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ICD-10 Grace Period Ends

It has been a year since the implementation of the new diagnostic coding system known as ICD-10. CMS provided for a one year period during which the use of codes that did not meet the highest level of specificity were allowed on claims without the risk of audit or other punitive action. This grace period was intended to allow time to adapt to the new coding system. Now the grace period has ended and effective October 1, 2016, CMS expects that all providers will code to the highest level of specificity and include the necessary supporting documentation. It is likely that commercial payors will follow Medicare's guidance.

It is important to note that there may be instances in which it is appropriate to utilize unspecified codes. For example, when there is insufficient clinical information about a health condition, a provider may use a code that is not fully specific. Once the diagnostic test result or other additional information is available to make a definitive diagnosis, then the more specific code would be appropriate.

CMS Offers MIPS Flexibility for 2017

CMS has indicated that it plans to allow flexibility to providers who will participate in the MIPS program scheduled to begin next year. CMS Acting Director Andy Slavitt published a blog after the release of the proposed rule that establishes the Merit-Based Incentive Program under the MACRA legislation. Slavitt proposed that there would be four compliance options available to providers in 2017.

The first option would be to allow providers to avoid a 2019 negative payment adjustment as long as they were able to submit some data to the quality payment program in 2017. Under the second option, providers would be permitted to submit data to the program for part of the calendar year rather than the full year. Under this option providers may still be able to qualify for a small bonus payment in 2019. The third option would be for those providers who believe that they are ready to participate fully in the MIPS program to submit the required data in 2017 and then accept the 2019 adjustment depending on their performance relative to their peers. The final option would be for those providers who could comply with MACRA and not have to submit MIPS data by participating in an advanced alternative payment model such as a Track 2 or 3 Medicare Shared Savings Program. Under this option, assuming that the providers see sufficient numbers of Medicare beneficiaries or receives enough Medicare payments via the APM, they would be eligible for a 5% incentive payment in 2019.

If you have questions , please contact your consultant or you can reach Bryan Burke at bburke@hci-ebs.com or 1-800-572-5275.

99214 Claims on the Rise

The Medicare utilization statistics for 2015 have been released. For Part B claims the most frequently submitted codes are 99213 and 99214. For years the 99213 code has had the distinction of being the most frequently used code, but 99214 has been gaining ground, especially since the elimination of coverage for outpatient consult codes by Medicare in 2010.

Coding patterns have always tended to vary by specialty. For the office E/M codes, 99214 has tended to outpace 99213 for specialties such as cardiology and hematology/oncology. For primary care those two codes have always tended to be used more equally. For specialties such as dermatology, the lower level visit code has traditionally outpaced the higher level code.

Whether the increase in utilization is due to the loss of the consult codes or a result of the increased use of EHR technology which may allow physicians to use tools to access data in the health records and bring it forward to justify a higher level of service, it is important to remember that medical decision making should drive code selection and medical necessity evident in the documentation will always continue to play a primary role in the selection of the proper code.

Here are the Medicare utilization statistics from 2015 for Part B nationally for the top two codes.

Part B Physician/Supplier National Data - CY2015
Top 200 Level 1 Current Terminology (HCPCS/CPT) Codes
Rank by Charges

Code	Allowed Charges	# of Services
99214	$ 9,891,277,157	95,564,075
99213	$ 6,925,839,306	99,683,743

Anthem Virginia

Anthem Virginia has released a new participating provider amendment to its current contracts. This amendment was mailed out on September 24, 2016, and providers have 40 days to respond to the new contract changes. Otherwise they will become effective on January 1, 2017. The new amendment contains new allowances that will go into effect in 2017 as well.

HCI-EBS, Inc. has reviewed this agreement and the new fee schedule. If you are interested in how this will affect your practice, please contact your consultant or phone us at 1-800-572-5275.

If you have any questions or want additional information, please contact your consultant:
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