank fields represent that no information has been released by the plan.

Don't be surprised that, if you call any of the payers about sequestration, the customer service representatives are confused by your query. It appears that thorough training is not complete.

**Medical assistance fee increase—good news [for internal/family medicine & pediatrics]**

On January 22, 2013, Medical Assistance (MA) informed all enrolled physicians (Physician Type 31) of the requirements to qualify for increased MA reimbursement for primary care services, effective with date-of-service January 1, 2013, through December 31, 2014.

The MA reimbursement is to be no less than the Medicare rate for E&M codes 99201 through 99499, and for vaccine administration codes 90460, 90461, 90471, 90472, 90473 and 90474.

*MA Bulletin* 31-13-11 goes on to explain that physicians in only three specialties qualify for the increased fees. The physician must attest to his/her board certification OR attest that at least 60 percent of his/her billings rendered to MA beneficiaries are for the CPT codes listed above. The attestation is performed via MA's PCP Attestation Form and may be uploaded via ePEAP, e-mailed, faxed or mailed.

Hopefully qualified practices/physicians jumped onto this wagon by the end of January, but if for some

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| CPT Code | MA Only non-PCP | MA Only Spec 322 | $ Increase | % Increase | Medicare 1st MA 2nd | $ Increase | % Increase |
|---|---|---|---|---|---|---|---|
| 99201 | $20.00 | $44.45 | $24.45 | 122% | $41.78 | $21.78 | 109% |
| 99202 | 35.33 | 75.76 | 40.43 | 114% | 71.28 | 35.95 | 102% |
| 99203 | 54.25 | 110.16 | 55.91 | 103% | 103.98 | 49.73 | 92% |
| 99204 | 90.37 | 168.95 | 78.58 | 87% | 159.18 | 68.81 | 76% |
| 99205 | 117.54 | 209.35 | 91.81 | 78% | 197.38 | 79.84 | 68% |
| 99211 | 20.00 | 20.50 | 0.50 | 3% | 19.24 | (0.76) | -4% |
| 99212 | 26.00 | 44.45 | 18.45 | 71% | 41.78 | 15.78 | 61% |
| 99213 | 35.00 | 73.85 | 38.85 | 111% | 69.85 | 34.85 | 100% |
| 99214 | 54.42 | 108.67 | 54.25 | 100% | 102.69 | 48.27 | 89% |
| 99215 | 78.05 | 146.10 | 68.05 | 87% | 137.71 | 59.66 | 76% |
| 99304 | 43.75 | 94.68 | 50.93 | 116% | 89.41 | 45.66 | 104% |
| 99305 | 56.15 | 134.51 | 78.36 | 140% | 127.05 | 70.90 | 126% |
| 99306 | 69.92 | 169.76 | 99.84 | 143% | 160.74 | 90.82 | 130% |
| 99307 | 23.29 | 44.78 | 21.49 | 92% | 42.30 | 19.01 | 82% |
| 99308 | 36.65 | 69.63 | 32.98 | 90% | 65.75 | 29.10 | 79% |
| 99309 | 51.27 | 91.29 | 40.02 | 78% | 86.23 | 34.96 | 68% |
| 99310 | 60.31 | 136.00 | 75.69 | 126% | 128.79 | 68.48 | 114% |

reason that did not happen by April 1 (to obtain the increase retroactive to date-of-service January 1), attestation forms submitted after April 2 will qualify for the increased rates beginning with the date of form receipt by MA's Provider Enrollment Unit.

As you can imagine, it is taking several weeks for MA to process the attestation forms. To avoid the need to audit for appropriate payments retrospectively, a physician may want to hold claims until approval is received, but be careful to adhere to MA's 180-day timely filing rule.

An interesting nuance of this program is that MA beneficiaries covered under service program codes HCB03 and HCB05 do not qualify for the increased fee.

For physicians who serve a large MA-covered patient population, the increased revenue can be significant, as evidenced in the above table for 17 commonly used E&M codes for internal medicine.

By now you are probably wondering: Are the MA+Choice Organizations (MCOs) required to adhere to the MA fee increases? Yes, they are! PA DPW had requested plans from all MCOs by April 17. The CMS regulation requires that DPW first approve the MCO's plans, and then CMS has to approve each state's plan to ensure compliance with the regulation. As of this writing, we have been unable to obtain definite information from the area's most prevalent MCOs (Gateway Health Plan, United HealthCare Community Plan or UPMC for You).

It is recommended that physicians identify the claims for which they expect additional MCO reimbursement; thereby, after the MCOs administer the increase, one can assure that all claims are paid the appropriate additional monies.

Although additional attention will need to be paid to MA claims to ensure that the higher reimbursement is obtained, such substantial fee increases certainly justify devoting energy to developing a strategy for doing so.

**New categories of evaluation & management CPT codes—good news (maybe)**

It is noteworthy that CPT has finally made available specific codes to report patient-centered management support provided for coordinating support to those living at home or in a domiciliary, rest home or assisted living facility:

- Complex Chronic Care Coordination (CCCC) Services: 99487, 99788, 99489.

And, for only one face-to-face visit, followed by

| 2013 FEE SCHEDULE: Transitional and Coordination of Care Reimbursement | | | | | | |
|---|---|---|---|---|---|---|
| | CPT Code | Description | Work RVUs 2013[1] | KHPW DOS 1.14.13[2] | Medicare 2013[3] | UPMC 2013[4] |
| | 99487 | CCCC first hour clinical staff time no face-to-face per mo. | 1.00 | 80.33 | Not Listed | |
| | 99488 | CCCC first hour clinical staff time with one face-to-face per mo. | 2.50 | 180.41 | Not Listed | |
| + | 99489 | CCCC ea add 30 min. | 0.50 | 40.16 | Not Listed | |
| | 99495 | Transitional care management mod complexity | 2.11 | 160.65 | 156.97 | 145.98 |
| | 99496 | Transitional care management high complexity | 3.05 | 226.95 | 221.69 | 206.17 |

[1]Work RVUs obtained from CMS Website effective date 1.1.13. CCCC codes proposed RVUs obtained from AMA website.
[2]Obtained from Navinet. New codes for 2013 DOS 1.14.13 used because differs from DOS 1.1.13.
[3]Obtained from Novitas Solutions Website, 2013 Effective Date 1.1.13.
[4] Per E-mail UPMC no changes to 2012 fee schedule. New CPT codes paying 93% of Medicare.

non-face-to-face interactions with other caregivers to transition a patient from a facility to the patient's community setting:

- Transitional Care Management (TCM) Services: 99495, 99596.

It is equally noteworthy that CMS currently will not pay for CCCC Services.

Because CCCC and TCM can be billed only once per calendar month, the documentation and reporting requirements must be managed quite differently from what most physicians are accustomed to.

To date, this writer knows of no physician who has implemented the use of these five codes.

If your practice performs CCCC services (for non-Medicare patients), and TCM services for all patients, see the approved amounts for three (3) local Payers in the above table.

It may be worth developing an effective way to take advantage of these new billing opportunities.

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