# CPT Code Update & Alternative Payment Mechanisms

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## Disclosures

- Consultant:
  - FAIR Health, Inc
  - Innovative Diagnostic Laboratory
- Advisory Committees:
  - United Healthcare
  - Humana
  - Blue Shield of California
  - Avella Specialty Pharmacy

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## CPT Changes for 2016

- GI
  - New Codes
    - 43210: EGD with with esophagogastric fundoplasty, partial or complete, includes duodenoscopy when performed
    - 0392T: Laparoscopy, surgical, esophageal sphincter augmentation procedure, placement of sphincter augmentation device (ie, magnetic band) [LINX]
    - 0393T: Removal of esophageal sphincter augmentation device
    - 0397T: ERCP with optical endomicroscopy (OE) (report in conjunction with cat I ERCP codes)
    - 0403T: Preventive behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day
    - 0405T: Oversight of the care of an extracorporeal liver assist system patient requiring review of status, review of laboratories and other studies, and revision of orders and liver assist care plan (as appropriate), within a calendar month, 30 minutes or more of non-face-to-face time

## CPT Changes for 2016

- GI
  - Revision
    - 91040: Esophageal balloon distension study, modify to "provocation, when performed"
  - Clarification
    - 91200: liver elastography can be reported with E/M on same date of service
  - Deletions
    - 0240T: high resolution esophageal manometry, use 91010 to report
    - 0241T: high resolution esophageal manometry with stimulation / perfusion, use 91013 to report

## CPT Changes for 2016

- Vaccine codes - Deletion of 17 vaccine products no longer available in US
  - 90645: Hemophilus influenza b vaccine (Hib), HbOC conjugate (4 dose schedule), for intramuscular use
  - 90646: Hemophilus influenza b vaccine (Hib), PRP-D conjugate, for booster use only, intramuscular use
  - 90669: Pneumococcal conjugate vaccine, 7 valent, for intramuscular use
  - 90692: Typhoid vaccine, heat- and phenol-inactivated (H-P), for subcutaneous or intradermal use90693
  - 90703: Tetanus toxoid adsorbed, for intramuscular use
  - 90704: Mumps virus vaccine, live, for subcutaneous use
  - 90705: Measles virus vaccine, live, for subcutaneous use
  - 90706: Rubella virus vaccine, live, for subcutaneous use
  - 90708: Measles and rubella virus vaccine, live, for subcutaneous use

## CPT Changes for 2016

- Vaccine code deletions
  - 90712: Poliovirus vaccine, (any type[s]) (OPV), live, for oral use
  - 90719: Diphtheria toxoid, for intramuscular use
  - 90720: Diphtheria, tetanus toxoids, and whole cell pertussis vaccine and Hemophilus influenza B vaccine (DTP-Hib), for intramuscular use
  - 90721: Diphtheria, tetanus toxoids, and acellular pertussis vaccine and Hemophilus influenza B vaccine (DTaP/Hib), for intramuscular use
  - 90725: Cholera vaccine for injectable use
  - 90727: Plague vaccine, for intramuscular use
  - 90735: Japanese encephalitis virus vaccine, for subcutaneous use

## CPT Changes for 2016

- Vaccine codes: new
  - 90697: Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use
  - 90620: Meningococcal recombinant protein and outer membrane vesicle vaccine, serogroup B (MenB), 2 dose schedule, for intramuscular use
  - 90621: Meningococcal recombinant lipoprotein vaccine, serogroup B (MenB), 3 dose schedule, for intramuscular use
  - 90625: Cholera vaccine, live, adult dosage, 1 dose schedule, for oral use

## CPT Changes for 2016

- Prolonged Services
  - Codes 99415, 99416 are used when a prolonged evaluation and management (E/M) service is provided in the office or outpatient setting that involves prolonged clinical staff face-to-face time beyond the typical face-to-face time of the E/M service, as stated in the code description.
  - The physician or qualified health care professional is present to provide direct supervision of the clinical staff.
  - This service is reported in addition to the designated E/M services and any other services provided at the same session as E/M services.

## CPT Changes for 2016

- Prolonged services
  - 99415: Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service)
    - (Use 99415 in conjunction with 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215)
    - (Do not report 99415 in conjunction with 99354, 99355)
  - 99416: each additional 30 minutes (List separately in addition to code for prolonged service)
    - (Use 99416 in conjunction with 99415)

## CPT Changes for 2016

- Instructions on reporting prolonged services
  - Codes 99415, 99416 are used to report the total duration of face-to-face time spent by clinical staff on a given date providing prolonged service in the office or other outpatient setting, even if the time spent by the clinical staff on that date is not continuous.
  - Time spent performing separately reported services other than the E/M service is not counted toward the prolonged services time.
  - Code 99415 is used to report the first hour of prolonged clinical staff service on a given date. Code 99415 should be used only once per date, even if the time spent by the clinical staff is not continuous on that date.

## CPT Changes for 2016

- Instructions on reporting prolonged services
  - Prolonged service of less than 45 minutes total duration on a given date is not separately reported because the clinical staff time involved is included in the E/M codes.
  - The typical face-to-face time of the primary service is used in defining when prolonged services time begins. For example, prolonged clinical staff services for 99214 begin after 25 minutes, and 99415 is not reported until at least 70 minutes total face-to-face clinical staff time has been performed.
  - When face-to-face time is noncontiguous, use only the face-to-face time provided to the patient by the clinical staff.

## CPT Changes for 2016

- Instructions on reporting prolonged services
  - Code 99416 is used to report each additional 30 minutes of prolonged clinical staff service beyond the first hour.
  - Code 99416 may also be used to report the final 15-30 minutes of prolonged service on a given date.
  - Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.
  - Codes 99415, 99416 may be reported for no more than two simultaneous patients
  - Facilities may not report 99415, 99416.

## Total Duration of Prolonged Services

| Total Duration of Prolonged Services | Code(s) |
|---|---|
| less than 45 minutes | Not reported separately |
| 45-74 minutes | 99415x1 |
| 75-104 minutes | 99415x1 AND 99416x1 |
| 105 minutes or more | 99415x1 AND 99416x2 or more for each additional 30 minutes |

## The Transition to Value

- Measurement of value and quality for doctors and facilities determines
  - Network Inclusion
  - Coverage
  - Reimbursement
- Requires facilities and doctors to work closely together and share financial risk as well as potential profits

## Value-based purchasing concepts

**AHRQ**

- Buyers hold providers accountable for cost and quality
- Information on quality, outcomes, health status
- Reduce inappropriate care
- Identify and reward best performers

**Business Group on Health**

- Demand side strategy: measure, report and reward excellence
- Coalitions consider access, price, quality, efficiency, and alignment of incentives
- Public reporting, enhanced payments, and increased market share

## Challenges facing health care

- "Value based purchasing" places pressures on hospitals and physicians to eliminate redundancy, inappropriate, unnecessary and costly care
- Payers, purchasers and MACRA push providers toward bundled services / episode payments that define quality and efficiency
- Instead of "how much did you do", value-based care moves us to "how well did the patient do"
- Physicians and administrators must break down silos to redesign care delivery or suffer the consequences of a failed system

## What will value-based care require?

- Reimbursement linked to measurement of
  - quality
  - efficient service delivery
  - safety
  - cost reduction thru improvement
- Public reporting and sharing of data
- Leverage evidence-based clinical decision support to turn data and information into knowledge
- Coordinate care across settings to effectively manage chronic diseases and populations
  - Providers held accountable through APM (alternative payment models) where rewards and consequences conditional on achieving performance
- Empower and engage consumers

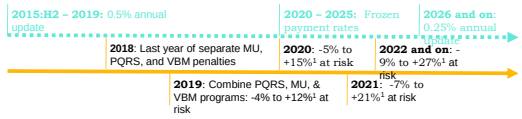
## MACRA, physician fees, and quality payments

| Year | Medicare Fee Schedule |
|---|---|
| 2015 -2019 | .5% increase each year |
| 2019- 2025 | 2019 rates plus ability to receive additional payment through Merit-Based Incentive Payment System (MIPS) |
| 2019 -2024 | 5% bonus for those participation in qualified alternative payment models |

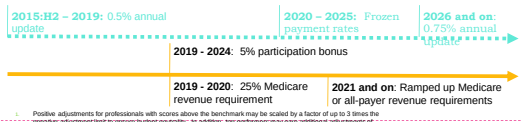
## SGR Repeal Creates Two Tracks for Providers

- Providers Must Choose Enhanced FFS or Accountable Care Options

**Merit-Based Incentive Payment System**




**Advanced Alternative Payment Models**[2]




1. Positive adjustments for professionals with scores above the benchmark may be scaled by a factor of up to 3 times the negative adjustment limit to ensure budget neutrality. In addition, top performers may earn additional adjustments of up to 10 percent.
2. APM participants who are close to but fall short of APM bonus requirements will not qualify for bonus but can report MIPS measures and receive incentives, or can decline to participate in MIPS.

Source: *The Medicare Access and CHIP Reauthorization Act of 2015;* Advisory Board analysis.

## MIPS

| Consolidates 3 Current Programs Beginning 2019 | Merit-Based Incentive Payment System |
|---|---|
| **The Physician Quality Reporting System (PQRS)** that incentivizes professionals to report on quality of care measures;<br><br>**The Value-Based Modifier (VBM)** that adjusts payment based on quality and resource use in a budget-neutral manner; and<br><br>**Meaningful use of EHRs** (MU) that entails meeting certain requirements in the use of certified EHR systems. | Payments to professionals will be adjusted based on performance in the unified MIPS starting in 2019 |
| Applies to: | MD/DO, PA, NP, CRNA |

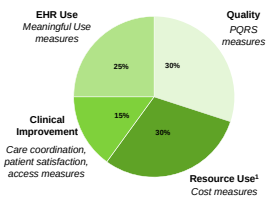
## New Law Strengthens Move To Value Incentives

- Builds on Trend of Increasing Provider Accountability Even Within FFS

**Merit-Based Incentive Payment System (MIPS) Summary**

- Sunsets current Meaningful Use, Value-Based Modifier, and Physician Quality Reporting System (PQRS) penalties at the end of 2018, rolling requirements into a single program
- Adjusts Medicare payments based on performance on a single budget-neutral payment beginning in 2019
- Applies to physicians, NPs, clinical nurse specialists, physician assistants, and certified RN anesthetists
- Includes improvement incentives for quality and resource use categories

**MIPS Performance Category Weights**




- Resource Use measures would be weighted less during first two years of MIPS program, reaching 30 percent in the third year of the program. Quality measures would be weighted more than 30 percent during the first two years to make up the difference.

Source: *The Medicare Access and CHIP Reauthorization Act of 2015;* Advisory Board analysis.

## MIPS four categories impact FFS payment based on composite performance

| | |
|---|---|
| Quality<br><br>30 percent | Measures used in the existing quality performance programs (PQRS, VBM, EHR MU),<br><br>Secretary to solicit recommended measures<br><br>Measures used by qualified clinical data registries |
| Resource Use<br><br>30 percent | Measures used in the current VBPM program<br><br>Additional process to report specific role in treating the beneficiary<br><br>Research on how to improve risk adjustment to ensure professionals are not penalized for serving sicker or more costly patients |
| Meaningful Use<br><br>15 percent | Current EHR Meaningful Use requirements, demonstrated by use of a certified system<br><br>Professionals who report quality measures through certified EHR systems for the MIPS quality category are deemed to meet the meaningful use clinical quality measure component |
| Clinical Practice Improvement Activities<br><br>25 percent | Professionals will be assessed on their effort to engage in clinical practice improvement activities.<br><br>Activities must be applicable to all specialties and attainable for small practices and professionals in rural and underserved areas |

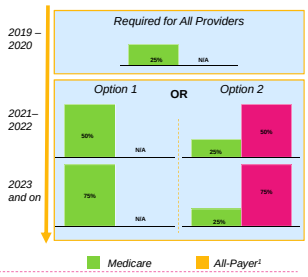
## APM Bonus Rewards Participation in New Models

Option Signals Policymakers' High Expectations for Risk-Based Models

**Advanced Alternative Payment Model (APM) Summary**

- Requires significant share of provider revenue in APM with two-sided risk, and quality measurement; or in some cases participation in certified patient-centered medical homes (PCMHs)
- Provides financial incentives (5% annual bonus in 2019-2024) and exemption from MIPS requirements
- Includes partial qualifying mechanism that allows providers that fall short of APM requirements to report MIPS measures and receive corresponding incentives or to decline to participate in MIPS

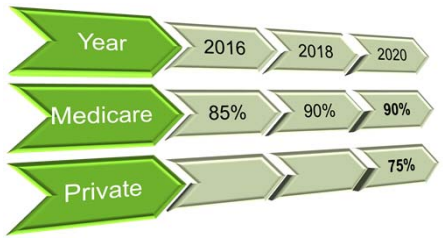
**Required Percentage of Revenue Under Risk-Based Payment Models**



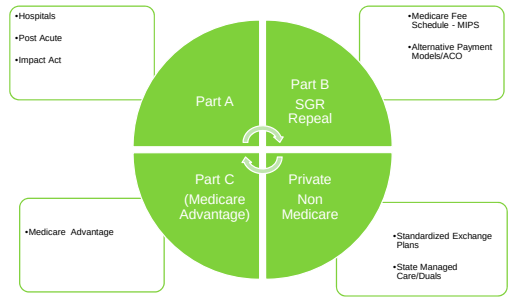

1. Risk-based contracts with Medicare Advantage plans count toward the all-payer requirement category.

Source: *The Medicare Access and CHIP Reauthorization Act of 2015*; Advisory Board analysis.

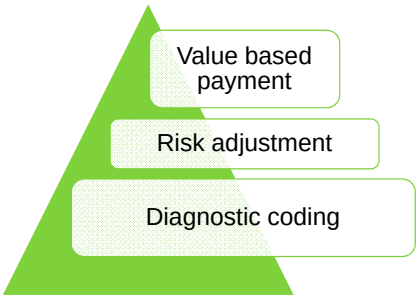
## Percent of payment in quality/value based models DHHS/Private Payors February, 2015



## Risk adjustment is now embedded across Medicare and private plans




## Physician diagnostic coding drives risk adjustment and thus payment




## What is a Narrow Network

- Tailored, tiered, and high performance provider networks
  - Focused on quality and with substantially lower premiums
  - Restrict network participation to the most effective / efficient providers
  - Different deductibles, co-pays, and coinsurance for providers in different tiers of the network
- Payment mechanisms can include
  - Performance-based contracts
  - Bundled care / episode payments
  - Shared risks and savings
  - Capitated budgets with prices 19-25% below PPO/HMO rates
- Unlike the HMO networks of the 1990s, current narrow networks are selected based on quality and cost metrics, not simply price

## Transition of Narrow Networks

- Original narrow networks focused solely on securing price concessions from providers
- Today's version focuses on 'value' which includes
  - Reduction in overall health care costs across the health care continuum for an employee population
  - Quality performance
  - Patient satisfaction
  - Wellness and well-being
  - Care transitions
  - Addressing socio-economic factors

## Logic of Tiered Networks

- Identify providers that offer the greatest value
- Use differential cost sharing to steer patients to preferred providers
- Those with the lowest willingness to pay for the "non-preferred" providers will switch
- Threat of switching may affect provider behavior in ways that are consistent with payer objectives

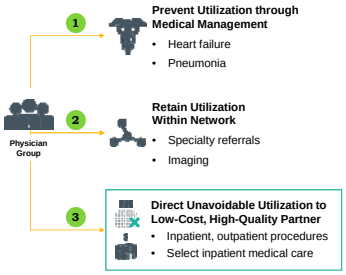
## "Managing" the insured population

- Narrow steerage of certain patients to "centers of excellence"
  - Cardiovascular care
  - Transplants
  - Orthopedic and rehabilitative services
- Exclusion of high-cost providers from networks on a service line basis
- Incentives for employees to choose lower cost options in the marketplace
- How will you demonstrate your value to the entity that controls your PCP referral base?

## Re-evaluating Historical Referral Decisions

Demand: Directing and Destruction

**Three Options for Accountable Providers**




**Prevent Utilization through Medical Management**
- Heart failure
- Pneumonia

**Retain Utilization Within Network**
- Specialty referrals
- Imaging

**Direct Unavoidable Utilization to Low-Cost, High-Quality Partner**
- Inpatient, outpatient procedures
- Select inpatient medical care

**Demand Direction as Important as Destruction**

**50%**

Percentage of total savings attributed to lower cost referrals for organizations participating in BCBS Massachusetts' Alternative Quality Contract

Source: Song Z, et al. "The 'Alternative Quality Contract,' Based On A Global Budget, Lowered Medical Spending And Improved Quality." *Health Affairs*, 31.8 (2012): 1885-1894; Health Care Advisory Board interviews and analysis.

## Seeking a Collaborative Partner

New Preferred Partnership Driven by Shared Vision

**Partnership Goals**

**Partner on Care Coordination**
- Dedicated resources for care coordination initiatives
- Development, adoption of unified care standards
- Seamless patient integration

**Collaborate on Total Cost Management**
- Targeted focus on episodic cost control
- Coordinated leadership, governance
- Principled referral decisions

**Atrius Health** → **Ideal Partner**

**Atrius Health, Beth Israel Deaconess Medical Center**
- Atrius Health, an independent alliance of six physician groups and one home health/hospice provider in eastern and central Massachusetts; Beth Israel Deaconess Medical Center (BIDMC), a 649-bed academic medical center located in Boston, MA
- Atrius Health issued request for proposal for tertiary hospital partner to collaborate on Triple Aim goals with emphasis on care coordination, cost control
- Designed partnership contract around shared care coordination goals

Source: Health Care Advisory Board interviews and analysis.

## Increasing prevalence of tiered and limited network plans

- Tiered network plans
  - All firms, 2014: 19%
    - 18% of large employers (over 200 employees)
    - 19% of small employers (3-199 employees)
  - Most major commercial insurance firms now offering a tiered network product
  - More prominent role in certain geographies
- Limited network plans
  - Prominent in the ACA exchanges
  - Exclude lowest quality providers, least cost-efficient providers, or both
  - Lower premiums for consumers but little to no coverage for care from out-of-network
  - Stronger incentives for providers

## "Value-Based" Care: Patients and Doctors

| | Information | | Financial Incentive |
|---|---|---|---|
| | Quality | Costs | Tiering |
|  | ★★★ | $ | **High value**<br>**$20 Co-payment** |
|  | ★★★ | $$ | **Average value**<br>**$50 Co-payment** |
|  | ★ | $$$ | **Low value**<br>**$100 Co-payment** |

## Creating a Patient Cost Profile



GI Bleed — $13,000

Colonoscopy — $1,500

Preventive care — $1,500

Total cost = $16,000

Mrs. Smith

## Comparing Costs for Each Episode

$

| | Care assigned to Dr. Matthews | Average for that condition |
|---|---|---|
| **GI Bleed** | $13,000 | $18,500 |
| **Preventive care** | $1,000 | $500 |
| **Colonoscopy** | $2,000 | $1000 |
| **TOTAL** | $16,000 | $20,000 |

## Tiered networks impact patient choices of new doctors

- Significant loyalty to physicians seen previously -- in contrast to prescription drugs
- New (and unknown) physicians are more likely to be viewed by patients as substitutable
- The effect of tiering may be at the lower end of the distribution rather than moving patients to the "best" performers
  - Physicians in the worst-performing tier experienced 12% loss in share of new patients

- Center for Health Information and Analysis
  2014 Annual Report on the Performance of the Massachusetts Health Care System

## Toward an Economics of Value

Adapting to New Rules of Competition

| | Health System Strategy, 2003-2013<br>*"Price-Extractive Growth"* | Health System Strategy, 2014-2025<br>*"Value-Based Growth"* |
|---|---|---|
| **Description** | **Grow by being bigger:** Leverage market dominance to secure prime pricing, network status | **Grow by being better:** Leverage cost, quality, service advantage to attract key decision makers |
| **Key Success Factors** | • Expand market share<br>• Strengthen service lines<br>• Exert pricing leverage<br>• Solidify referrals<br>• Secure physicians<br>• Increase utilization | • Expand covered lives<br>• Compete on outcomes<br>• Minimize total cost<br>• Assemble network<br>• Offer convenience<br>• Expand access |
| **Target of Strategy** | • Commercial payers<br>• Government purchasers<br>• Physicians | • Employers<br>• Individuals<br>• Population health managers |
| **Performance Metrics** | • Discharges<br>• Service line share<br>• Fee-for-service revenue<br>• Pricing growth<br>• Occupancy rate<br>• Process quality | • Share of lives<br>• Geographic reach<br>• Risk-based revenue<br>• Share of wallet<br>• Outcomes quality<br>• Total cost of care |
| **Competitive Dynamics** | • Service line competition<br>• Centers of excellence<br>• Referral channels<br>• Physician loyalty | • Comprehensive care<br>• Patient engagement<br>• Clinical quality<br>• Service quality |
| **Critical Infrastructure** | • Inpatient capacity<br>• Outpatient imaging centers<br>• Clinical technology<br>• Ambulatory surgery centers | • Primary care capacity<br>• Care management staff and systems<br>• IT analytics<br>• Post-acute care network |
| **Key Leaders** | • CEO<br>• CFO<br>• COO<br>• CMO<br>• CNO<br>• Board | • CEO<br>• CFO<br>• COO<br>• CMO<br>• CNO<br>• Board<br>• CPE<br>• CTO<br>• CIO |