2018 Coding & Reimbursement Update

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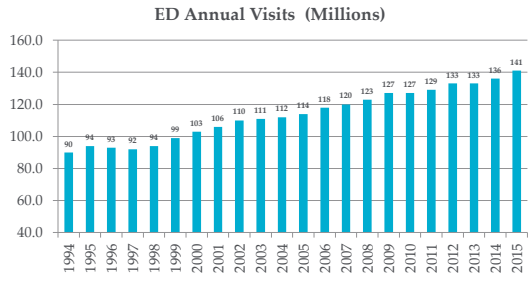
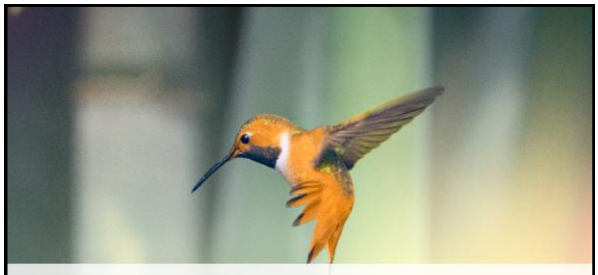
The Safety Net for Society

- Over half of the 35.4 million annual inpatient admissions in the United States begin in the ED
- 5 times as many ED visits are treated and released
- ED visits outpaced population growth since 1993
- The number of ED visits increased 14.8 % from 2006 to 2014. The U.S. population grew 6.9 %
- ED visits by those in the lowest quartile of income rose 23% from 2006-2014
- The rate of mental health / substance abuse-related ED visits increased 44.1 percent from 2006 to 2014

The Healthcare Cost and Utilization Project sponsored by sponsored By The Agency for Healthcare Research and Quality (AHRQ)

Anyone with Anything at Anytime





What To Watch Out For In 2018?

Copy Pasting Cloning

Office of Inspector General OIG

Inappropriate copy pasting could inflate claims to support billing higher service levels.

Identical notations were noted for different patients with different problems. In several instances language was exactly the same. Most of the physical exam was identical.

CMS Contractor

Cloned documentation: it would not be expected the same patient had the same exact problem, symptoms, and required the exact same documentation on every encounter.

Cloned documentation does not meet medical necessity requirements for coverage of services. Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made.

BlueCross BlueShield

CMS

Bad News on the Horizon

February 22, 2017

Thank you for taking the time to meet with the Fraud Investigation and Prevention Unit ("FIP") of Blue Cross and Blue Shield [redacted]

In brief, FIP has found:

1. A significant portion of the computer generated documentation submitted by you to FIP for Evaluation and Management ("E/M") services appeared to be pre-populated or copied

Based on the medical record review that FIP conducted, and as a result of the insufficient documentation found in your medical records and incorrect coding and billing, repayment of $[redacted] to BCBS [redacted] overpayments made to [redacted]

They Really Mean It

Re: Medical Record Review Findings & Overpayment – Dr.

As detailed in the Findings, the core issue here is not that Dr. [redacted] utilized an EMR system for documenting E/M services, but rather that "[a] significant portion of the computer generated documentation . . . appeared to be pre-populated or copied from previous dates of service for [certain] patients, or from previous dates of service from other patients, rather than being specifically updated with pertinent information for the actual dates of service for those patients." In other words, Dr. [redacted]'s medical records did not properly or accurately document the extent and type of E/M services he may have provided to a patient at a particular visit, in

Documentation Guidelines: Practical Application

Level	HPI	ROS	PFSHx	PE
1	1	0	0	1
2	1	1	0	2
3	1	1	0	2
4	4	2	1	5
5	4	10	2	8

Documentation Best Practice: Defending the Patient's Acuity

- Document a differential diagnosis:
  - Chest pain: ACS, GERD, Pneumothorax, PE
- Clearly state co-morbidities
  - IDDM, Htn, Lymphoma
- Be aware of diagnoses qualifying as high risk
  - Abrupt change in mental status
    - Seizure, TIA, weakness, numbness

Key Documentation Areas

Clearly document data reviewed:

- **Review and summary of old records**

  Old Record Review:
  Last visit 10.1.17- BNP >3,000. EF 34%. Creatinine 2.3

- History from someone other than the patient
- Discussions with other providers
  - **Admitting physician**
- Independent interpretations (EKGs)
- Independent visualization (x-rays)

WPS Target Probe Educate

Emergency Room Services CPT Code 99281-99285

CMS has authorized WPS Government Health Administrators (GHA) to conduct the Targeted Probe and Educate (TPE) review process. This is a required process for providers identified by Medical Review. If your facility is chosen, a WPS Nurse Analyst will contact you. Providers will then have **45 days** to submit medical record information that supports the services billed. Before you send the requested records, GHA suggests a clinician double-check the accuracy of your submitted claim.

WPS GHA may refer providers/suppliers to **RAC or UPIC** if providers do not respond to ADR requests and submit the requested documentation to WPS GHA.

WPS GOVERNMENT HEALTH ADMINISTRATORS

Auditor Downcoded to 99284

HPI: The patient is a 52 year old male presenting with severe fatigue which has increased over the past few days associated with nausea and increased thirst. Patient denies past medical history.

MDM: CBC with differential, Chem panel, UA, LFTs, Troponin, EKG

Documentation reviewed: ED nurse's notes

Plan: Admit to inpatient

Impression: Hyperglycemia

No documentation of:
- ✓ Risk with differential diagnoses
- ✓ Old record review- had 2 office visits with elevated BS
- ✓ Discussion with other providers PMD, Hospitalist and Endocrine
- ✓ Recvd. 2.5 liters IVF and Insulin drip. Bicarb was 7. BS 680

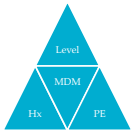
99285 Upheld

HPI: 68 year old with PMH of CAD HTn, and IDDM — Comorbidity
With several days of worsening lower extremity swelling.
Also reports recent productive cough and low grade fever.
PE: Breath sounds + crackles bil bases, 2+ pitting edema to knees
DDx: ACS, CHF, pulmonary edema, pneumonia — Extensive diff dx & high risk conditions

MDM : CBC, CMP, BNP, Troponin, EKG, CXR obtained. EKG interpretation by ED provider: septal infarct age undetermined, CXR interpretation by ED provider: bil. baslar infiltrates, BNP elevated at 864, Troponin neg. — Extensive Data
ED Course: Treated with Lasix 80 mg IV and MSO4 2 mg IV
BS 385 (Tx SQ Insulin) — High risk medication
Old record reviewed with summary- Previous admission last May for Pneumonia and renal insufficiency
Case discussed with DR XXX (IM/Cardiology) for admission with continuity of care
Final Diagnosis- CHF, Pneumonia — Ongoing Additional Tx

Documentation Best Practices

- 4 HPI for most presentations
- Small or large macro for ROS and PE depending on complexity
- Completed Past Medical and Social Hx
  - Family Hx as relevant
- Recognize Hx and acuity caveat opportunities
- Robust medical decision making
  - Combined with Hx/PE = LEVEL



2018 RBRVS EQUATION

Work RVUs
Practice Expense RVUs
+Liability Insurance RVUs
Total RVUs for a given code

RVU_{Total} X Conv. Factor
= Medicare Payment

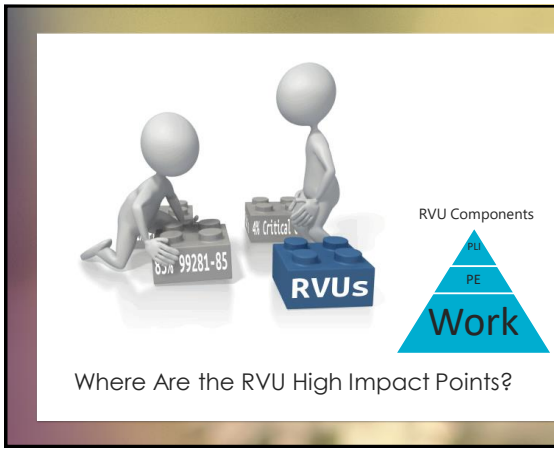
2018 RVUs

Code	2017 Work	2018 Work	2017 PE	2018 PE	2017 PLI	2018 PLI	2017 Total RVUs	2018 Total RVUs
99281	0.45	0.45	0.11	0.11	0.04	0.04	0.60	0.60
99282	0.88	0.88	0.21	0.21	0.08	0.08	1.17	1.17
99283	1.34	1.34	0.29	0.29	0.12	0.12	1.75	1.75
99284	2.56	2.56	0.53	0.53	0.23	0.23	3.32	3.32
99285	3.80	3.80	0.75	0.75	0.35	0.34	4.90	4.89
99291	4.50	4.50	1.43	1.42	0.39	0.38	6.32	6.30

2018 RVU Evolution

- **Work RVUs** typically only change as part of a **large mandated review**
  - **78% (Work)** of our RVUs stable 2017-2018
- Practice Expense and PLI (Liability) are updated each year with small variations

- 2018 RVU Analysis
- 2018 ED work RVUs stable
- 2018 Total RVUs tiny changes



2018 Medicare Payment per RVU: Conversion Factor Update

- Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
- REPEALED SGR – no more 21% cuts
- 2016-2019 ½% increases to the conversion factor
- PQRS, VBM, and EHR incentive programs rolled up
- Merit Based Incentive Payment System (MIPS)
  - 2018 data ⟶ 2020 payment +/- 5%

2018 Conversion Factor

- 2017 will end the year at $35.8887
- 2018 11 cent increase

2018 Medicare Physician Final Rule page 1149

TABLE 48: Calculation of the Final CY 2018 PFS Conversion Factor

CY 2017 Conversion Factor		**35.8887**
Statutory Update Factor	0.50 percent (1.0050)	
CY 2018 RVU Budget Neutrality Adjustment	-0.10 percent (0.9990)	
CY 2018 Target Recapture Amount	-0.09 percent (0.9991)	
CY 2018 Conversion Factor		**35.9996**

2018 Final Rule Impact by Specialty

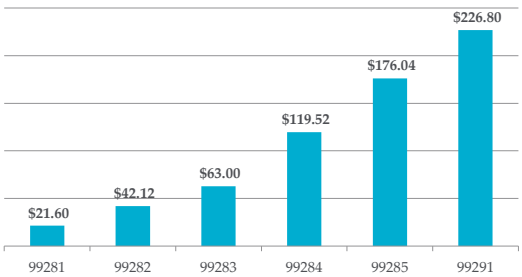
- Winners
  - Psychology & clinical social workers
- Even
  - Emergency medicine and most others
- Losers
  - ENT -2%
  - Allergy -3%
  - Diagnostic testing -4%

2018 Physician Final Rule Page 1152

TABLE 50: CY 2018 PFS Estimated Impact on Total Allowed Charges by Specialty*

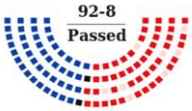
(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact**
TOTAL	$93,149	0%	0%	0%	0%
ALLERGY/IMMUNOLOGY	$247	0%	-3%	0%	-3%
ANESTHESIOLOGY	$2,018	-1%	0%	0%	-1%
AUDIOLOGIST	$66	0%	0%	0%	0%
CARDIAC SURGERY	$312	0%	0%	0%	0%
CARDIOLOGY	$6,705	0%	-1%	0%	1%
CHIROPRACTOR	$779	0%	1%	0%	1%
CLINICAL PSYCHOLOGIST	$762	0%	2%	0%	2%
CLINICAL SOCIAL WORKER	$670	0%	3%	0%	3%
COLON AND RECTAL SURGERY	$167	0%	0%	0%	0%
CRITICAL CARE	$334	0%	0%	0%	0%
DERMATOLOGY	$3,485	0%	1%	0%	1%
DIAGNOSTIC TESTING FACILITY	$773	0%	-4%	0%	-4%
EMERGENCY MEDICINE	$3,191	0%	0%	0%	0%

Documentation & Coding 2018 Increases with Each E/M Level

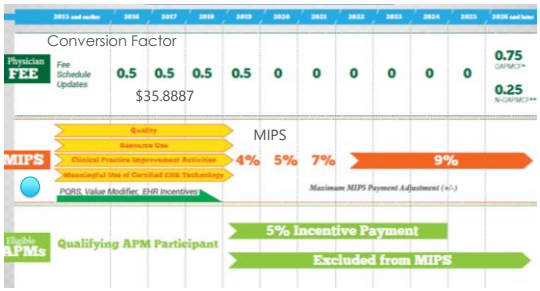


The Dreaded SGR Is Gone!

Date: Apr 14, 2015
Senate Vote #144
114th Congress
H.R. 2:
Medicare Access and CHIP Reauthorization Act of 2015



MACRA Quality and Payment Timeline



A Deep Dive Into the 2018 Medicare Physician Fee Schedule

GPCI Floor Not Extended in NPRM or FR

ADDENDUM E. FINAL 2017 GEOGRAPHIC PRACTICE COST INDICES (GPCIs) BY STATE AND MEDICARE LOCALITY*

Carrier	Locality Number	Locality Name	2016			2017			2018		
			PW GPCI (with 1.0 Floor)	PE GPCI	MP GPCI	PW GPCI (with 1.0 Floor)	PE GPCI	MP GPCI	PW GPCI	PE GPCI	MP GPCI
10102	00	ALABAMA	1.000	0.886	0.611	1.000	0.888	0.552	0.979	0.890	0.492
10102	01	ALASKA**	1.500	1.107	0.712	1.500	1.112	0.710	1.500	1.117	0.708
10102	00	ARIZONA	1.000	1.000	0.877	1.000	0.986	0.856	0.980	0.971	0.834
10102	13	ARKANSAS	1.000	0.867	0.534	1.000	0.870	0.555	0.971	0.872	0.576
10112	54	BAKERSFIELD, CA	1.027	1.063	0.458	1.024	1.079	0.610	1.020	1.074	0.599

But the Work GPCI Floor May Yet Remain

* The 1.0 Work GPCI floor required by Section 201 of the MACRA of 2015 expires on December 31, 2017, therefore the Work GPCIs for 2018 do not reflect a 1.0 floor.
**Work GPCI reflects a 1.5 floor in Alaska established by the MIPPA.
***PE GPCI reflects a 1.0 floor for frontier states established by the ACA.

- Announcement is expected to be included in the Medicare extenders package that came out of Senate Finance last week which offered up the 2 year extension
- Very important to rural GPCI areas

Specialty Impact Table for the Proposed Rule

TABLE 40: CY 2018 PFS Estimated Impact on Total Allowed Charges by Specialty*

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact**
TOTAL	$92,628	0%	0%	0%	0%
ALLERGY/IMMUNOLOGY	$245	0%	-3%	0%	-3%
ANESTHESIOLOGY	$2,009	-1%	0%	0%	0%
AUDIOLOGIST	$66	0%	0%	-1%	-1%
CARDIAC SURGERY	$311	0%	0%	-1%	-2%
CARDIOLOGY	$6,671	0%	-1%	-1%	-2%
CHIROPRACTOR	$772	0%	1%	0%	1%
CLINICAL PSYCHOLOGIST	$756	0%	2%	0%	2%
CLINICAL SOCIAL WORKER	$664	0%	3%	0%	3%
COLON AND RECTAL SURGERY	$166	0%	0%	-1%	-1%
CRITICAL CARE	$332	0%	0%	0%	0%
DERMATOLOGY	$3,475	0%	0%	-1%	-1%
DIAGNOSTIC TESTING FACILITY	$765	0%	-6%	0%	-6%
EMERGENCY MEDICINE	$3,176	0%	0%	-1%	-1%
ENDOCRINOLOGY	$477	0%	0%	0%	0%
FAMILY PRACTICE	$6,307	0%	0%	0%	0%

2018 PLI Proposed Risk Factors and Premiums

CY 2018 Malpractice Risk Factors and Premium Amounts by Specialty

Specialty Code	Specialty Name	Non-Surgical Risk Factor	Surgical Risk Factor	Non-surgical Normalized Premium Rate	Surgical Normalized Premium Rate
01	General Practice	1.80	3.72	$14,776	$30,521
02	General Surgery		6.75		$55,375
03	Allergy Immunology	1.00	1.00	$8,201	$8,201
04	Otolaryngology	1.53	4.08	$12,517	$33,486
05	Anesthesiology	2.58	2.58	$21,137	$21,137
06	Cardiology	1.90	1.90	$15,587	$15,587
07	Dermatology	2.77	2.77	$22,750	$22,750
08	Family Practice	1.67	3.74	$13,696	$30,640
93	Emergency Medicine	2.29	5.03	$18,761	$41,277
94	Interventional Radiology	2.82	2.82	$23,087	$23,087
97	Physician Assistant	1.00	1.00	$8,201	$8,201

Difference 2017 to 2018

- 2018

Specialty Code	Specialty Name	Non-Surgical Risk Factor	Surgical Risk Factor	Non-surgical Normalized Premium Rate	Surgical Normalized Premium Rate
93	Emergency Medicine	2.29	5.03	$18,761	$41,277

- 2017

Specialty Code	Specialty Name	Non-Surgical Risk Factor	Surgical Risk Factor	Non-surgical Normalized Premium Rate	Surgical Normalized Premium Rate
93	Emergency Medicine	2.84	4.74	$23,825	$39,821

- Premium decrease of $5,064.00 Nonsurgical (21.25%)
- Premium increase of $1,456.00 Surgical (3.66%)
- Scaling Factors?

Basic Approach CMS Uses to Determine PLI RVU

- The methodology is generally the same used in the initial development of resource-based malpractice RVUs in 2000, the major difference being the use of more current data. The formula to determine the malpractice for a given procedure is comprised of three major components: (1) specialty's risk factor, (2) specialty weight for a given procedure compared to all other specialties, and (3) work value for the procedure.
- The result from this calculation is then scaled and adjusted for budget neutrality through a multi-step process. The current year "raw" PLI RVUs are scaled so that the sum of the PLI RVUs for the current year, weighted by the service count, is the same as the prior year. CMS also applies a floor of 0.01 and then CMS goes through another round of budget neutrality adjustments.
- The procedure's work RVU is a proxy to account for differences in risk-of-service (ROS) among procedures. CMS chose work RVUs as the best available proxy for determining ROS "since work RVUs reflect differences in time, intensity, and difficulty among procedures, and are generally accepted as accurate."
- The surgical specialty risk factor is appropriately much higher than for medical specialties. For example, the proposed specialty risk factor for general surgeons is 7.18, and 4.03 for general practice.

PLI Response in the Final Rule

- After consideration of the comments received, we stated that we would consider the possibility of using the updated MP data to update the specialty risk factors used in the calculation of the MP RVUs prior to the next 5-year update in future rulemaking (81 FR 80191 through 80192). Since MP premium data are used to update both the MP GPCIs and the MP RVUs, going forward we believe it would be logical to align the update of MP premium data used to determine the MP RVUs with the update of the MP GPCI. Section 1848(e)(1)(C) of the Act requires us to review and, if necessary, adjust the GPCIs at least every 3 years. The next review of the GPCIs must occur by CY 2020.

Documentation Guideline Reform

- CMS Sought comment on changing the current documentation guidelines
- Specifically sought comment on whether it would be appropriate to remove our documentation requirements for the history and physical exam for all E/M visits at all levels. We stated that we believed MDM and time are the more significant factors in distinguishing visit levels, and that the need for extended histories and exams is being replaced by population-based screening and intervention, at least for some specialties.

CMS Response to DG Review

- We also believe the public comments illustrate that many of the issues with the E/M documentation guidelines are not simply a matter of undue administrative burden. The guidelines reflect how work was performed and valued a number of years ago, and are intimately related to the definition and description of E/M work as well as its valuation.
- We expect to continue to work on all of these issues with stakeholders in future years though we are immediately focused on revision of the current E/M guidelines in order to reduce unnecessary administrative burden.

ED E/M Value Review in 2018

We received information suggesting that the work RVUs for emergency department visits did not appropriately reflect the full resources involved in furnishing these services. Specifically, stakeholders expressed concerns that the work RVUs for these services have been undervalued given the increased acuity of the patient population and the heterogeneity of the sites, such as freestanding and off-campus emergency departments, where emergency department visits are furnished. Therefore, we sought comment on whether CPT codes 99281-99285 (Emergency department visits for the evaluation and management of a patient) should be reviewed under the misvalued code initiative.

Response: We agree with the majority of commenters that these services may be potentially misvalued given the increased acuity of the patient population and the heterogeneity of the sites where emergency department visits are furnished. As a result, we look forward to reviewing the RUC's recommendations regarding the appropriate valuation of these services for our consideration in future notice and comment rulemaking. Additionally, regarding the commenters' concerns about documentation guidelines for E/M services, we refer readers to section II.I for details regarding our comment solicitation on documentation for E/M guidelines more generally.

On Reporting Coordination of Care in the ED

- **Comment:** We received a few comments recommending ways in which we might better involve specialists in the provision of CCM or care management broadly (such as payment to emergency department physicians when they act as primary care practitioners, or payment to multiple practitioners involved in managing a given patient at a given time). Also a few commenters recommended that CMS allow more than one practitioner to bill CCM per month. They believe there were situations where more than one practitioner co-manages a patient, or that particularly complex patients who would benefit from CCM services also benefit from seeing multiple health care providers.
- **Response**: Only one practitioner can report CCM per month, consistent with both CPT guidance and the authorizing statute for payment of CCM services (section1848(b)(8)(B) of the Act). However, we agree there may be circumstances in which more than one practitioner expends resources managing or helping manage a CCM patient. We will continue to explore ways in which we might better identify and pay for costs incurred by multiple practitioners who coordinate and manage a patient's care within a given month, and are interested in hearing more about the relevant circumstances, potential gaps in coding, and the exact nature of the work performed or costs incurred.

Observation Code Language Change

- Added the words "outpatient hospital" before "observation" in the preamble and under each code descriptor [FEC Implications?]

Initial Observation Care

New or Established Patient

►The following codes are used to report the encounter(s) by the supervising physician or other qualified health care professional with the patient when designated as outpatient hospital "observation status." This refers to the initiation of observation status, supervision of the care plan for observation and performance of periodic reassessments. For observation encounters by other physicians, see office or other outpatient consultation codes (99241-99245) or subsequent observation care codes (99224-99226) as appropriate.◄

Watch for the Blue Triangle

▲ 99220 **Initial observation care,** per day, for the evaluation and management of a patient, which requires these 3 key components:

- **A comprehensive history;**
- **A comprehensive examination; and**
- **Medical decision making of high complexity.**

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.

New Chest X-ray Codes for 2018

►(71010 has been deleted. To report, use 71045)◄

►(71015 has been deleted. To report, use 71045)◄

►(71020 has been deleted. To report, use 71046)◄

►(71021 has been deleted. To report, use 71047)◄

►(71022 has been deleted. To report, see 71047, 71048)◄

- **71045** Radiologic examination, chest; single view
  CPT Changes: An Insider's View 2018
- **71046** 2 views
  CPT Changes: An Insider's View 2018
- **71047** 3 views
  CPT Changes: An Insider's View 2018
- **71048** 4 or more views
  CPT Changes: An Insider's View 2018

Telemedicine Modifier 95

- 95 (Synchronous telemedicine services rendered via real time interactive audio and video telecommunications system)
- The modifier descriptor specifies that the service must be synchronous, meaning in real time, for correct application
- The totality of the information exchanged must be commensurate with the key components or other requirements to have reported the service or procedure as if the distant provider were physically present with the patient

Telemedicine Modifier 95

- The CPT Editorial Panel considered, but apparently chose not to include, a second new modifier for asynchronous (not real time interaction) services, perhaps because of a lack of specificity for the services with which the modifier would be used
- CMS has had a HCPCS modifier, GT (Via interactive audio and video telecommunication systems) available for use, but this is a new modifier for CPT

CPT Activity- Telemedicine

- CMS reminds stakeholders that requests to add services to the list of Medicare telehealth services must be received no later than December 31 of each calendar year to be considered for the next rulemaking cycle The following requests were received in CY 2016 for inclusion in 2018 organized by the two categories for telehealth services created by Medicare
  - (1) Services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services.
  - (2) Services that are not similar to the current list of telehealth services, (This includes an assessment of whether the service is accurately described by the corresponding code when furnished via telehealth and whether the use of a telecommunications system to furnish the service produces demonstrated clinical benefit to the patient.)

CPT Telemedicine

- Modifier 95 (Synchronous telemedicine services rendered via real time interactive audio and video telecommunications system)
- Appendix P, which lists 79 codes that may be used for reporting synchronous telemedicine services when using interactive telecommunications equipment that incudes, at a minimum, audio and video.
- CPT requires proof of payer policy that covers a telemedicine service by code for it to be included in Appendix P.
- Possible addition of current G codes?
  - G0425 Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communication with the patient via telehealth; and
  - G0426 Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communication with the patient via telehealth

CPT Opioid Counseling

ACEP put forth the Code Change Proposal in September:

- This is a new service to be described in CPT. Recent state regulations require the physician or other qualified health care professional to discuss the risks and benefits of narcotic use, including the accidental or intentional use by others, as well as the signs of overdose and addiction, as well as offer naloxone prescription and training in its use. In addition, they are required to access the state's Prescription Drug Monitoring Program (PDMP) to determine any recent controlled substance prescriptions and document this information in the patient record.

CPT Assistant Article on Fracture Care

- Compromise to surveying at the RUC
- Drafts have been exchanged for over a year
- Issues are over definition of restorative care and use of modifier 54
- CPT definition of manipulation as a proxy for restorative?
  - Manipulation is used throughout the musculoskeletal fracture and dislocation subsections to specifically mean the attempted reduction or restoration of a fracture or joint dislocation to its normal anatomical alignment by the application of manual forces."
- Possible publication in the November 2017 *CPT Assistant*

ACEP's CCIIO Lawsuit

- ACEP's lawsuit was in response to a regulation from the Centers for Medicare & Medicaid Services (CMS) about out-of-network emergency physician payment, which outlines the "greatest of three" options. As written, this rule opened the door for insurers to use black box methods to determine physician payments without providing any means to verify the data.
- The U.S. District Court for the District of Columbia has granted in part ACEP's Motion for Summary Judgement.
- The ruling does not invalidate the rule, but it is a clear step in the right direction.
- The court said the department had "all but ignored" concerns raised about the rule by groups, including ACEP, and directed the department to respond to the concerns, specifically about using a transparent database that is not manipulatable by insurance companies.

Conclusions

- Document clinical data and details to decrease audit risk
- Documentation guidelines may be extensively reviewed in the future
- 2018 RVUs are stable but ED work RVUs will be reviewed
- Small conversion factor increases continue
- Quality programs growing in economic importance
- Lots of CPT Activity

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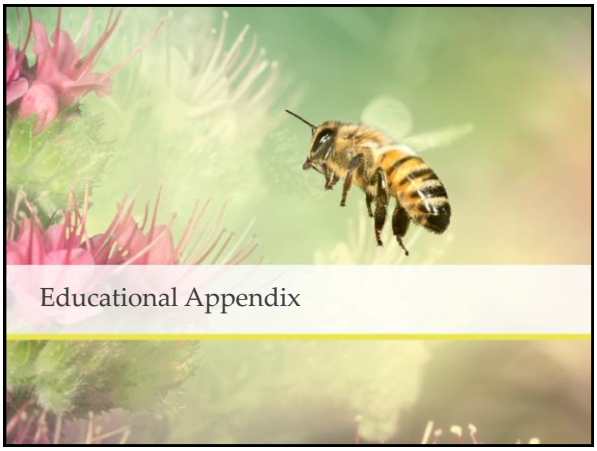


Educational Appendix

Conversion Factor Appendix : Target Recapture Detail

PAMA- (Protecting Access To Medicare Act)- annual **target** for reductions in PFS expenditures resulting from adjustments to re. lative values of **misvalued codes.** We estimate the CY 2018 net reduction in expenditures resulting from adjustments to relative values of misvalued codes to be 0.41 percent. Does not meet the 0.5 percent target. Payments under the fee schedule must be reduced by the **target recapture amount**. As a result, we estimate that the CY 2018 target recapture amount will produce a reduction to the conversion factor of **-0.09%.**

2018 OPPS page 1148

Conversion Factor Appendix : RVU Budget Neutrality

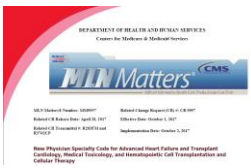
Section 1848(c)(2)(B)(ii)(II) of the Act requires that increases or decreases in RVUs may not cause the amount of **expenditures for the year to differ by more than $20 million** from what expenditures would have been in the absence of these changes. If this threshold is exceeded, we **make adjustments to preserve budget neutrality** which for 2018 is **.10%**

2018 OPPS page 1149

2018 Abscess Documentation & Coding

- NGS RE: Incision and Drainage Date issued: 5-15-17
  - A simple abscess generally requires only a single puncture or single incision. A complicated abscess y requires more effort to treat. Examples of complicated abscesses are the following: an abscess with 3-4 tracks requiring breaking up of loculated compartments; an abscess requiring undermining of the skin and subcutaneous tissue and extensive laying open of the cavity. In these circumstances, at minimum, locally injected anesthesia is usually required.

New Toxicology Specialty Code in Pecos



Medical Toxicology C8

- PECOS shall populate the following extracts with the new physician specialties
- Ordering/Referring
- CAH Method 2 Attending and Rendering
- General Attending Physician Services

Contact Information

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