

CAC PIAC Meeting Notes Nov. 2015

This year's meeting took place in National Harbor MD in November over two days and covered a wide variety of issues from ICD-10, PQRS, the Medicare fee schedule and private insurance, among many other Medicare and private insurance reimbursement issues.

Carolyn Cunningham MD began the meeting with a discussion on the importance of state CAC representation as a liaison between the contractor and you the state association member. It is here where inconsistent medical review policies are discussed. She went on to discuss types of Medicare policies such as national and local coverage determinations and how CAC representatives play an integral role in helping to shape these policies. Many CMS manuals exist and are available on the CMS website for review. She mentioned the two most likely reasons for LCD development are patient safety and new technology but did not provide any podiatric examples for either. She continued by discussing pre and post pay medical reviews and provided the example of practitioners claiming an E+M and a nail debridement code on separate claims as a reason for this.

Marjorie Kanof MD discussed the Medicare physician fee schedule changes for 2016. As of January 1st the conversion factor went down from \$35.9335 to \$35.8279. A second major bullet point was that CPT code 11750 (nail matrixectomy) was reduced from 1.99 RVU's to 1.58 RVU's and that was to reflect the number of post operative visits to 1 and the code was subsequently crosswalked with 10140. Moderate sedation continues to be on the list of possible misvalued codes in the future as it is currently lumped in with procedural codes that include the sedation.

Dr. Kanof continued with a discussion on Merit-based Incentive Payment System citing that in 2019 PQRS, EHR and Value Modifier penalties sunset and MIPS begins encompassing all of those penalties into one with 4% maximal reductions in 2019 up to 9% maximum reductions in 2022 and beyond.

Thomas Walke PhD discussed the data from the provider fee schedule Medicare physician data file. This file includes provider information for more than 950,000 providers participating in Medicare and includes those provider's service information and payment information on the over 90 billion dollars paid to beneficiaries in 2013. In this report is public access to whether or not the physician is reporting for PQRS and is participating in the EHR initiative. This information is vital in shaping Medicare policies moving forward and is available on the APMA website.

Dr. James Christina DPM discussed meaningful use. His important points included that everyone, regardless of being in stage 1 or stage 2, now has a 90 day reporting period. You can report any consecutive 90 day period as compared to last year when that time must have fallen within a calendar year quarter. The biggest complaint of stage two thus far has been the patient engagement requirements, these, as well as the public reporting requirements have been modified and are now easier for the physician to report. In 2018 everyone will be required to report for a full year as a part of stage 3. EHR certification requirements will not

change in 2015-2017, the technology used for the 2014 reporting period will continue to suffice. A full review of the 10 modified meaningful use objectives for stage 2 are available on the APMA website. If an eligible provider is unable to meet the requirements they may qualify for a hardship exemption. Check www.cms.gov/EHRIncentivePrograms for more information. As far as the physician quality reporting system (PQRS) no changes from the previous year. Failure to participate in 2016 will invoke a 2% penalty in 2018.

The CAC-PIAC Annual Meeting will be held in early November 2016 in Baltimore MD.

Kevin Blue, DPM, CAC-PIAC Representative