Start PQRS Now! It’s Not As Hard As You Think

NOTE: CMS has just added additional presentations of the webinar below – please check the end of the article for added dates. MPW

What is PQRS?

The Physician Quality Reporting System (Physician Quality Reporting or PQRS) is a CMS reporting program that uses a combination of incentive payments (**carrots**) and payment adjustments (**sticks**) to promote reporting of quality information by eligible professionals.

Program Points:

- **How:** Eligible professionals submit data.
- **What:** Quality measures for covered Physician Fee Schedule (PFS) services
- **Who:** Medicare Part B Fee-for-Service (FFS) beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer)

What are the 2013 Deadlines for

PQRS?

October 15, 2013 – Last day to elect Administrative Claims option to avoid the 2015 payment adjustment!

- A reporting mechanism under which an EP or group practice elects to have CMS analyze claims data to determine which measures an EP or group practice reports
- Deadline for group practices to submit a self-nomination statement via a CMS-developed website
- Group practices consisting of 100+ EPs, beginning in 2015, will be subject to the Value Based Modifier based on PQRS reporting in 2013
- Deadline for groups consisting of 100+ EPs to elect quality tiering approach to VBM

Why Should I Care About Participating in PQRS in 2013?

Beginning in 2015, the program also applies a payment adjustment to eligible professionals who do not satisfactorily report data on quality measures for covered professional services. The 2015 PQRS payment adjustment will be based on 2013 program year data, so if you do not participate in 2013, you will receive less payment for Medicare services in 2015.

STEP 1: Are You Eligible?

Determine if you are eligible to participate for purposes of the PQRS incentive payment and payment adjustment. A list of medical care professionals considered eligible to participate in PQRS is available in **here.** Read this list carefully, as not all entities are considered "eligible professionals" because they are reimbursed by Medicare under other fee schedule methods than the Physician Fee Schedule (PFS).

Individual eligible professionals **do not** need to sign-up or pre-register in order to participate in the Physician Quality Reporting.

STEP 2: What Reporting Method Will You Use?

Determine which PQRS reporting method best fits your practice. PQRS has several methods in which measure data can be reported –

- to CMS on Medicare Part B claims (**more details here** and **claim sample here**)
- to a qualified Physician Quality Reporting registry (**more details here**)
- to CMS via a qualified electronic health record (EHR) product (**more details here**)
- to a qualified Physician Quality Reporting data submission vendor – Group Practice Reporting Option (GPRO) only (**more details here**)

In order to satisfactorily report, it is important to review each method's specific reporting criteria. For additional guidance, refer to the **2013 Physician Quality Reporting System (PQRS) Implementation Guide here** and view the 2013 Physician Quality Reporting System Participation Decision Tree starting on **page 19**.

STEP 3: Will You Report Individual Measures or a Measures Group?

If the chosen method to report is claims-based or registry-based, determine which measure reporting option (individual measures or measures group) best fits your practice. Review the specific criteria for the **chosen reporting option** in order to satisfactorily report.

STEP 4: Choose Three Individual Measures or One Measure Group

If already participating in PQRS, there is no requirement to select new/different measures for the 2013 PQRS.

All PQRS measures and their available reporting methods can be reviewed in the **2013 Physician Quality Reporting System (PQRS) Measures List here.**

Notice that each measure or measure group has a **reporting frequency or timeframe** requirement for each eligible patient seen during the reporting period by each individual eligible professional (NPI). The reporting frequency (i.e., report each visit, once during the reporting period, each episode, etc.) is found in the instructions section of each measure specification or in the Measure Group Overview section. Ensure that all members of the team understand and capture this information in the patients' medical record to facilitate reporting.

Upcoming CMS Webinars

For more information about PQRS and the other ways you can increase your Medicare payments in 2013, or in the years ahead, attend one of two upcoming webinars on "CMS 2013 Medicare Incentives Programs." I've posted the handout from this webinar below.

Wednesday, May 1, 12:30 PM –2:00 PM EDT

http://www.eventbrite.com/event/6060470029#

Friday, May 3, 1:30 PM – 3:00 PM EDT

http://www.eventbrite.com/event/6060698713#

Tuesday, May 7, 2:30 PM – 4:00 PM EDT

http://www.eventbrite.com/event/6534552021

Wednesday, May 8, 11:30 AM – 1:00 PM EDT

http://www.eventbrite.com/event/6534951215

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Thursday, May 9, 7:00 PM – 8:30 PM EDT

http://www.eventbrite.com/event/6535252115

A recording of the CMS 2013 Medicare Incentives Webinar is available in the Adobe webinar room linked below:

https://webinar.cms.hhs.gov/p15399995/

2013 Incentive National Handout from CMS from **ManageMyPractice**

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12 Ways to Supercharge Your Practice in 2012: #12 – 9 Ways to Maximize Your Medicare Payments

Medicare has so many programs that have the potential to increase or decrease your payments that practices need a list to keep them straight.

Here’s your list with information on which programs are mutually exclusive and which can be combined.

1. Electronic Health Records (EHR) Incentive Program

- You must be an eligible provider to participate.
- You must be the owner of the EHR, although you do not need to have paid for the EHR.
- The EHR must be certified.
- You can choose to participate in Medicare (federally administered) or Medicaid (state administered) program.
- You must register for the programs.
- You must attest or document that you have adopted, implemented, upgraded or demonstrate meaningful use.
- Eligible professionals choosing to participate the Medicare program can each earn up to $44K over 5 years, and eligible professionals choosing to participate in the Medicaid program can each earn up to $63,750 over 6 years.

2. ePrescribing Incentive Program

- Eligible professionals do not need to register for the program.
- You can participate in one of three ways: via submitting codes on claim forms, via an EHR or via a registry
- Each professional needs to report 10 eRx events for Medicare patients for dates of service before June 30, 2012 OR apply for one of five exclusions or four exemptions.
- EPs who are successful e-prescribers can qualify to earn an incentive payment based on a percentage of their

total estimated Medicare PFS allowed charges processed not later than 2 months after the end of the reporting period. For reporting year 2012, EPs who are successful e-prescribers can qualify to earn an incentive payment equal to 1.0 percent of allowed charges. For reporting year 2013, EPs can qualify to earn an incentive payment of 0.5 percent of allowed charges. Beginning in 2012, EPs who are not successful e-prescribers in 2011 and do not qualify for a hardship exception will be subject to a payment adjustment equal to 1.0 percent of their Medicare PFS allowed charges. The payment adjustment increases to 1.5 percent in 2013 and 2.0 percent in 2014.

3. PQRS (Physician Quality Reporting System)

- Originally called PQRI (Physician Quality Reporting Initiative) is the basis for pay-for-performance models.
- Physicians may report individually or practices may choose a set of three measures that relate to the type of patients they see. Measures are performed and modifiers are attached to claims.
- Bonuses are available until 2014; starting in 2015 practices not participating in PQRS will receive a negative payment adjustment.
- For reporting years 2012 through 2014, EPs who satisfactorily report Physician Quality Reporting System measures will earn an incentive payment equal to 0.5 percent of allowed charges. Additionally, for reporting years 2011 through 2014, EPs who satisfactorily report Physician Quality Reporting System measures can qualify to earn an additional 0.5 percent incentive payment by, more frequently than is required to qualify for or maintain board certification status, participating in a

maintenance of certification program and successfully completing a qualified maintenance of certification program practice assessment. Beginning in 2015, EPs who do not satisfactorily report under the Physician Quality Reporting System will be subject to a payment adjustment equal to 1.5 percent of their Medicare PFS allowed charges. The payment adjustment increases to 2.0 percent in 2016 and beyond.

4. Medicare Wellness Visits

- Many practices are losing money due to the confusion over what Medicare pays for and what Medicare doesn't pay for. Medicare introduced three new visits in 2010 and many providers continue to have trouble understanding and providing them correctly.
- The "Welcome to Medicare" visit is technically called the "Initial Patient Physical Examination" (IPPE), but to everyone's dismay, it is not a physical examination at all, with the exception of basic visits such as height, weight, BMI, blood pressure and pulse, and the potential for an EKG and an Abdominal Aortic Aneurysm screening. The Annual Wellness Visit (AWV) and the Subsequent Annual Wellness Visit are not physical examinations either, yet almost ALL patients believe that Medicare now gives free annual physicals.
- Practices must train all staff and physicians to use the correct terminology first. I suggest everyone stop using the phrases "annual physical" or "complete physical" with Medicare patients. Patients can request and receive:
    - A Welcome to Medicare Visit with no exam (no deductible, no co-insurance)
    - A first annual Wellness Visit with no exam (no deductible, no co-insurance)
    - A Subsequent Annual Wellness Visit with no exam

every year thereafter (no deductible, no co-insurance)

- What patients think they want is either a preventive visit, which Medicare will NOT pay for, or a standard Evaluation & Management (E/M) visit, which their deductible and co-insurance will apply to.
- The only way the practice can win is by driving home to patients what Medicare does pay for and doesn't pay for and making sure your documentation matches the code you submit to Medicare.

5. The ABN (Advance Beneficiary Notice)

- Many practices miss revenue when they provide services to Medicare patients that are statutorily excluded from Medicare benefits.
- These may be services that do not meet the Medicare definition of medical necessity or are provided at more frequent intervals than Medicare approves.
- Identifying these non-covered services is the hard thing, however, unless your EMR can alert you to a service that will not be paid by Medicare, and if the patient requests the service and signs an ABN prior to the provision of the service In this case, the practice may collect the full fee from the patient.

6. Primary Care Incentive Payment Program (PCIP)

- Eligible Providers (Clinical Nurse Specialists, Nurse Practitioners, Physician Assistants, and Physicians who have their primary specialty designation in family

medicine, internal medicine, geriatric medicine or pediatric medicine) can receive a 10% incentive payment for services under Part B.

- The PCIP program, which was created by the Patient Protection and Affordable Care Act, requires Medicare to pay primary care providers, whose primary care billings comprise at least 60 percent of their total Medicare allowed charges, a quarterly 10-percent bonus from Jan. 1, 2011, until the end of December 2015.
- Eligible primary care physicians furnishing a primary care service in a Health Professional Shortage Area (HPSA) area may receive both a HPSA and a PCIP payment.

7. HPSA (Health Professional Shortage Area)

- Medicare makes bonus payments annually of 10% to physicians who provide medical care services in geographic areas that lack sufficient health care providers to meet the needs of the population.
- Payments are automatic; there is no need to register or report anything on the claim for
- If services are provided in ZIP code areas that do not fall entirely within a full county HPSA or partial county HPSA, the AQ modifier must be entered on the claim to receive the bonus.

8. HPSA (Health Professional Shortage Area) Surgical Incentive Payment (HSIP)

- The Affordable Care Act of 2010, Section 5501 (b)(4)

expands bonus payments for general surgeons in HPSAs. Effective January 1, 2011 through December 31, 2015, physicians serving in designated HPSAs will receive an additional 10% bonus for major surgical procedures with a 10 or 90 day global period.

- Payments are automatic; there is no need to register or report anything on the claim form.
- If services are provided in ZIP code areas that do not fall entirely within a full county HPSA or partial county HPSA, the AQ modifier must be entered on the claim to receive the bonus.

9. NEW! Comprehensive Primary Care Initiative (CPCi)

- Payment model per beneficiary per month (PBPM) for care management of Medicaid and Medicare patients
- Markets in Arkansas, Colorado, New jersey, New York, Ohio/Kentucky, Oklahoma and Oregon for Medicaid patients
- Arkansas, Colorado, Ohio and Oregon are the four states for Medicaid pilots.
- Multiple payers, including CMS, will be paying a monthly care management fee to support the 5 primary care functions of:
    - Risk-stratified care management
    - Access and continuity
    - Planned care for chronic care & preventive care
    - Patient & caregiver engagement
    - Coordination of care across the medical neighborhood
- Primary care practices in the states and markets can apply from June 15 to July 20, 2012 **(application here.**)

What Medicare Bonus or Incentive Programs Can Be Claimed Together?

- PQRS can claimed with eRx.
- PQRS can be claimed with EHR.
- HPSA and PCIP are automatic and are not affected by any other programs
- EHR and eRx can both be claimed but you cannot earn both an eRx incentive and an EHR incentive in the same year if you elect to receive the EHR incentive payment through Medicare. **NOTE: Just because you cannot claim the eRx bonus in conjunction with EHR incentive, you must still continue to ePrescribe to avoid the eRx penalty!**

Medicare This Week: National Provider Call on Registration and Attestation, New CMS Video Education on Youtube, Updates from the Medical Learning Network

- **National Provider Call: Medicare & Medicaid EHR Incentive Programs; Registration and Attestation for Eligible Professionals (jump to story)**

- **Provider Education Video Presentations Now Available on the CMS YouTube Channel (jump to story)**

- **Updates from the Medicare Learning Network (jump to story)**

National Provider Call: Medicare & Medicaid EHR Incentive Programs; Registration and Attestation for Eligible Professionals

Did you know that as of March 30, over $1.4 billion has been paid to eligible professionals (EPs) under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs? Over 222,000 EPs have actively registered to participate in the programs. This is the last year EPs can earn the full Medicare incentive payment – don't let this opportunity pass you by. Learn what you need to do to participate in the program.

Target Audience: Eligible Professionals (EPs): Doctors of Medicine or Osteopathy, Doctors of Dental Surgery or Dental Medicine, Doctors of Podiatric Medicine, Doctors of Optometry,

Chiropractors, Nurse Practitioners, Certified Nurse Midwives, Physician Assistants (PA) who practice at an FQHC/RHC led by a PA. (NOTE: Hospital-based EP's may not participate – An EP is considered hospital-based if 90% or more of the EP's services are performed in a hospital inpatient or emergency room setting). For more information, including Medicaid patient volume requirements, visit the EHR Incentive Programs Eligibility webpage.

Registration information will be provided soon on the CMS Upcoming National Provider Calls webpage.

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Provider Education Video Presentations Now Available on the CMS YouTube Channel

CMS has posted a selection of provider education presentations on a variety of Medicare Program topics to the CMS YouTube Channel, including the following presentations listed below. Click on the title to view the presentation.

Medicare Shared Savings Program

- ~~Medicare Shared Savings Program and Advance Payment Model Application Process – This presentation was presented on March 1, 2012. CMS subject matter experts provide an overview and updates to the Medicare Shared Savings Program application and Advance Payment Model application processes, followed by a question and answer session. Run time: 59 minutes.~~
  UPDATE: A new presentation has been posted with a slideshow from a national provider call on July 31st,

2012
Watch the NEW Medicare Shared Savings Program and Advance Payment Model Application Process. Run time: 83 minutes.

- Medicare Shared Savings Program Overview – This presentation was presented on December 7, 2011. John Pilotte, Director of the Performance-Based Payment Policy Group at CMS presents an overview of the Medicare Shared Savings Program, followed by a question and answer session. Run time: 50 minutes.

Hospital Value-based Purchasing

- Hospital Value-based Purchasing: Dry Run of the FY 2013 Hospital VBP Program – This presentation was presented on February 28, 2012. CMS subject matter experts provide an overview and updates on the Hospital Value-Based Purchasing Program for fiscal year 2013 and how hospitals will be evaluated. A question and answer session follows the presentations. Run time: 90 minutes.
- Medicare Spending Per Beneficiary Measure – This presentation was presented on February 9, 2012. CMS subject matter experts provide an overview on the background of the Medicare Spending Per Beneficiary Measure, as well as an explanation of how the measure is calculated, including the approach to risk adjustment and payment standardization. Run time: 84 minutes.

Physician Quality Reporting System and Electronic Prescribing Incentive Program

- Welcome to the Electronic Prescribing eRx Incentive Program – This presentation was recorded on March 28, 2012. CMS subject matter experts provide an overview of the Medicare Electronic Prescribing (eRx) Incentive Program. Highlights include a brief program background, a look at the program website and documentation, high-level steps on how to get started; available resources

and who to contact for help. Run time: 16 minutes.

- Welcome to the Physician Quality Reporting System – This presentation was recorded on February 1, 2012. CMS subject matter experts provide an overview of the Medicare Physician Quality Reporting System. Highlights include a brief background of the program, a look at the program website and documentation, high-level steps to get you started, available resources and who to contact for help. Run time: 15 minutes.

Medicare Physician Feedback Program

- Medicare Physician Feedback Program: Payment Standardization and Risk Adjustment – This presentation was presented on December 21, 2011. CMS subject matter experts discuss how and why per capita cost measures are adjusted under the Physician Feedback Program and in the Quality and Resource Use Reports. This call provided an opportunity to: (1) have a public dialogue about our methodology, (2) obtain stakeholder input, and (3) discuss ways to further improve these cost adjustment processes. Run time: 118 minutes.

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Updates from the Medicare Learning Network

From the MLN: New Fast Fact and Archive on MLN Provider Compliance Webpage – A new fast fact is now available on the MLN Provider Compliance webpage. This webpage provides the latest Medicare Learning Network® (MLN) products designed to help Medicare Fee-For-Service providers understand – and avoid – common billing errors and other improper activities. You can

now view previous fast facts on the MLN Provider Compliance Fast Fact Archive page. Please bookmark this page and check back often as a new fast fact is added each month.

From the MLN: "Negative Pressure Wound Therapy Interpretive Guidelines" MLN Matters® Article Released – MLN Matters® Special Edition Article #SE1222, "Negative Pressure Wound Therapy Interpretive Guidelines" has been released and is now available in downloadable format. This article is designed to provide education on CMS-approved guidelines that accrediting organizations can use to accredit suppliers that provide Negative Pressure Wound Therapy (NPWT) equipment to Medicare beneficiaries. It includes a list of relevant local coverage determinations and standards to help DMEPOS suppliers comply with standards and guidelines for NPWT equipment.

From the MLN: "Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards" Booklet Revised – Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Quality Standards Booklet (ICN 905700) has been revised and is now available in downloadable and hard copy format. This booklet is designed to provide education on durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). It includes DMEPOS quality standards as well as information on Medicare deemed Accreditation Organizations (AOs) for DMEPOS suppliers.

From the MLN: "Quick Reference Information: Preventive Services" and "Quick Reference Information: Medicare Immunization Billing" Revised – The MLN has revised the recently updated Quick Reference Information: Preventive Services (ICN 006559) and Quick Reference Information: Medicare Immunization Billing (ICN 006799) educational tools. We have updated these charts to include the recently released flu code Q2034. All other information remains the same.

From the MLN: "Medicare Fraud & Abuse: Prevention, Detection, and Reporting" Web-Based Training – New – This Web-Based

Training (WBT) course is designed to provide education on how to identify Medicare fraud and abuse and understand the related laws and penalties. It includes information on what entities and safeguards protect against and detect fraud and abuse, as well as how you can help prevent and report it. Continuing education credit is available for this course. To access a new or revised WBT course, visit the MLN Products webpage and click on "Web-Based Training (WBT) Courses" under "Related Links" at the bottom of the webpage.

From the MLN: "Explaining the Difference Between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN)" MLN Matters® Article Released –

MLN Matters® Special Edition Article #SE1216, "Explaining the Difference Between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN)" has been released and is now available in downloadable format. This article is designed to provide education on the differences between a National Provider Identifier (NPI) and a Provider Transaction Access Number (PTAN). It includes information about new enrollees, revalidation, the relationship between the NPI and PTAN, and how providers can protect their identity in the Provider Enrollment Chain & Ownership System (PECOS).

From the MLN: "MLN Products Catalog" Revised – The MLN has revised the MLN Products Catalog. The May 2012 MLN Products Catalog is a free interactive downloadable document that links you to online versions of MLN products or the product ordering page for hardcopy materials. Once you have opened the catalog, you may either click on the title of an individual product or on "Formats Available."

HHS Releases a Proposed Rule for ICD-10 Go-Live October 2014

Today HHS announced a proposed rule **(complete rule here – 175 page pdf)** that would delay the go live for ICD-10 from October 1, 2013 to October 1, 2014. What follows are excerpts from the proposed rule.

Why Has HHS Proposed a Change to the Live Date for ICD-10-CM and ICD-10-PCS?

The final rule adopting ICD-10-CM and ICD-10-PCS (collectively, "ICD-10") as HIPAA standard medical data code sets was published in the Federal Register on January 16, 2009. The ICD-10 final rule requires covered entities to use ICD-10 beginning October 1, 2013.

In late 2011 and early 2012, **three issues** emerged that led Secretary of HHS Kathleen Sebelius to reconsider the compliance date for ICD-10:

1. The industry transition to Version 5010 did not proceed as effectively as expected;
2. Providers expressed concern that other statutory initiatives are stretching their resources; and
3. Surveys and polls indicated a lack of readiness for the ICD-10 transition.

The Transition to Version 5010

As the industry approached the January 1, 2012 Version 5010 compliance date, a number of implementation problems emerged,

some of which were unexpected. These included–

- Trading partners were **not ready** to test the Version 5010 standards due to vendor delays in delivering and installing Version 5010-compliant software to their provider clients;
- Version 5010 errata were issued to correct **typographical mistakes** and other maintenance issues that were discovered as the industry began its internal testing of the standards, which delayed vendor delivery of compliant products and external testing;
- Differences between address requirements in the "provider billing address" and "pay to" address fields adversely affected **crossover claims processing;**
- **Inconsistent payer interpretation** of standard requirements at the front ends of systems resulted in rejection of claims, as well as other technical and standard misinterpretation issues;
- Edits made in test mode that were later **changed** when claims went into production without adequate notice of the change to claim submitters; and
- **Insufficient end to end testing** with the full scope of edits and business rules in place to ensure a smooth transition to full production.

Given concerns that industry would not be compliant with the Version 5010 standards by the January 1, 2012 compliance date, the HHS announced on November 17, 2011 that they would not initiate any enforcement action against any covered entity that was not in compliance with Version 5010 until March 31, 2012, to enable industry adequate time to complete its testing and software installation activities. **On March 15, 2012, this date was extended an additional 3 months, until June 30, 2012.**

The ICD-10 final rule set October 1, 2013 as the compliance date, citing industry testimony presented to NCVHS (National Committee on Vital and Health Statistics) and many of the over 3,000 industry comments received on the ICD-10 proposed rule.

The analysis in the ICD-10 final rule with regard to setting a compliance date emphasized the interdependency between implementation of ICD-10 and Version 5010, and the need to balance the benefits of ICD-10 with the need to ensure adequate time for preparation and testing before implementation.

As noted in the ICD-10 final rule, "[w]e cannot consider a compliance date for ICD-10 without considering the dependencies between implementing Version 5010 and ICD-10. We recognize that any delay in attaining compliance with Version 5010 would negatively impact ICD-10 implementation and compliance." (74 FR 3334) Based on NCVHS recommendations and industry feedback received on the proposed rule, we determined that "24 months (2 years) is the minimum amount of time that the industry needs to achieve compliance with ICD-10 once Version 5010 has moved into external (Level 2) testing." (74 FR 3334) In the ICD-10 final rule, we concluded that the October 2013 date provided the industry adequate time to change and test systems given the 5010 compliance date of January 1, 2012.

As implementation of ICD-10 is predicated on the successful transition of industry to Version 5010, we are concerned that the delays encountered in Version 5010 have affected ICD-10 planning and transition timelines.

Providers have Expressed Concern that Other Statutory Initiatives are Stretching Their Resources

Since publication of the ICD-10 and Modifications final rules, a number of other statutory initiatives were enacted, requiring health care provider compliance and reporting. Providers are concerned about their ability to expend limited resources to implement and participate in the following initiatives that all have similar compliance timeframes:

1. **The EHR Incentive Program** was established under the Health Information Technology for Economic and Clinical Health (HITECH) Act, a part of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5). Medicare and Medicaid incentive payments are available to eligible professionals and hospitals for adopting electronic health record (EHR) technology and demonstrating meaningful use of such technology. Eligible professionals and hospitals that fail to meaningfully use EHR technology could be subject to Medicare payment adjustments beginning in FY 2015.
2. **The Physician Quality Reporting System** is a voluntary reporting program that provides incentives payments to eligible professionals and group practices that satisfactorily report data on quality measures for covered Physician Fee Schedule services furnished to Medicare Part B Fee-for-Service beneficiaries.
3. **The eRx Incentive Program** is a reporting program that uses a combination of incentive payments and payment adjustments to encourage electronic prescribing by eligible professionals. Beginning in 2012 through 2014, eligible professionals who are not successful electronic prescribers are subject to a payment adjustment.
4. Finally, section 1104 of the Affordable Care Act imposes **additional HIPAA Administrative Simplification requirements** on covered entities.

<u>January 1, 2013</u>

• Operating rules for eligibility for a health plan and health care claim status transactions

<u>December 31, 2013</u>

• Health plan compliance certification requirements for health care electronic funds transfers (EFT) and remittance advice, eligibility for a health plan, and health care claim status transactions

<u>January 1, 2014</u>

- Standards and operating rules for health care electronic funds transfers (EFT) and remittance advice transactions

December 31, 2015

- Health plan compliance certification requirements for health care claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, health care claims attachments, and referral certification and authorization transactions

January 1, 2016

- Standard for health care claims attachments
- Operating rules for health care claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, referral certification and authorization transactions

Proposed October 1, 2014

- Unique health plan identifier

Current State of Industry Readiness for ICD-10

It is crucial that all segments of the health care industry transition to ICD-10 at the same time because the failure of any one industry segment to successfully implement ICD-10 has the potential to affect all other industry segments. Ultimately, such failure could result in returned claims and provider payment delays that disrupt provider operations and negatively impact patient access to care.

In early 2012, it became evident that sectors of the health care industry would not be prepared for the October 1, 2013 ICD-10 compliance date. Providers in particular voiced concerns about their ability to meet the ICD-10 compliance date as a result of a number of factors, including obstacles they experienced in transitioning to Version 5010 HIPAA Requirements from the Affordable Care Act and the other

initiatives that stretch their resources. A CMS survey conducted in November and December 2011 (hereinafter referred to as the CMS readiness survey) found that 26 percent of providers surveyed indicated that they are at risk for not meeting the October 1, 2013 compliance date.

Given the evidence that segments of the health care industry will likely not meet the October 1, 2013 compliance date, the reasons for that likelihood, and the likelihood that a compliance date delay would significantly improve the successful and concurrent implementation of ICD-10 across the health care industry, we are proposing to extend the compliance date for ICD-10.

One-Year Delay Justification

The HHS is proposing to extend the compliance date for ICD-10 for 1 year, from October 1, 2013 to October 1, 2014. This change would be reflected in the regulations at 45 CFR 162.1002. While a number of alternatives were considered for the delay, as discussed in the Impact Analysis of this proposed rule, it is believed a 1-year delay would provide sufficient time for small providers and small hospitals to become ICD-10 compliant and would be the least financially burdensome to those who had planned to be compliant on October 1, 2013.

To determine the new compliance date for ICD-10, the need for additional time for small providers and small hospitals to become compliant was balanced with the financial burden of a delay on entities that have developed budgets and planned process and system changes around the October 1, 2013 compliance date. Entities that have started planning and working toward an October 1, 2013 implementation would incur costs by having to reassess and adjust implementation plans and maintain contracts to manage the transition beyond October 1, 2013. We concluded that a 1-year delay would strike a reasonable balance by providing sufficient time for small

providers and small hospitals to become compliant and would minimize the financial burden on those entities that have been actively planning and working toward being compliant on October 1, 2013.

Finally, in its March 2, 2012 letter to the Secretary on a possible delay of the ICD-10 compliance date, the NCVHS urged that any delay should be announced as soon as possible and should not be for more than 1 year. The NCVH made this recommendation in consideration of its belief that a delay would cause a significant financial burden "that accrues with each month of delay."

The HHS believes that a 1-year delay would benefit all covered entities, even those who had are actively planning and striving for a 2013 implementation. A 1-year delay would enable the industry as a whole to test more robustly and implement simultaneously, which would foster a smoother and more coordinated transition to ensure the continued and uninterrupted flow of health care claims and payment.

Therefore, the HHS is proposing that covered entities must comply with ICD-10 on October 1, 2014.

Bonus: Some Interesting Data I Found in the ICD-10 Proposed Rule:

- The total number of health care claims in 2013 is projected to be 5.8 billion.
- The cost to health plans for manually processing a pended claim is $2.30 per claim.
- According to the Medical Group Management Association (MGMA), the staff time required to manually process a returned claim is 15 minutes, at a cost of approximately $4.14 for labor, a factor derived from the Bureau of Labor Statistics. This includes staff time spent to correct the error and resubmit claims that are returned.
- Using the experience of one university's bachelor's-

level health information management program, students take the ICD coding course in the spring of their junior year. Students enrolling in Spring 2012 courses will graduate in May 2013. Anticipating the October 1, 2013 compliance date, the university started offering ICD-10 courses this spring in place of ICD-9 with the understanding that it will be preparing students for employment after graduating in 2013. If ICD-10 is delayed a year, as proposed in this rule, the 30 students in the program will have to take ICD-9 courses in addition to their ICD-10 courses in order to obtain the ICD-9 competencies to get jobs. The extra course will cost each of the 30 students approximately $2,000 (in-state tuition) or a total of $61,000.

- Total cost of a 1-year delay in the compliance date of ICD-10 = $3,808M (mean average)
- According to the U.S. Census Bureau, Detailed Statistics, 2007 Economic Census, there are approximately 220,100 physician practices.. The U.S. Census Bureau data indicates that two percent of physician practices have revenues of $10 million or more, therefore approximately 4,400 physician practices are not small entities.
- According to the Small Business Administration’s size standards, a small entity is defined as follows according to health care categories: Offices of Physicians are defined as small entities if they have revenues of $10 million or less; most other health care providers (dentists, chiropractors, optometrists, mental health specialists) are small entities if they have revenues of $7 million or less; hospitals are small entities if they have revenues of $34.5 million or less.
- The 2007 Census Bureau reports that there are approximately 6,500 hospitals. The data indicates that 85 percent of hospitals have sales/receipts/revenues of $10 million or more.
- Statistics cost of delaying ICD-10 to 2014 were based

on:

- Physician practices with less than 50 physicians = 233,239
- Physician practices with 50 to 100 physicians = 590
- Physician practices with more than 100 physicians = 393
- Hospitals with less than 100 beds = 2757
- Hospitals with 100 to 400 beds = 2486
- Hospitals with more than 400 beds = 521

Haven’t Started Your ICD-10 Preparations Yet?

Start your plan by reviewing the resources below:

- Centers for Medicare and Medicaid Services (CMS) ICD-10 overview
- American Health Information Management Association (AIHMA) ICD-10 implementation
- American Academy of Professional Coders (AAPC) ICD-10 implementation

Manage My Practice offers ICD-10 transition help to physician practices, focusing on documentation improvement to support ICD-10 coding. For more information, please complete the contact form ***here.***