2025 Medicare Update Part 3

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Disclosures

Gabriel Halperin, DPM, FACFAS, DABFAS has no relevant financial interests to disclose.

Disclosure will be made when a product is discussed for an unapproved use.

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Commercial support was not received for this activity.

Learning Objectives

- Identify new programs that CMS is planning
- Analyze the Medicare Carrier's expectations regarding our documentation
- Demonstrate to use the language of the LCD to protect our documentation
- Understand the different audits and appeals
- Introduce potential new services that can enhance, ethically, our office income
- Identify the sources available to us to code correctly for services rendered to our patients

2025 MIPS

2024 MIPS EXCEPTION

- MIPS EUC EXCEPTION APPLICATIONS MAY BE USED TO REQUEST REWEIGHTING FOR ANY OR ALL FOUR MIPS PERFORMANCE CATEGORIES IF A MIPS ELIGIBLE CLINICIAN ENCOUNTERS AN EXTREME SITUATION BEYOND THEIR CONTROL.
- NOTE THAT CMS WILL NOT ACCEPT MIPS EUC EXCEPTION APPLICATIONS DUE TO COVID-19 FOR THE 2024 PERFORMANCE YEAR.
- ELIGIBLE CLINICIANS AND GROUP PRACTICES MAY USE THE 2024 MIPS EUC EXCEPTION APPLICATION IF THEY WERE IMPACTED BY DISRUPTIONS RELATED TO THE CHANGE HEALTHCARE CYBERATTACK IN LATE FEBRUARY 2024.

- **CHANGE HEALTHCARE IS A SUBSIDIARY OF UNITED HEALTH GROUP. THE CYBER-ATTACK HAD IMPACTED WITH FINANCIAL CONSEQUENCES FOR PATIENTS, PROVIDERS, AND COMMUNITIES. THE IMPACT ON PROVIDERS MADE DELAYED AND INTERRUPTED ON CLAIM SUBMISSION, ERA RETRIEVAL AND PAYMENT.**
- **ON THE EXTREME AND UNCONTROLLED CIRCUMSTANCES EXCEPTION APPLICATION, YOU CAN CHECK ON EVENT TYPE FOR RANSOM/MALWARE (CHANGE HEALTHCARE CYBERATTACK).**

MIPS

If prevented the provider “from collecting MIPS data for an extended period of time.”

2025 MIPS EXCEPTION

2025 PHE WILDFIRES EXCEPTION

- THIS IS WHAT WE HAVE BEEN TOLD:
- AUTOMATIC EXCEPTION
- DO NOT SEND IN ANY MIPS DOCUMENTATION YET
- CMS WILL ANNOUNCE THE EXCEPTION IN MARCH
- WILL BE INDIVIDUAL AND GROUP
- WILL BE ON THE QPP PAGE

MIPS PERFORMANCE INFORMATION

2024 Quality Performance category

Quality Measures
30% of Final Score

Improvement Activities
15% of Final Score

Promoting Interoperability
25 % of Final Score

Cost Measure
30% of Final Score

2025 Quality Performance category – the same score weight with 2024

Quality Measures
30% of Final Score
This percentage can change due to :
Special Statuses, Exception applications or APM Entity Participation

Improvement Activities
15% of Final Score
This percentage can change due to :
Special statuses or Exception applications

Promoting Interoperability
25 % of Final Score
This percentage can change due to :
Special statuses, Exception applications or APM Entity Participation

Cost Measure
30% of Final Score
This percentage can change due to :
Exception applications

MIPS PERFORMANCE INFORMATION

2025 Performance year

- 75 Point performance threshold the same as previous year 2024
- 75% Maintain Data completeness requirement through 2028 performance year
- MIPS Payment Adjustments range from -9% to +2.15%
- Data Submission – January 02 - March 31, 2026

MIPS PERFORMANCE INFORMATION

MIPS 2025 Requirements:

QUALITY MEASURES

SUBMIT COLLECTED DATA FOR AT LEAST 6 MEASURES

(INCLUDING OUTCOME MEASURE OR HIGH PRIORITY MEASURE) OR

A COMPLETE SPECIALTY MEASURE SET.

6 BONUS POINTS WILL CONTINUE TO BE ADDED FOR CLINICIANS IN SMALL PRACTICES WHO AT LEAST SUBMIT ONE MEASURE.

Promoting Interoperability

Submit collected data for the required measures in each objective (unless an exclusion is claimed) for the same 180 continuous days or more during a year.

Submitted data required to use an EHR's CMS identification code from the Certified Health IT Product List (ASTP)

Automatic Reweighed which means that exempt from reporting:

- Ambulatory Surgical Center (ASC)-based
- Hospital-based
- Non-patient facing
- Small practice (can be applied to APM entities)

Hardship Exception may apply:

- Using decertified EHR technology
- Insufficient Internet connectivity
- Extreme and uncontrollable Circumstances
- Lack of control over the availability of CEHRT

MIPS PERFORMANCE INFORMATION

MIPS 2025 Requirements:

IMPROVEMENT ACTIVITIES

CLINICIANS, GROUPS AND VIRTUAL GROUPS WITH SMALL PRACTICE, RURAL, NON-PATIENT FACING OR HEALTH PROFESSIONAL SHORTAGE AREA –SPECIAL STATUS MUST ATTEST TO 1 ACTIVITY

ALL OTHER CLINICIANS, GROUPS AND VIRTUAL GROUPS MUST ATTEST TO 2 ACTIVITIES

IN THE 2025 PERFORMANCE PERIOD, IMPROVEMENT ACTIVITIES WON'T BE WEIGHED

IMPROVEMENT ACTIVITIES HAVE A MINIMUM OF A CONTINUOUS 90-DAYS PERFORMANCE PERIOD DURING CALENDAR YEAR 2025

Cost Measures

Clinicians and groups don't have to submit any data for this performance category.

MIPS will use Medicare administrative claims data to calculate cost measure performance

MIPS PERFORMANCE INFORMATION

MIPS 2025 Quality Measures alternatives for PODIATRY

MEASURE NAME	MEASURE DESCRIPTION	eMEASURE ID	eMEASURE NQF	NQF	QUALITY ID	NQS DOMAIN	MEASURE TYPE	HIGH PRIORITY MEASURE	DATA SUBMISSION METHOD	SPECIALTY MEASURE SET	PRIMARY MEASURE STEWARD
QPP SPECIALITY: PODIATRY											
Connection to Community Service Provider	Percent of patients 18 years or older who screen positive for one or more of the following health related social needs (HRSNs): food insecurity, housing instability, transportation needs, utility help needs, or interpersonal safety; and had contact with a Community Service Provider (CSP) for at least 1 of their HRSNs within 60 days after screening.	None	None	None	486	None	Process	TRUE	MIPS clinical quality measures (MIPS CQMs)	Allergy/Immunology,Audiology,Cardiology,Certified Nurse Midwife,Chiropractic Medicine,Clinical Social Work,Dermatology,Emergency Medicine,Endocrinology,Family Medicine,Gastroenterology,General Surgery,Geriatrics,Infectious Disease,Internal Medicine,Interventional Radiology,Mental/Behavioral Health,Nephrology,Neurology,Neurosurgical,Nutrition/ Dietician,Obstetrics/Gynecology,Oncology,Ophthalmology,Orthopedic Surgery,Otolaryngology,Pediatrics,Physical Medicine,Physical Therapy/Occupational Therapy,Plastic Surgery,Podiatry,Preventive Medicine,Pulmonology,Rheumatology,Skilled Nursing Facility,Speech Language Pathology,Thoracic Surgery,Urgent Care,Urology,Vascular Surgery	OCHIN
Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy - Neurological Evaluation	Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months.	None	None	None	126	None	Process	FALSE	MIPS clinical quality measures (MIPS CQMs)	Endocrinology,Family Medicine,Internal Medicine,Physical Therapy/Occupational Therapy,Podiatry,Preventive Medicine	American Podiatric Medical Association
Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention - Evaluation of Footwear	Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who were evaluated for proper footwear and sizing.	None	None	None	127	None	Process	FALSE	MIPS clinical quality measures (MIPS CQMs)	Physical Therapy/Occupational Therapy,Podiatry	American Podiatric Medical Association
Falls: Plan of Care	Percentage of patients aged 65 years and older with a history of falls that had a plan of care for falls documented within 12 months.	None	None	0101	155	None	Process	TRUE	MIPS clinical quality measures (MIPS CQMs)	Audiology,Family Medicine,Geriatrics,Internal Medicine,Neurology,Orthopedic Surgery,Otolaryngology,Physical Medicine,Physical Therapy/Occupational Therapy,Podiatry,Preventive Medicine,Skilled Nursing Facility	National Committee for Quality Assurance
Falls: Screening for Future Fall Risk	Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.	CMS139v13	None	0101	318	None	Process	TRUE	Electronic clinical quality measures (eCQMs)	Audiology,Family Medicine,Geriatrics,Internal Medicine,Nephrology,Orthopedic Surgery,Otolaryngology,Physical Therapy/Occupational Therapy,Podiatry	National Committee for Quality Assurance

MEASURE NAME	MEASURE DESCRIPTION	eMEASURE ID	eMEASURE NQF	NQF	QUALITY ID	NQS DOMAIN	MEASURE TYPE	HIGH PRIORITY MEASURE	DATA SUBMISSION METHOD	SPECIALTY MEASURE SET	PRIMARY MEASURE STEWARD
Functional Status Change for Patients with Lower Leg, Foot or Ankle Impairments	A patient-reported outcome measure (PROM) of risk-adjusted change in functional status (FS) for patients 14 years+ with foot, ankle or lower leg impairments. The change in FS is assessed using the FOTO Lower Extremity Physical Function (LEPF) PROM. The measure is adjusted to patient characteristics known to be associated with FS outcomes (risk adjusted) and used as a performance measure at the patient, individual clinician, and clinic levels to assess quality.	None	None	None	219	None	Patient Reported Outcome	TRUE	MIPS clinical quality measures (MIPS CQMs)	Chiropractic Medicine,Orthopedic Surgery,Physical Therapy/Occupational Therapy,Podiatry	Focus on Therapeutic Outcomes, Inc.
Gains in Patient Activation Measure (PAM) Scores at 12 Months	The Patient Activation Measure (PAM) (Registered Trademark) is a 10- or 13- item questionnaire that assesses an individual's knowledge, skills and confidence for managing their health and health care. The measure assesses individuals on a 0-100 scale that converts to one of four levels of activation, from low (1) to high (4). The PAM performance measure (PAM-PM) is the change in score on the PAM from baseline to follow-up measurement.	None	None	2483	503	None	Patient Reported Outcome	TRUE	MIPS clinical quality measures (MIPS CQMs)	Allergy/Immunology,Cardiology,Certified Nurse Midwife,Clinical Social Work,Dermatology,Endocrinology,Family Medicine,Gastroenterology,Geriatrics,Infectious Disease,Internal Medicine,Nephrology,Neurology,Obstetrics/Gynecology,Oncology,Physical Therapy/Occupational Therapy,Podiatry,Preventive Medicine,Pulmonology,Rheumatology,Urology	Insignia Health, LLC, a wholly owned subsidiary of Phreesia
Patient-Centered Surgical Risk Assessment and Communication	Percentage of patients who underwent a non-emergency surgery who had their personalized risks of postoperative complications assessed by their surgical team prior to surgery using a clinical data-based, patient-specific risk calculator and who received personal discussion of those risks with the surgeon.	None	None	None	358	None	Process	TRUE	MIPS clinical quality measures (MIPS CQMs)	General Surgery,Orthopedic Surgery,Otolaryngology,Plastic Surgery,Podiatry,Thoracic Surgery,Urology,Vascular Surgery	American College of Surgeons
Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	Percentage of patient visits for patients aged 18 years and older seen during the measurement period who were screened for high blood pressure AND a recommended follow-up plan is documented, as indicated, if blood pressure is elevated or hypertensive.	CMS22v13	None	None	317	None	Process	FALSE	Medicare Part B claims measures,Electronic clinical quality measures (eCQMs),MIPS clinical quality measures (MIPS CQMs)	Allergy/Immunology,Audiology,Cardiology,Dermatology,Emergency Medicine,Gastroenterology,General Surgery,Mental/Behavioral Health,Nephrology,Neurology,Oncology,Orthopedic Surgery,Otolaryngology,Physical Medicine,Plastic Surgery,Podiatry,Rheumatology,Skilled Nursing Facility,Urgent Care,Urology,Vascular Surgery	Centers for Medicare & Medicaid Services

MEASURE NAME	MEASURE DESCRIPTION	eMEASURE ID	eMEASURE NQF	NQF	QUALITY ID	NQS DOMAIN	MEASURE TYPE	HIGH PRIORITY MEASURE	DATA SUBMISSION METHOD	SPECIALTY MEASURE SET	PRIMARY MEASURE STEWARD
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Percentage of patients aged 12 years and older who were screened for tobacco use one or more times during the measurement period AND who received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period if identified as a tobacco user.	CMS138v13	None	None	226	None	Process	FALSE	Medicare Part B claims measures,Electronic clinical quality measures (eCQMs),MIPS clinical quality measures (MIPS CQMs)	Allergy/Immunology,Audiology,Cardiology,Certified Nurse Midwife,Clinical Social Work,Dermatology,Endocrinology,Gastroenterology,General Surgery,Infectious Disease,Mental/Behavioral Health,Nephrology,Neurology,Neurosurgical,Nutrition/Dietician,Oncology,Ophthalmology,Optometry,Orthopedic Surgery,Otolaryngology,Pediatrics,Physical Medicine,Physical Therapy/Occupational Therapy,Plastic Surgery,Podiatry,Pulmonology,Radiation Oncology,Rheumatology,Speech Language Pathology,Thoracic Surgery,Urgent Care,Urology,Vascular Surgery	National Committee for Quality Assurance
Screening for Social Drivers of Health	Percent of patients 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.	None	None	None	487	None	Process	TRUE	MIPS clinical quality measures (MIPS CQMs)	Allergy/Immunology,Audiology,Cardiology,Certified Nurse Midwife,Chiropractic Medicine,Clinical Social Work,Dermatology,Emergency Medicine,Endocrinology,Family Medicine,Gastroenterology,General Surgery,Geriatrics,Infectious Disease,Internal Medicine,Interventional Radiology,Mental/Behavioral Health,Nephrology,Neurology,Neurosurgical,Nutrition/Dietician,Obstetrics/Gynecology,Oncology,Ophthalmology,Orthopedic Surgery,Otolaryngology,Pediatrics,Physical Medicine,Physical Therapy/Occupational Therapy,Plastic Surgery,Podiatry,Preventive Medicine,Pulmonology,Rheumatology,Skilled Nursing Facility,Speech Language Pathology,Thoracic Surgery,Urgent Care,Urology,Vascular Surgery	Centers for Medicare & Medicaid Services

MEASURE NAME	MEASURE DESCRIPTION	eMEASURE ID	eMEASURE NQF	NQF	QUALITY ID	NQS DOMAIN	MEASURE TYPE	HIGH PRIORITY MEASURE	DATA SUBMISSION METHOD	SPECIALTY MEASURE SET	PRIMARY MEASURE STEWARD
QPP MEASURE: GENERAL											
Adult COVID-19 Vaccination Status - **NEW IN 2026**	Percentage of patients aged 18 years and older seen for a visit during the performance period that are up to date on their COVID-19 vaccinations as defined by Centers for Disease Control and Prevention (CDC) recommendations on current vaccination.	None	None	None	500	None	Process	FALSE	MIPS clinical quality measures (MIPS CQMs)	Allergy/Immunology,Cardiology,Endocrinology,Family Medicine,Geriatrics,Infectious Disease,Internal Medicine,Nephrology,Obstetrics/Gynecology,Oncology,Pathology,Pulmonology,Radiation Oncology,Skilled Nursing Facility,Speech Language Pathology,Vascular Surgery	Centers for Medicare & Medicaid Services
Adult Immunization Status	Percentage of patients 19 years of age and older who are up-to-date on recommended routine vaccines for influenza; tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap); zoster; and pneumococcal.	None	None	2620	493	None	Process	FALSE	MIPS clinical quality measures (MIPS CQMs)	Allergy/Immunology,Cardiology,Endocrinology,Family Medicine,Geriatrics,Infectious Disease,Internal Medicine,Nephrology,Obstetrics/Gynecology,Oncology,Otolaryngology,Preventive Medicine,Pulmonology,Rheumatology,Skilled Nursing Facility	National Committee for Quality Assurance
Advance Care Plan	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	None	None	0326	047	None	Process	TRUE	Medicare Part B claims measures,MIPS clinical quality measures (MIPS CQMs)	Cardiology,Certified Nurse Midwife,Clinical Social Work,Family Medicine,Gastroenterology,General Surgery,Geriatrics,Hospitalists,Internal Medicine,Nephrology,Neurology,Obstetrics/Gynecology,Oncology,Orthopedic Surgery,Otolaryngology,Physical Medicine,Preventive Medicine,Pulmonology,Rheumatology,Skilled Nursing Facility,Thoracic Surgery,Urology,Vascular Surgery	National Committee for Quality Assurance
Controlling High Blood Pressure	Percentage of patients 18-85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure was adequately controlled (<140/90mmHg) during the measurement period.	CMS165v13	None	None	236	None	Intermediate Outcome	TRUE	Medicare Part B claims measures,Electronic clinical quality measures (eCQMs),MIPS clinical quality measures (MIPS CQMs)	Cardiology,Endocrinology,Family Medicine,Internal Medicine,Obstetrics/Gynecology,Pulmonology,Rheumatology,Vascular Surgery	National Committee for Quality Assurance

MEASURE NAME	MEASURE DESCRIPTION	eMEASURE ID	eMEASURE NQF	NQF	QUALITY ID	NQS DOMAIN	MEASURE TYPE	HISH PRIORITY MEASURE	DATA SUBMISSION METHOD	SPECIALTY MEASURE SET	PRIMARY MEASURE STEWARD
Documentation of Current Medications in the Medical Record	Percentage of visits for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter.	CMS68v14	None	None	130	None	Process	TRUE	Electronic clinical quality measures (eCQMs),MIPS clinical quality measures (MIPS CQMs)	Allergy/Immunology,Audiology,Cardiology,Certified Nurse Midwife,Clinical Social Work,Dermatology,Endocrinology,Family Medicine,Gastroenterology,General Surgery,Geriatrics,Hospitalists,Infectious Disease,Internal Medicine,Mental/Behavioral Health,Nephrology,Neurology,Neurosurgical,Nutrition/ Dietician,Obstetrics/Gynecology,Oncology,Ophthalmology,Optometry,Orthopedic Surgery,Otolaryngology,Physical Medicine,Physical Therapy/Occupational Therapy,Plastic Surgery,Preventive Medicine,Pulmonology,Rheumatology,Speech Language Pathology,Thoracic Surgery,Urgent Care,Urology,Vascular Surgery	Centers for Medicare & Medicaid Services
Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan	Percentage of patients aged 18 years and older with a BMI documented during the current encounter or within the previous twelve months AND who had a follow-up plan documented if most recent BMI was outside of normal parameters.	CMS69v13	None	None	128	None	Process	FALSE	Medicare Part B claims measures,Electronic clinical quality measures (eCQMs),MIPS clinical quality measures (MIPS CQMs)	Not Available	Centers for Medicare & Medicaid Services

Note:	Highlight are the measures sorted by specialty on QPP: Podiatry
	Please review on specification for Collection types (there are 5 types of collection/submission), Diagnosis (ICD-10 CM), Procedures (CPT Codes) and Service Performed (Place of Services) that qualify on the measure you choose.

MIPS PERFORMANCE INFORMATION

MIPS 2025 QPP Exception Applications

- Apply to MIPS eligible Clinicians, groups and virtual groups.
- Reweight any or all MIPS performance categories

2 Exception applications available to clinicians:

The MIPS Extreme and uncontrollable Circumstances (EUC) Exception

Submit an application to reweight for **any or all performance categories (encounter an extreme and uncontrollable circumstance that outside your control)**, such as:

- Unable to collect Information
- Unable to submit information
- Impact normal processes

The MIPS Promoting Interoperability Performance category Hardship Exception

Submit to request **reweighting specifically for the Promoting Interoperability performance category** if qualify, such as:

- Decertified HER technology
- Insufficient Internet connectivity
- Lack control over the availability of CEHRT
- Face extreme and uncontrollable circumstances such as disaster, practice closure, severe financial distress or vendor issue

Apply MIPS Exception Application by sign-in on **qpp.cms.gov** and choose “Exception Application” and select “Extreme and Uncontrollable Circumstances or Promoting interoperability Hardship.

If approved, you don’t have to report for the requested MIPS performance category or categories and those categories will be reweighed

The application submission deadline is December 31, 2025

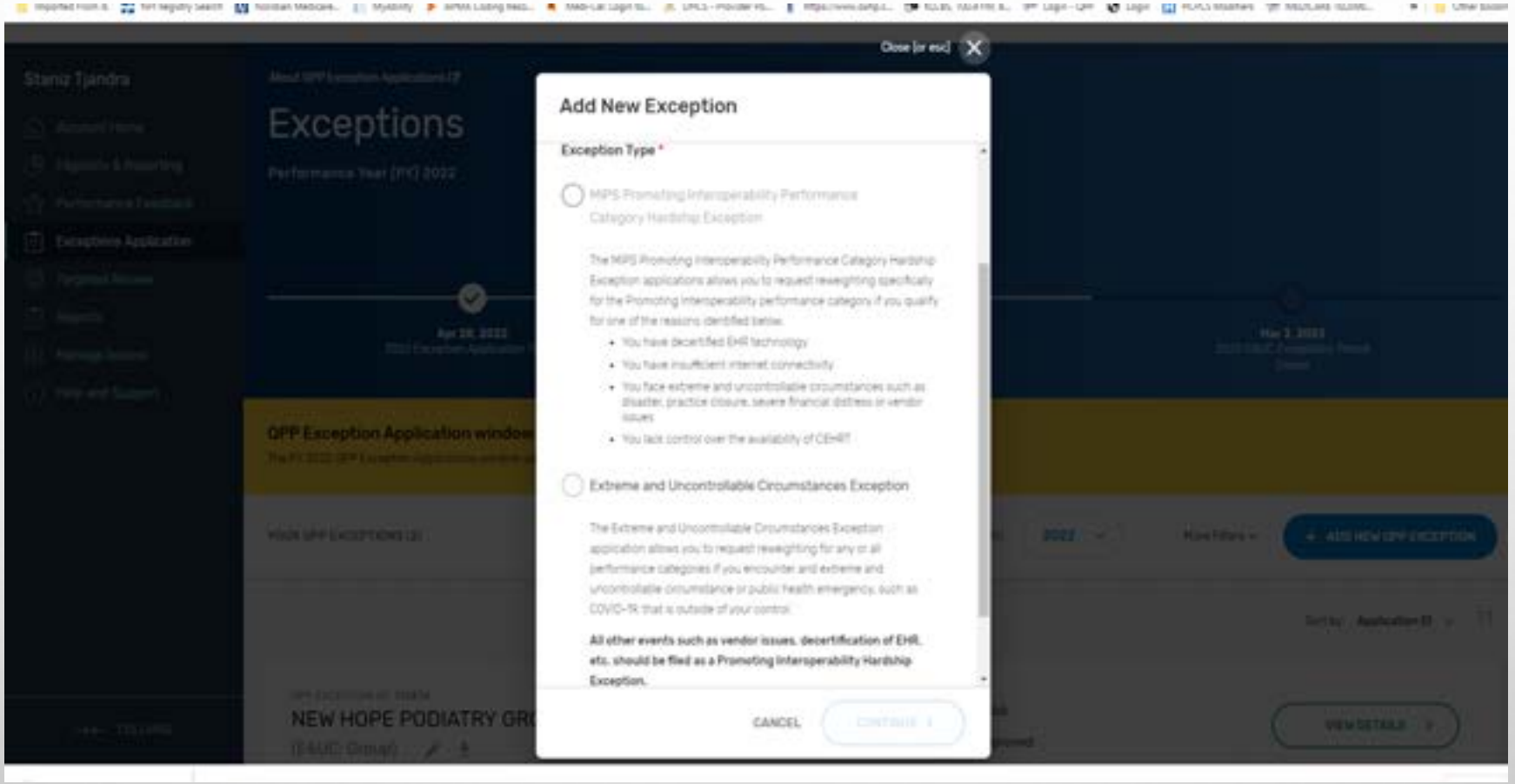
Apply for Exception Application

Go to qpp.cms.gov and Login
On the Account Home, scroll down on Exception application and click

start an application

Or the left side, choose "Exception Application"
On the right over the top, click on +ADD NEW QPP EXCEPTION
Will pop up window with details to select and select "Extreme and Uncontrollable Circumstances". (sample on next slide)
Most of cases will get approve right away and sometimes need to get approval after their review.

The MIPS 2025 EUC Exception application will be available in the spring 2025 and will remain open until December 31, 2025


Close (or esc)
Add New Exception
Exception Type *
MIPS Promoting Interoperability Performance Category Hardship Exception
The MIPS Promoting Interoperability Performance Category Hardship Exception applications allows you to request reweighting specifically for the Promoting Interoperability performance category if you qualify for one of the reasons identified below.
You have decertified EHR technology
You have insufficient internet connectivity
You face extreme and uncontrollable circumstances such as disaster, practice closure, severe financial distress or vendor issues
You lack control over the availability of CEHRT
Extreme and Uncontrollable Circumstances Exception
The Extreme and Uncontrollable Circumstances Exception application allows you to request reweighting for any or all performance categories if you encounter and extreme and uncontrollable circumstance or public health emergency, such as COVID-19, that is outside of your control.
All other events such as vendor issues, decertification of EHR, etc. should be filed as a Promoting Interoperability Hardship Exception.
CANCEL
Exceptions
Staniz Tjandra
NEW HOPE PODIATRY GR

MIPS 2024
GABRIEL J HALPERIN - PODIATRY

MIPS 2024 QUALITY MEASURES — NEW HOPE PODIATRY GROUP INC

#47*
Advance Care Plan: Communication and Care Coordination

*Percentage of patients **aged 65 years and older** who have an advance care plan or surrogate decission maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan and **NOT HOSPICE***

#126
Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy - Neurological Evaluation

Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months.

#127
Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention - Evaluation of Footwear

*Percentage of patients **aged 18 years and older** with a diagnosis of diabetes mellitus who were evaluated for proper footware and sizing*

#155*
Falls: Plan of Care

*Percentage of patients **aged 65 years and older** with a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with injury). Documentation of patient reported history of falls is sufficient and **NOT HOSPICE***

#130*
Documentation of Current Medications in Medical Record

*Percentage of visits for patients **aged 18 years and older** for which the eligible professional or clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list **must** include ALL known prescriptions, over-the-counters (OTC) products, herbals, and vitamins, minerals, dietary (nutritional) supplements AND **must** contain the medications' name, dosage, frequency and route of administration*

***All visits occuring** during the 12 month performance period*

493 Adult Immunization Status

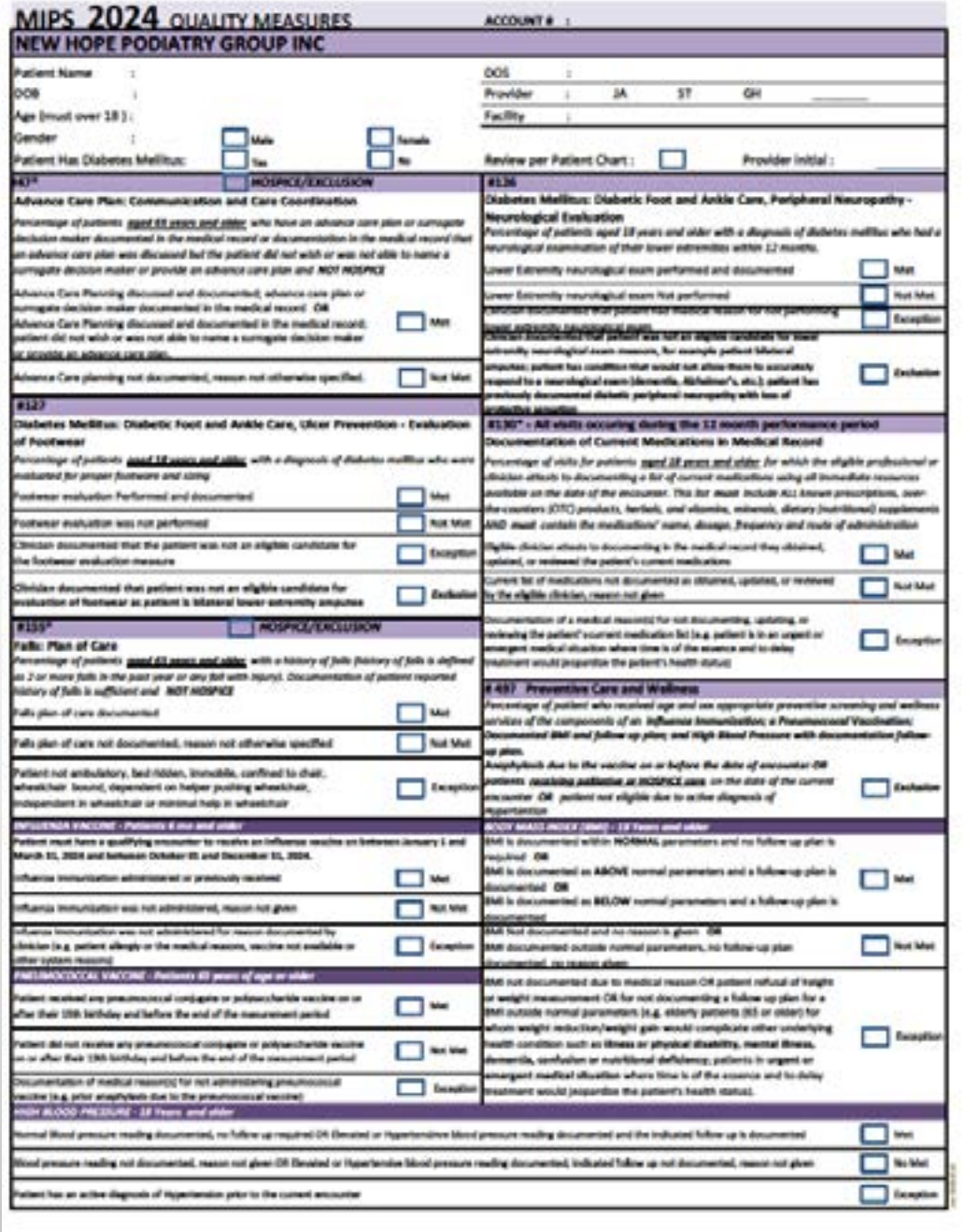
*Percentage of patient 19 years of age and older who are up-to-date on recommended routine vaccine for **Influenza; Tetanus and Diphtheria (Td) or Tetanus, Diphtheria and acellular Pertussis (Tdap); Zoster and Pneumoccocal.***

*Active Chemotherapy during the measurement period **OR** bone marrow transplant during the measurement period **OR** In **HOSPICE** or using Hospice services during the measurement period **OR** History of Immunocompromising condition, cochear implants, anatomic or functional asplenia, sickle cell anemia & hemoglobin diseaseor cerebrospinal fluid leaks any time during the patient's history prior to or during the measurement period. (HIV-B20 ; ESRD-N186)*

INFLUENZA VACCINE - Patients 19 years of age and older	Pneumococcal Conjugate VACCINE - Patients 66 years of age or older
Patient received or did not receive an Influenza vaccine on or between July 1 of the year prior to measurement period and June 30 of the measurement period	Patient received or did not receive any pneumococcal conjugate or polysaccharide vaccine on or after their 60th birthday and before the end of the mesurement period
Td or Tdap VACCINE - Patients 19 years of age and older	**Herpes Zoster VACCINE - on or after the Patients 50th birthday**
Patient received or did not receive at least one Td vaccine or one Tdap vaccine between 9 years prior to the encounter and the end of the measurement period	Patient received or did not receive at least one dose of the herpes zoster live vaccine or two doses of the herpes zoster recombinant vaccine (at least 28 days apart) anytime on or after the patients 50th birthday before or during the measurement period

MIPS 2024 QUALITY MEASURES WORKSHEET

GABRIEL J HALPERIN - PODIATRY



MIPS 2024 QUALITY MEASURES

ACCOUNT # :

NEW HOPE PODIATRY GROUP INC

Patient Name :

DOB :

Age (must over 18) :

Gender : Male Female

Patient Has Diabetes Mellitus: Yes No

DOS :

Provider : JA ST GH

Facility :

Review per Patient Chart : Provider Initial :

#47* HOSPICE/EXCLUSION

Advance Care Plan: Communication and Care Coordination

Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan and NOT HOSPICE

Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record OR Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker — Met

Advance Care planning not documented, reason not otherwise specified — Not Met

#127

Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention - Evaluation of Footwear

Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who were evaluated for proper footwear and sizing

Footwear evaluation Performed and documented — Met

Footwear evaluation was not performed — Not Met

Clinician documented that the patient was not an eligible candidate for the footwear evaluation measure — Exception

Clinician documented that patient was not an eligible candidate for evaluation of footwear as patient is bilateral lower extremity amputee — Exclusion

#155* HOSPICE/EXCLUSION

Falls: Plan of Care

Percentage of patients aged 65 years and older with a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with injury). Documentation of patient reported history of falls is sufficient and NOT HOSPICE

Falls plan of care documented — Met

Falls plan of care not documented, reason not otherwise specified — Not Met

Patient not ambulatory, bed-ridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair — Exception

INFLUENZA VACCINE - Patients 6 mo and older

Patient must have a qualifying encounter to receive an influenza vaccine on between January 1 and March 31, 2024 and between October 01 and December 31, 2024.

Influenza immunization administered or previously received — Met

Influenza immunization was not administered, reason not given — Not Met

Influenza immunization was not administered for reason documented by clinician (e.g. patient allergy or the medical reasons, vaccine not available or other system reasons) — Exception

PNEUMOCOCCAL VACCINE - Patients 65 years of age or older

Patient received any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period — Met

Patient did not receive any pneumococcal conjugate or polysaccharide vaccine on or after their 19th birthday and before the end of the measurement period — Not Met

Documentation of medical reason(s) for not administering pneumococcal vaccine (e.g. prior anaphylaxis due to the pneumococcal vaccine) — Exception

#126

Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy - Neurological Evaluation

Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months.

Lower Extremity neurological exam performed and documented — Met

Lower Extremity neurological exam Not performed — Not Met

Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure, for example patient bilateral amputee; patient has condition that would not allow them to accurately respond to a neurological exam (dementia, Alzheimer's, etc.); patient has previously documented diabetic peripheral neuropathy with loss of protective sensation — Exception

Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure, for example patient bilateral amputee; patient has condition that would not allow them to accurately respond to a neurological exam (dementia, Alzheimer's, etc.); patient has previously documented diabetic peripheral neuropathy with loss of protective sensation — Exclusion

#130* - All visits occuring during the 12 month performance period

Documentation of Current Medications in Medical Record

Percentage of visits for patients aged 18 years and older for which the eligible professional or clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters (OTC) products, herbals, and vitamins, minerals, dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration

Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications — Met

Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given — Not Met

Documentation of a medical reason(s) for not documenting, updating, or reviewing the patient's current medication list (e.g. patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status) — Exception

69 / Preventive Care and Wellness

Percentage of patient who received age and sex appropriate preventive screening and wellness services of the components of an Influenza Immunization; a Pneumococcal Vaccination; Documented BMI and follow up plan; and High Blood Pressure with documentation follow-up plan.

Anaphylaxis due to the vaccine on or before the date of encounter OR patients receiving palliative or HOSPICE care on the date of the current encounter OR patient not eligible due to active diagnosis of hypertension — Exclusion

BODY MASS INDEX (BMI) - 18 Years and older

BMI is documented within NORMAL parameters and no follow up plan is required OR BMI is documented as ABOVE normal parameters and a follow-up plan is documented OR BMI is documented as BELOW normal parameters and a follow-up plan is documented — Met

BMI Not documented and no reason is given OR BMI documented outside normal parameters, no follow-up plan documented, no reason given — Not Met

BMI not documented due to medical reason OR patient refusal of height or weight measurement OR for not documenting a follow up plan for a BMI outside normal parameters (e.g. elderly patients (65 or older) for whom weight reduction/weight gain would complicate other underlying health condition such as illness or physical disability, mental illness, dementia, confusion or nutritional deficiency; patients in urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status) — Exception

HIGH BLOOD PRESSURE - 18 Years and older

Normal Blood pressure reading documented, no follow up required OR Elevated or Hypertensive blood pressure reading documented and the indicated follow up is documented — Met

Blood pressure reading not documented, reason not given OR Elevated or Hypertensive blood pressure reading documented, indicated follow up not documented, reason not given — Not Met

Patient has an active diagnosis of hypertension prior to the current encounter — Exception

MIPS 2024 AND 2025
GABRIEL J HALPERIN - PODIATRY

Improvement Activities for PODIATRY

ACTIVITY NAME	ACTIVITY DESCRIPTION	ACTIVITY ID	SUBCATEGORY NAME	ACTIVITY WEIGHTING
Patient Navigator Program	Implement a Patient Navigator Program that offers evidence-based resources and tools to reduce avoidable hospital readmissions, utilizing a patient-centered and team-based approach, leveraging evidence-based best practices to improve care for patients by making hospitalizations less stressful, and the recovery period more supportive by implementing quality improvement strategies.	IA_CC_17	Care Coordination	None

SAMPLE APPROVE HARDSHIP LETTER FOR GABRIEL J HALPERIN – PODIATRY 2024

Exported on: 12/24/2024

2024 QPP EXCEPTION ID: 167191

NEW HOPE PODIATRY GROUP INC (E&UC. Group)

Status: Submitted - Approved

Group Details

Group TIN

*****3166

Group Practice Name

NEW HOPE PODIATRY GROUP INC

Submitter Details

Submitted By

Staniz Tjandra

Preferred Contact Information

(323) 264-7796

Contact Email Address

uelingw@cslwound.com

Submitter/Third Party Intermediary Relationship

Physician Staff

Additional Staff Access Email(s)

Not Defined

Extreme and Uncontrollable Circumstances Details

Event Type

Ransom/ Malware (Change Healthcare Cyberattack)

Event Date Range

02/21/2024 - 10/31/2024

Event Description

Delayed and interupted on claim submission, ERA retrieve and payment.

Performance Categories Affected

Quality, Improvement Activities, Promoting Interoperability, Cost

COMPLETE INFORMATION FOR MIPS:

https://qpp.cms.gov

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Legislative Update

House Committee Leadership Changes

Committee	Retiree
Financial Services	Chair Patrick McHenry (R-NC)
Rules	Chair Michael Burgess (R-TX)
Energy and Commerce	Chair Cathy McMorris Rodgers (R-WA)
Appropriations	Chair Kay Granger (R-TX)
Select China	Chair Mike Gallagher (R-WI)

Health Committee Departures

House Energy and Commerce Retirees

- **Republicans**
  - McMorris Rodgers (WA)
  - Burgess (TX)
  - Bucshon (IN)
  - Pence (IN)
  - Duncan (SC)
  - Armstrong (ND)
- **Democrats**
  - Kuster (NH)
  - Eshoo (CA)
  - Cardenas (CA)
  - Sarbanes (MD)
  - Blunt Rochester (DE)

House Ways and Means Retirees

- **Republicans**
  - Wenstrup (OH)
  - Drew Ferguson (GA)
- **Democrats**
  - Blumenauer (OR)
  - Kildee (MI)

Health Committee Additions

House Energy and Commerce Hopefuls

- **Republicans**
  - Fry (SC)
  - Langworthy (NY)
  - Keane (NJ)
  - Laurel Lee (FL)
  - Hunt (TX)
  - Bentz (OR)
- **Democrats**
  - Ross (NC) - McClellan (VA)
  - Carter (LA) - Mullin (CA)
  - Magaziner (RI) - Casten (IL)
  - Crockett (TX) - Levin (CA)
  - Stansbury (NM) - Deluzio (PA)
  - Sykes (OH) - Wild (PA)
  - Menendez (NJ) - Sorensen (IL)
  - Caraveo (CO) - Petterson (CO)

House Ways and Means Hopefuls

- **Republicans**
  - Yakym (IN)
  - Beane (FL)
  - McCormick (GA)
  - Collins (GA)
  - Miller (OH)
  - Timmons (SC)
- **Democrats**
  - **Plasket (VI)**
  - **Horsford (NV)**
  - **Boyle (PA)**
  - **Souzzi (NY)**
  - Stevens (MI) - Torres (NY)
  - Salinas (OR) - McBath (GA)
  - Strickland (WA) - Cherfilus-McCormick (FL)
  - Auchincloss (MA)
  - McGarvey (KYO
  - Jayapal (WA)

Health Care Impact

- **Work to be completed from 118th Congress:**
  - PBMs / Telehelath / Public Health Reauthorizations (SUPPORT Act, PAHPA) / Medicare physician payments
- **Looking ahead for 2025**
  - Debt Ceiling / Individual Tax Cuts Extensions
  - ACA Exchange Subsidies
  - Medicare physician payment reform?
  - Medicare Advantage policies?
  - More Drug Pricing?

APMA Priorities in 119th Congress

- **Losing a Champion for Podiatry – need to find new champions**

- **Need members from all parts of Congress that bring new experiences and have already begun the process:**
  - Sen. Todd Young (R-IN) – new lead R cosponsor for 118th
  - Dr. John Joyce (R-PA) – Doc Caucus and E&C
  - Darren Soto (D- FL) - E&C and history in FL legislature

- **Need more engagement, including:**
  - New Senate Democrat Lead for HELLP: Peters (D-MI) or Blunt-Rochester (D-DE) both potential new Finance members
  - Develop depth on E&C R and D to support long time supporters Guthrie (Potential E&C Chair) and DeGette (potential Health Sub Ranker)

APMA Priorities in Trump Administration

- **What will Trump's health priorities be?**
  - Provider Flexibility / Red Tape Relief
  - ACA changes - How to lower costs
  - HHS Secretary?
    - RFK. Jr
  - CMS Administrator?
    - Dr OZ
  - WH Staff
    - Drew Keyes (Speaker Johnson); Conor Sheehy (Senate Finance); Brian Blase (Paragon)

2024 Year-End Priorities

Medicare Fee Schedule

Abatement of cuts

MEI update

DEA/MATE Act

Extenders

PAHPA Reauthorization

NDAA

Board Certification

Allied Corps > Medical Corps

Lead Efforts to Advance Parity and Modernize Scope of Practice

Ensure podiatrists are recognized and permitted to practice to the full extent of their education and training in all laws and regulations.

- Implement federal **legislatives priorities** based on direction from members, APMA Legislative Committee and APMA Board.
- Advocate for legislation and regulatory policies which **promote parity in federal programs** such as Medicare and Medicaid.
- Identify and recruit **congressional Podiatry Champions** who will prioritize APMA's identified goals.
- Partner with state components on **state-level regulatory and legislative targets** with national impact.
- Develop a **nationwide scope of practice plan** at APMA's State Advocacy Forum.
- Leverage **CPA Financial Assistance and Innovation Grants** for states to advance overall nationwide strategy.
- Develop and implement **research and analytics plan** to create advocacy collateral.

Ensure Fair Reimbursement & Financial Sustainability

Ensure fair and sustainable payment rates for services provided by podiatrists.

- Advocate for legislation and regulatory policies that **promote access, quality, and fair reimbursements.**
- Ensure **podiatry's seat at legislative and regulatory tables** to ensure the establishment of reasonable and effective medical coverage policies.
- Engage policymakers in implementing the **Provider Engagement Model for CAC meetings** with CAC Engagement Coalition and MAC Workgroup.
- Develop and implement next steps for **CMS Coverage and Analysis Group (CAG).**
- **Develop APMA payment principles** and advocate with policymakers for market-driven, reasonable increases in physician reimbursement.
- **Oppose health insurer policies** that create an unnecessary burden or provide inappropriate reimbursement for essential patient services.
- Work with state components to develop a **national plan to address modifier (-59 and -25) abuse** including engagement with health insurers.
- Partner with AMA and other provider associations and on **a whitecoat advocacy effort** to demand Medicare Economic Index (MEI) payment reforms.

Expand Access to Quality, Patient-Centered Care

Expand access to lower extremity care provided by podiatrists, especially in underserved areas.

- Advocate for **expanded access to meaningful telehealth services** provided by podiatrists.
- **Expand coverage for services** provided by podiatrists under Medicare/Medicaid.
- Develop multispecialty coalition and engage legislative and regulatory policymakers as well as private payors regarding the **inclusion of APMA's Comprehensive Diabetic Lower Extremity Exam (CDLEE)**.

Ensure Continuity for a Strong Podiatry Workforce

Lead efforts for educational programs, policies, & funding to recruit, retain, and grow the podiatric workforce.

- Advocate for **development, reinstatement, and expansion of loan forgiveness programs** like the federal public health student loan program through Health Resources and Services Administration (HRSA).
- Create **data-driven advocacy collateral on the value of podiatry** in integrated care teams in all care settings and the implications and outcomes on quality and access.
- Continue to **grow and award scholarships** to all podiatric students through the Foundation.
- **Create a coalition of stakeholders** to advance recruitment, retention, and growth of podiatric workforce.
- Partner with MGMA, to **develop workforce/compensation report** for advocacy and for podiatrists to effectively negotiate fair compensation.

Public Promotion of Podiatry

Educate policymakers and the public on the role of podiatrists in preventing and managing chronic conditions.

- Lead national health initiatives and participate in local, state and national initiatives to **raise awareness about podiatric medicine and its benefits**.
- Lead a coalition of organizations to **improve public awareness of podiatry**, student recruitment and advocacy efforts in collaboration with other key organizations.
- Develop action plan to **address the downturn in Therapeutic Shoes for Persons with Diabetes (TSD) prescription and dispensing**, including a coalition of stakeholders, required research to demonstrate need, and specific program goals.
- **Identify, develop, and promote quality measures** which highlight the quality of care provided by podiatrists in public health programs (Medicare, Medicaid, VA, etc.)

How will we do it?

- Develop and implement plans to support/oppose/amend federal legislation
- Identify and engage stakeholders in the formation of new coalitions
- Leverage eAdvocacy on the state and national level.
- Identify and enfranchise State Advocates to serve as peer leaders.
- Develop resources and programs and provide education for APMA members to engage policymakers through grassroots political action and advocacy.
- Grow the APMAPAC and engage in more events to support podiatric advocacy champions.
- Utilize evidence-based, data-driven approach to research and education to develop meaningful advocacy collateral.
- Work with State components to reduce existing open CAC representative spots with Jurisdiction MACs.

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CAC / PIAC Meeting for 2024

November 2023

Washington DC

24th

Joint Annual National Podiatric Carrier Advisory Committee and Private Insurance Advisory Committee Meeting

November 15, 2024

Sheraton Suites Old Town

Alexandria, VA

CAC-PIAC

The CAC and PIAC structure consists of representatives appointed by state podiatric medical associations to assist members in resolving Medicare and private insurance-related concerns. Knowing and utilizing the state's appointed CAC and PIAC representatives, who are practicing podiatric physicians with expertise in dealing with insurance issues, may help in claims appeal, contracting, understanding medical policies, and more.

CAC-PIAC TO-DO'S

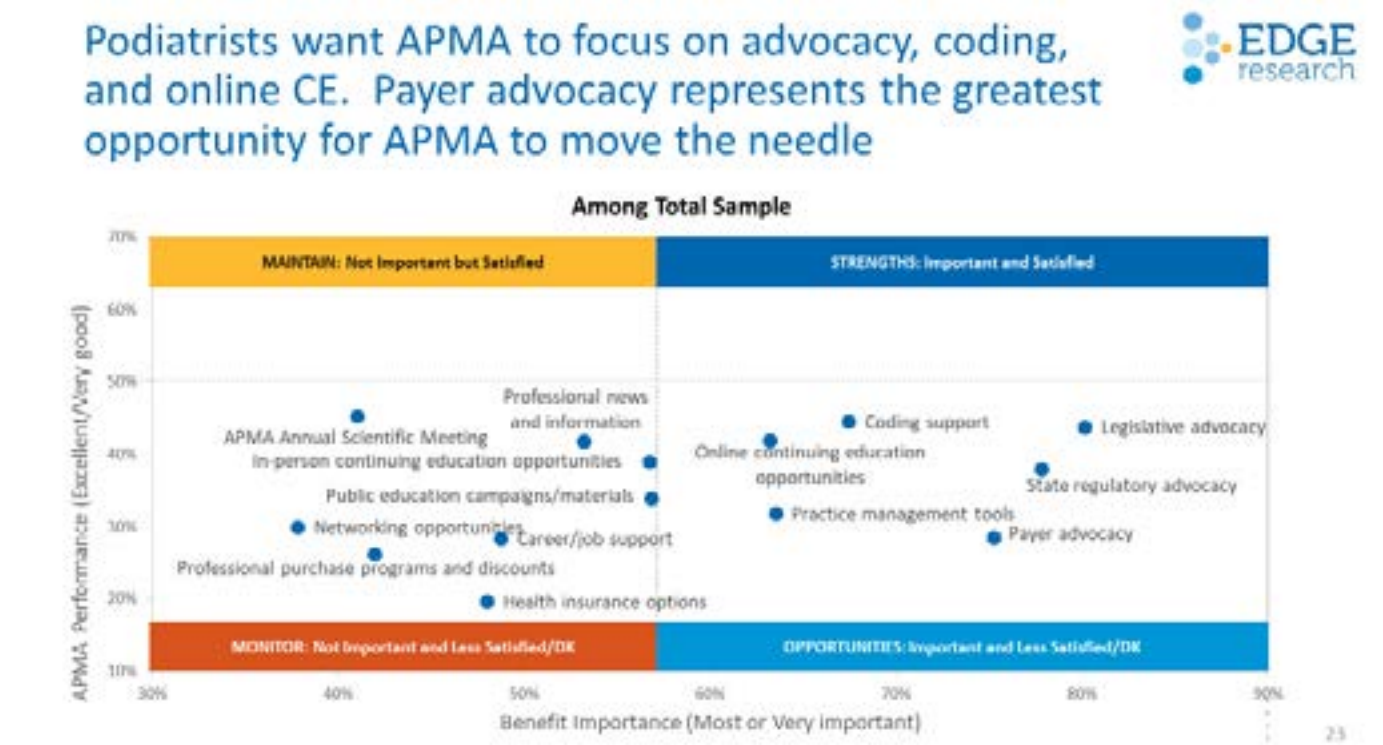
- Have a discussion with your state leaders about presenting this material with the members
- Share this PowerPoint presentation with you state association
- If you are serving as the official CAC representative for your state, be certain that their paperwork is formalized with their Medicare Administrative Contractor
- Check for updates on the proposed quarterly APMA Virtual CAC-PIAC follow up sessions
- Utilize tools and resources at www.apma.org/cacpiac
- Take Advantage of APMA Communities (https://apma.forumbee.com/) and new distribution lists cacpiac@apma.org, cac@apma.org, and piac@apma.org

2024 MEETING SUMMARY

Meeting Topics:

- APMA Update
- Medicare Update for 2025
- MIPS in 2025
- BMAD Data Update
- Working with CMDs and FCSO Update
- Legislative Update
- What It Means to be a CAC-PIAC Rep
- Private Insurance Issues and Advocacy

2024 APMA UPDATE



2024 APMA UPDATE - REGULATORY

- **Successful in having Novitas, First Coast, and others revise their Surgical Treatment of Nails LCAs to allow submission of medically necessary repeat nail avulsions and nail excisions**
- **Leading coalition working with CMS and MAC CMDs to ensure opportunities for CAC Reps to provide meaningful input**
- **Successfully advocated for Novitas and First Coast to add provider type for podiatrist to their claims processing systems**
- **Lobbied CMS and received MIPS Extreme and Uncontrollable Circumstances exception for providers impacted by the Change Healthcare cyberattack**

2024 APMA UPDATE - CPA

- **Victories**
  - **Proposal to restrict Wisconsin DPMs from using the terms "Physician" or Surgeon is defeated**
  - **Defeated efforts in NH, IA, and DC to combine DPM Board under Medical Licensing Board**
  - **Alabama to modernize scope**
- **Potential fix for DEA MATE omissions in Congress**
- **Ongoing support for Mississippi and Massachusetts in scope battles**
- **Developing Formal Position State on Call Payment**
- **Awarded almost $120K in assistance to states in Innovation and Assistance grants over past 5 years**

MEDICARE UPDATE FOR 2025

- **Final 2025 Conversion Factor: 32.2465 (-2.83% compared to 2024)**
  - **0.0% statutory annual update 0.02% budget neutrality adjustment**
  - **Elimination of Congressional assistance that was available for most of 2024 (2.93%)**
- **Medicare Telehealth Services**
  - **Waiver of geographic restrictions**
  - **Waiver of originating site requirements**
  - **Flexibilities will expire if congress doesn’t act fast**

MEDICARE UPDATE FOR 2025

- **Additional Flexibilities CMS**
  - **Removal of telehealth frequency limitations for:**
    - **Subsequent inpatient visits**
    - **Subsequent nursing facility visits**
    - **Critical care consultation services**
  - **Direct supervision via use of two-way audio/video communications technology**
  - **Use of virtual presence for teaching physician supervision – only when the service is being furnished virtually (resident and patient in different locations)**
  - **Waiver of requirement to report home address if they are providing telehealth services from their homes**
- **Additional Updates for Telehealth Policy for 2025 and Beyond**
  - **Permanently allowing audio-only telehealth and requiring the use of modifier 93 when certain conditions are met**

MIPS IN 2025

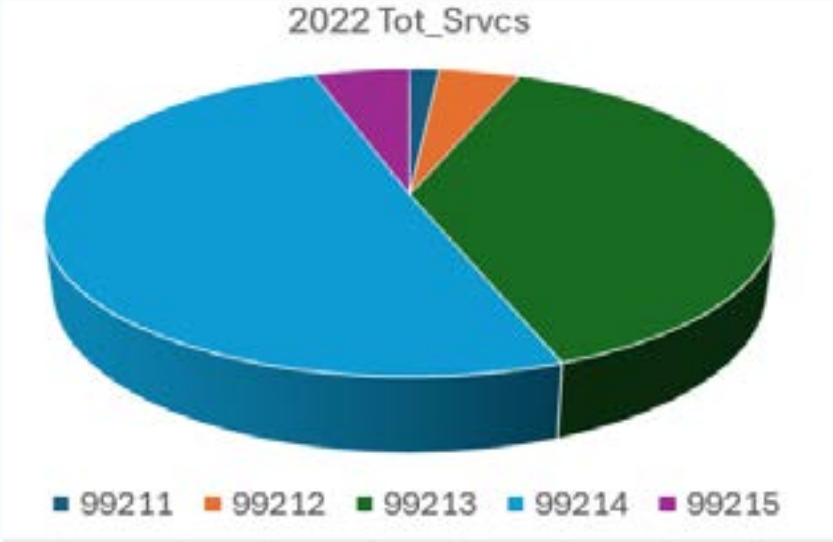
- **MIPS EUC Application**
  - **Application is not automatic**
  - **Go to: https://qpp.cms.gov/mips/exception-applications?py=2024**
- **MIPS Participation Status**
  - **Go to: https://qpp.cms.gov/participation-lookup**
- **2025 Updates**
  - **Minimum score threshold to avoid a penalty: 75 points (same as 2024)**
- **MIPS 2025 PY Webinar Services**
  - **www.apma.org/MIPSWebinars**
- **New resource page coming – keep eyes out for updates via *APMA Weekly Focus***

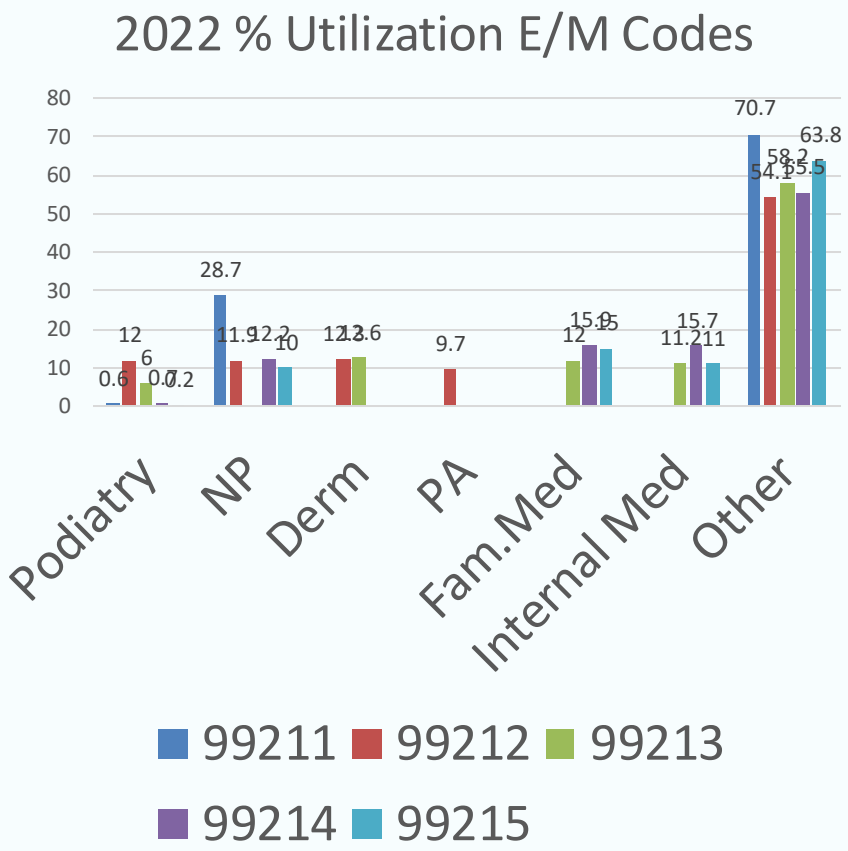
BMAD DATA UPDATE

- **Medicare Part A Spending in 2021**
  - **$$187,713,142,803**
- **Medicare Part B Spending in 2021**
  - **$208,409,052,818**
  - **Podiatry accounts for $2.9-3.3 billion (1.6-1.7% of all providers)**
- **Podiatry saw growth from 2017 to 2021**
- **Medicare Enrollee Demographics**
  - **Enrollment amongst 65+ increased**
  - **Medicare Advantage programs expanded by state/territory**
- **Durable Medical Equipment (DME)**
  - **Decline in the use of diabetic shoes from 2020 to 2022 (46% drop)**
  - **Total allowed amount for podiatry: $74,675,328, on total charges of $117,142,910**
  - **Average allowed amount per service deceased from $43 in 2018 to $42 in 2021**
  - **California, Floria, Pennsylvania, Georgia, New Jersey, Ohio, Maryland, and North Carolina were the top DME States of 2021**
  - **Charges in diabetic shoes has increased despite a decrease in usage**

BMAD DATA UPDATE

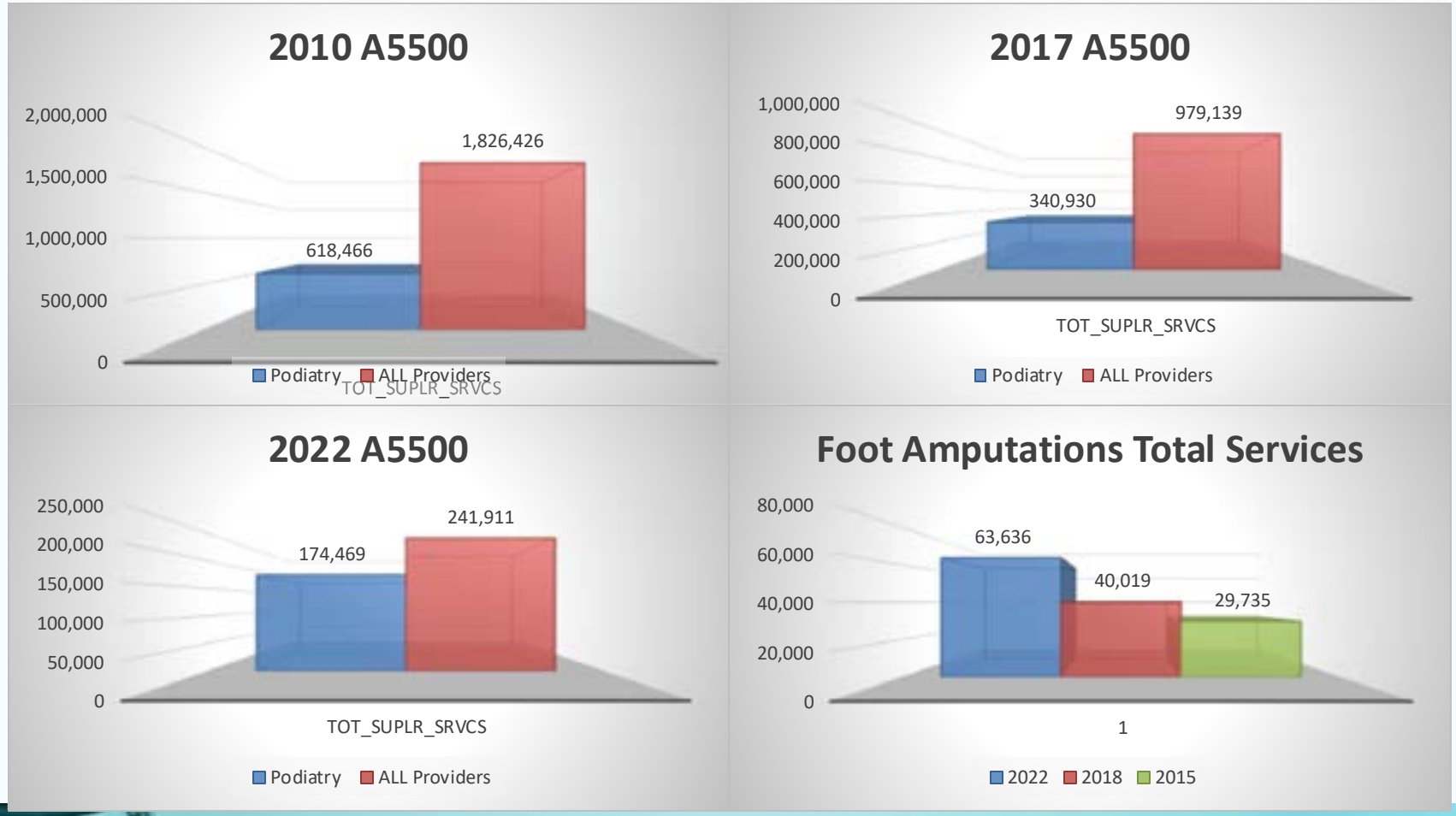
2022 % UTILIZATION E/M CODES





BMAD DATA UPDATE

Diabetic shoe trends 2010 + 2017 + 2022 for A5500-ALL DRs



WORKING WITH CMDS AND FCSO UPDATE

- MAC focuses on reasonable and necessary while the FDA focuses on safety
- The 2018 CURES Act
  - required MACs to write evidence-based policies and must be available for all environments while complying with section 1862 (A) (1) (A) of the Social Security Act
- Contractor Advisory Committee
  - Analogous to the role of MEDCAC
  - Role is to provide guidance on analyzing evidence
  - Must stay informed about data and studies used o develop policies
- Open Meeting for LCDs
  - Held after the proposed LCD is published for comment and occurs during the comment period

CAC BREAKOUT SESSIONS

MAC General (R=Rep, M=Member):

- **Are your members still experiencing complications that require redetermination for repeat CPT 11730 procedure, if so please explain in detail? (19% R, 27% M)**
- **Has your contractor instructed you to insert modifier KX for a medically reasonable and necessary repeat nail excision (CPT 11750) on the same toe? (13% M)**
- **Challenges with reimbursement related to nail trimming and debridement (CPT 11719-11721, G0127), along with corn and callus removal (CPT 11055-11057). Is this something as a representative you are experiencing today? (33% R, 53% M)**
- **Denial or reduction in payment when submitting significant and separately identifiable Evaluation and Management (E/M) services with other minor surgical procedures and the -25 modifier? (40% M)**
- **Issues related to RNs performing at-risk foot care. (14% R, 7% M)**
- **If your MAC does not allow for coverage of at-risk foot care when the underlying care for the asterisked condition is being provided by an NP or PA, has that been a problem for your members? (14% R, 27% M)**

LEGISLATIVE UPDATE

- **Utilize eAdvocacy!**
- **Legislative Updates**
  - **Several members from both Democratic and Republican parties are retiring from health committees**
  - **There are several new members joining committees these include for the House Energy and Commerce and the House Ways and Means**
- **Health Care Impact**
  - **Work that needs to be completed from the 118th Congress include PBMS, telehealth, public health authorizations, and Medicare physician payments**
  - **In 2025 there may be changes to the debt ceiling, individual tax cut extensions, ACA exchange subsidies, Medicare physician payment reform, Medicare advantage policies, and Medicare drug pricing**
- **Priorities for the 119th Congress**
  - **There is a need for more champions and engagement in legislation for podiatry**

WHAT IT MEANS TO BE A CAC-PIAC REP

- CAC and PIAC representatives are appointed by their state components to help resolve Medicare and private insurance concerns
- Process
  - CAC-PIAC representatives must have the knowledge and information that can develop over the years
  - Mentorship is essential in the growth and development of new CAC-PIAC representatives
  - APMA provides a wealth of resources for CAC-PIAC representatives to learn both the basics and resources needed to be successful in their role.
- Purpose of CAC
  - Create a mechanism for healthcare providers to stay up to date on evidence used to create LCDs
  - Encourage communication between the MAC and the healthcare community
  - Allow the representatives to review and provide feedback on quality of evidence used to make decisions

WHAT IT MEANS TO BE A CAC-PIAC REP

- **Purpose of PIAC**
  - **Provide guidance on how to resolve private insurance issues**
  - **Must understand coding and how insurance claims are processed**
  - **Provide recommendations for members about handling insurances issues as outlined in the PIAC Orientation manual**
- **Not the Role/ Responsibility of CAC and PIAC Representatives**
  - **Handling requests by industry to promote their concerns and products**
  - **Provide requests to advocate for their personal issues**
  - **Submit appeals or other requests on behalf of providers**
  - **Research for documents to substantiate provider appeal request**
- **Resources for CAC/PIAC Representatives**
  - **APMA CAC/PIAC Orientation Manual**
  - **APMA Coding Resource Center (apmacodingrc.org)**
  - **APMA CAC-PIAC distribution lists and APMA Communities (Forumbee)**
  - **MAC LCDs / CMS NCDs**
  - **Medicare Internet Only Manual (IOM)**

PRIVATE INSURANCE ISSUES AND ADVOCACY

When Responding to PI or MA questions we should know:

- **What line of business (Medicare, Medicaid, Employer, etc…)**
- **Contracted or non-contracted provider?**
- **Did you appeal?**

MA Market Snapshot

- **20% of Medicare Advantage enrollees are enrolled in special needs plans (Dual Eligible or D-SNPs); 17% are enrolled in employer group MA plans; and 62% are enrolled in general enrollment MA plans.**
- **Similar to other years, in 2024, enrollment is concentrated in a small number of Medicare Advantage organizations.**
  - **United Healthcare – 29%; Humana – 18%; BCBS plans – 14%; CVS Health – 12% and Kaiser – 6%; all other organizations have 21% combined.**

PRIVATE INSURANCE ISSUES AND ADVOCACY

- **Upcoming MA Regulatory Changes**
  - **Beginning in 2025, policy changes to increase integrated plans – dual eligibles get Medicare and Medicaid from the same organization**
  - **Beginning 2026 plans must mail mid-year notice of supplemental benefits that have not been used**
  - **Beginning in 2026, MAOs must report prior authorization data from the previous year data on their websites**
  - **Beginning January 1, 2027, MAOs must maintain an Application Programming Interface for prior authorization requests that meet regulatory standards.**

PIAC BREAKOUT SESSIONS

General

- **General availability of policies online and timely notice of policy changes**
- **Challenges with reimbursement related to nail trimming and debridement (CPT 11719-11721, G0127), along with corn and callus removal (CPT 11055-11057). Is this something as a representative you are experiencing today? (33% R, 53% M) – Aetna, BCBS, CIGNA, United**
- **Denial or reduction in payment when submitting significant and separately identifiable Evaluation and Management (E/M) services with other minor surgical procedures and the -25 modifier? (40% M) – Aetna, BCBS, CIGNA, United**
- **MA plan not paying office visit despite modifier-25; Pending litigation via TEG (Healthnet)**
- **Credentialing on the major insurance plans take an extended period of time.**
- **MA plans not paying office visit despite -25 modifier.**

DME

- **General availability of policies online and timely notice of policy changes**
- **Same/similar - Many commercials now following Medicare guidelines on same/similar. They are paying if notes validate (Humana, Medicare or commercial)**

24TH ANNUAL CAC-PIAC MEETING

For a comprehensive overview, which encompasses notes, recordings, and presentations, kindly visit:

www.apma.org/cacpiac2024

Contact APMA's Health Policy and Practice Department with any questions or concerns at healthpolicy.hpp@apma.org.

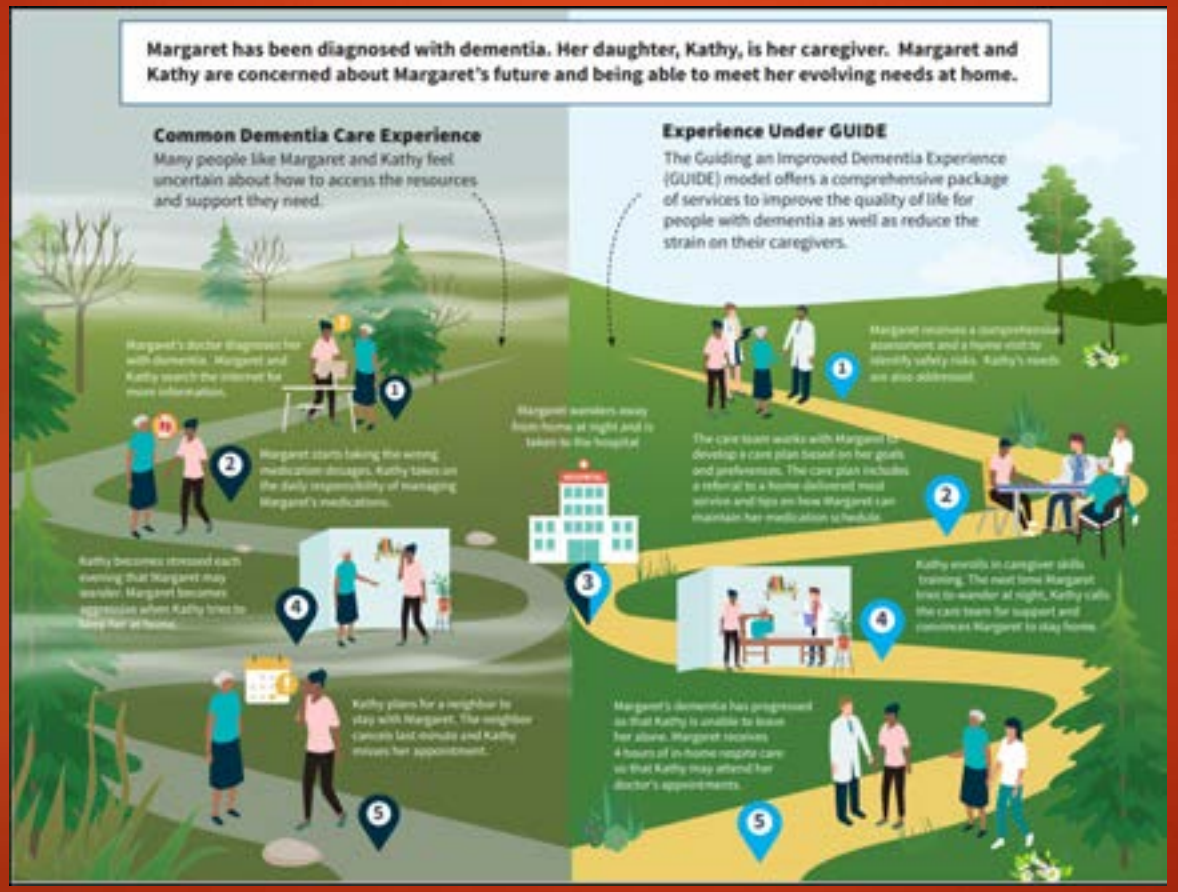
Noridian Medicare

Noridian CAC Meetings

G2211 Frequently Asked Questions (FAQ)

- CMS published HCPCS G2211 FAQs
  - Complex add-on code only billed with office or outpatient E/Ms
    - CPTs 99202-99205 and 99211-99215
- CMS FAQs_Office and Outpatient E/M Visit Complexity Add-On Code G2211
- Noridian hosted another G2211 webinar on Dec. 5, 2024
  - Register under Schedule of Events

GUIDE Model - Dementia Pathways Infographic



GUIDE Model

- Guiding an Improved Dementia Experience (GUIDE) Model
  - Supports people living with dementia and unpaid caregivers
  - Often see multiple chronic conditions and higher hospitalization rates
- Model launched July 1, 2024, with eight-year plan
- CMS (GUIDE) Model
- CMS GUIDE Model Frequently Asked Questions

Influenza Vaccines 2024-2025

- Influenza Vaccines 2024-2025
  - CMS Vaccine Pricing
- CMS provided updated fees to MACs in September
  - Noridian fees updated September 12, 2024
- Claims billed prior to update
  - Noridian continues mass adjustments; including G0008 and G0009 administration HCPCS
- All approved products are trivalent influenza vaccines

FYI: no-pay Medicare summary notice (MSN) mailings

- CR13627
- Effective date: 10/1/2024
- Implementation date: 10/7/2024
- When MSN mailed to **beneficiaries** notifying of "No-Pay"
  - Frequency changed from every 90 days to every 120 days

Medicare Summary Notice

- The Medicare Summary Notice (MSN) is a report that details any covered healthcare services and items a person on original Medicare receives in a 3-month period, along with the costs. It is not a bill, but rather a summary of services and a breakdown of payments.

Social Determinants of Health Risk Assessment

- CR13486
- Effective date: 1/1/2024
- Implementation date: 10/7/2024
- Annual Wellness Visit (AWV) option for the Social Determinants of Health (SDOH) Risk Assessment
  - Add modifier -33 to G0136 when included with AWV

TOP five inquiry calls to Provider Call Center (PCC)

Part B Calls	Solutions
Modifier Errors	Check CPT book and Noridian's Browse by Topic-Modifier's page
Medical Necessity	Check if policy involved and specialty under browse by webpage
Medicare Secondary Payer (MSP)	Utilize Noridian Medicare Portal (NMP) under MSP to confirm if patient has another primary insurer to Medicare (auto, etc.)
Claim Status	Utilize Noridian Medicare Portal (NMP)
Coding Errors	Check Denial Code Resolution under Claims and next NMP slide

CA/NV IMPAC Meeting 06/26/2024

Dr. Arthur Lurvey

noridian
Healthcare Solutions

Delivering solutions that put people first.

agenda

Call to order - Dr. Lurvey

Policy & Practice: A CMS Update
Noridian IMPAC meetings, Jurisdiction E

ASHBY WOLFE, MD, MPP, MPH
REGIONAL CHIEF MEDICAL OFFICER, CMS SEATTLE & SAN FRANCISCO

CENTERS FOR MEDICARE & MEDICAID SERVICES
JUNE 26 & 28, 2024

Objectives

- **CMS Updates**
  - Update on the National Quality Strategy: Quality In Motion
- **CMMI Update**
  - Status of select models announced by the CMS Innovation Center
- **Reminder: Billing Guidance and Resources**
- **Questions**

CMS National Quality Strategy

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/CMS-Quality-Strategy

Mission and Vision

Mission

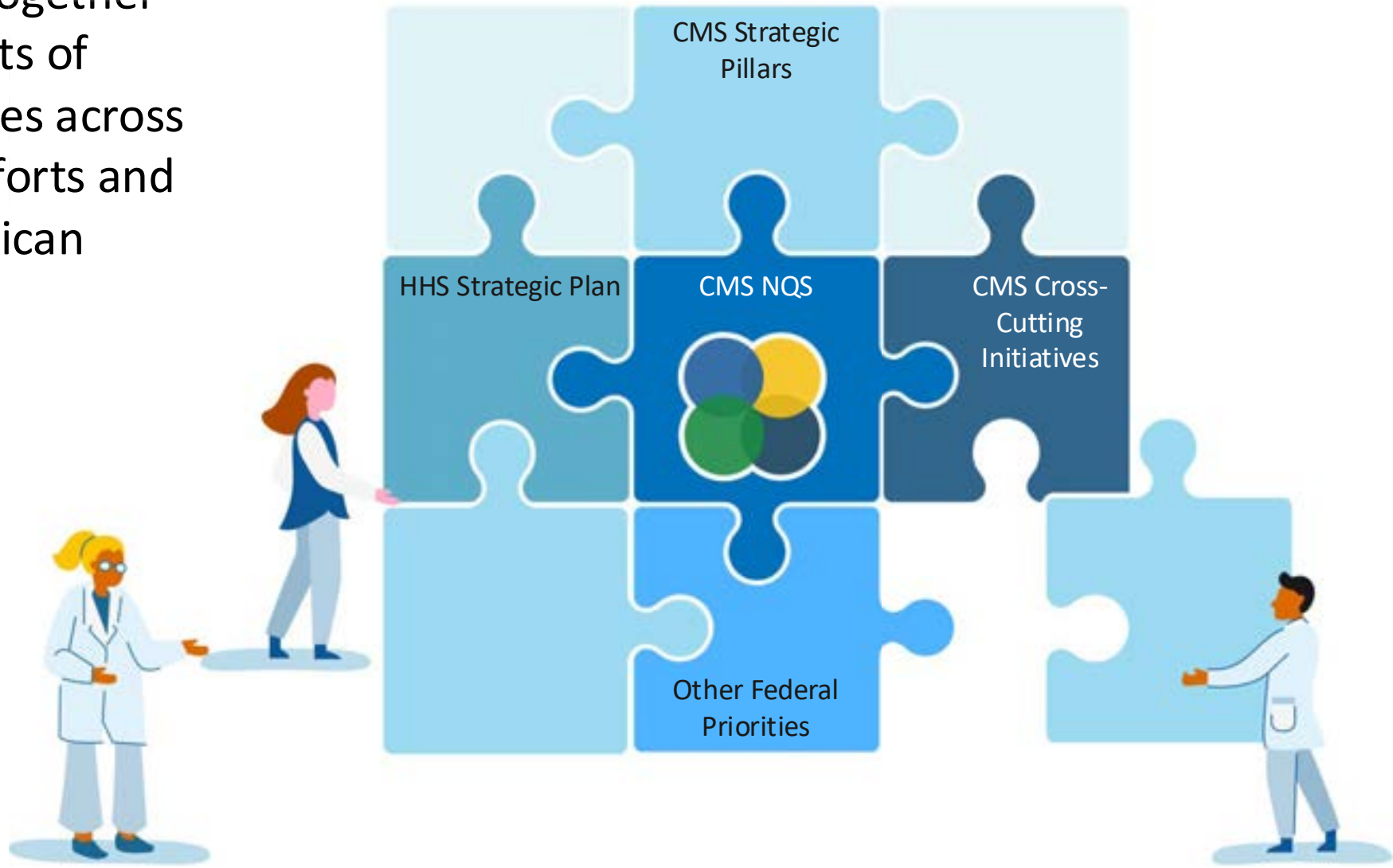
To achieve optimal health and well-being for all individuals.

Vision

CMS, a trusted partner, is shaping a resilient, high-value American health care system that delivers high-quality, safe, and equitable care for all.

The CMS NQS Is Part of a Larger Strategy to Improve Health Quality

The CMS NQS brings together the quality components of strategies and initiatives across the Agency to align efforts and better serve the American public.



Examples of Connections Across Strategic Efforts

CMS Strategic Pillars

- Advance Equity
- Engage Partners

CMS Cross-Cutting Initiatives

- Elevating Stakeholder Voices through Active Engagement
- Behavioral Health
- Maternity Care
- Rural Health
- Supporting Health Care Resiliency
- Safety and Quality of Care in Nursing Homes
- Data to Drive Decision-Making
- Integrating the 3Ms (Medicare, Medicaid & CHIP, Marketplace)

HHS Strategic Plan

- Health Equity
- Improve Health Outcomes
- Behavioral Health Integration
- Maternal Health

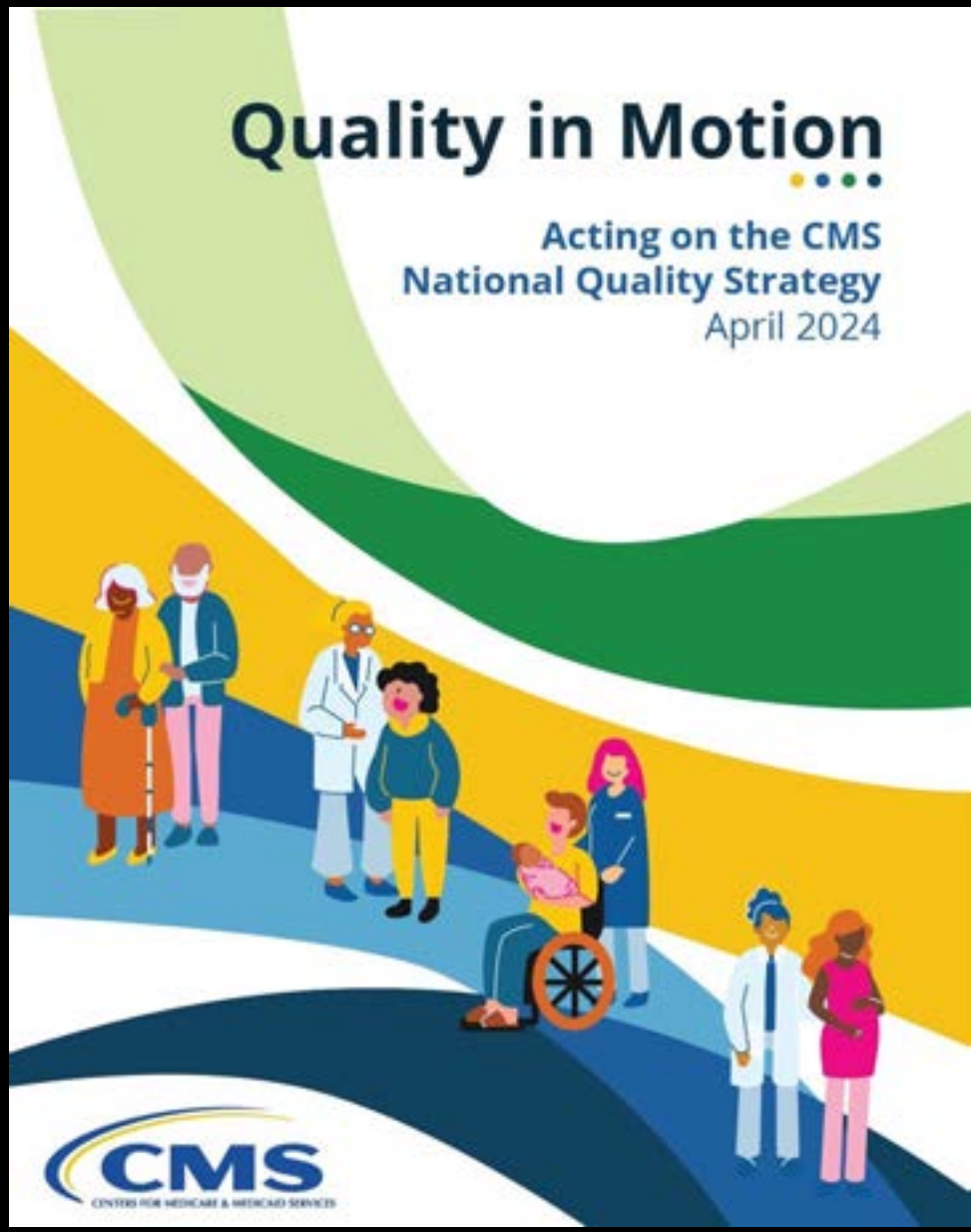
Other Federal Priorities

- Nursing Home Safety
- Equitable Long-Term Recovery and Resilience
- Patient Safety
- AI Assurance

CMS Uses All Available Levers to Promote High-Quality, Safe, and Equitable Care for All

New Publication: Quality in Motion
Acting on the CMS NQS

- Now available on: tinyurl.com/cms-quality-in-motion
- Details how CMS is putting the eight goals in action, using all the Agency's levers
- Emphasizes the connections across the CMS NQS goals
- Spotlights collaborative efforts to align with key partners



CMMI Model Updates

Innovation Center Strategic Refresh

Created for the purpose of developing and testing **innovative health care payment** and **service delivery models** within Medicare, Medicaid, and CHIP programs nationwide.

Innovation Center Priorities and Strategic Refresh

For more information, the Innovation Center Strategic Refresh White Paper is available on the CMS website.

CMS defines health equity as: The attainment of the highest level of health **for all people**, where everyone has a **fair and just opportunity** to **attain their optimal health** regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

https://www.cms.gov/priorities/innovation/overview

Making Care Primary

https://innovation.cms.gov/innovation-models/making-care-primary

Benefits of Participating in Making Care Primary

On-Ramp to VBC

Resources for organizations new to VBC to build accountability over time

Key features:

- Upfront Infrastructure Payment
- Phased in shift from FFS to population-based payment over Tracks 1 and 2
- No downside adjustment based on performance, rewards are focused on key clinical outcomes first

Tools to Improve Care Coordination

Data to improve patient care integration and learning tools to drive care transformation

Key features:

- Specialty care performance data sharing, prioritizing cardiology, orthopedics, and pulmonology
- New specialty integration payments to improve communication and collaboration
- Connection to health information exchange

Health Equity Advancement

Support to deliver coordinated, high-quality health care to diverse populations

Key features:

- Process for identifying and addressing health disparities in the populations that practices serve
- Increased payment for patients that require more intensive services to meet health goals.
- Focus on screening and referrals to address Health Related Social Needs (HRSNs)

Collaboration & Learning

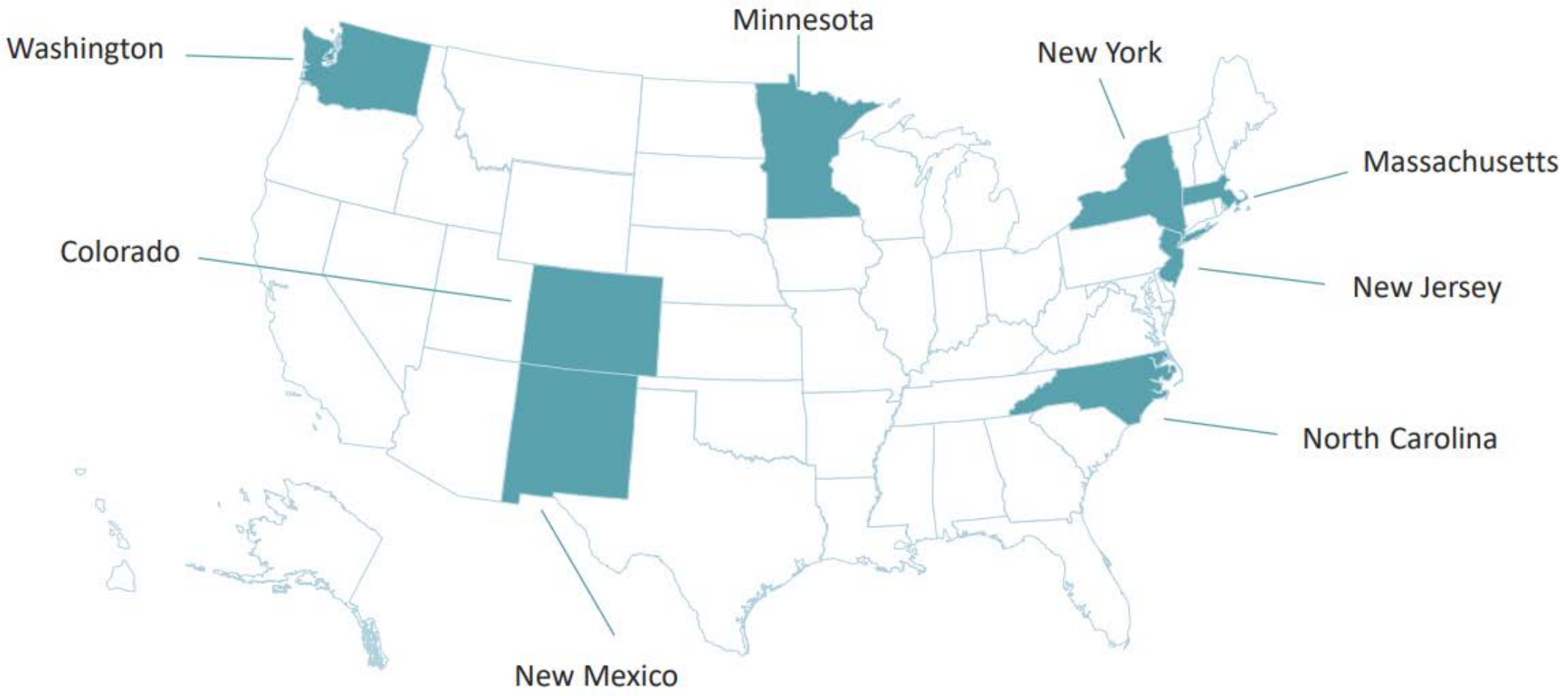
National and state level supports for participants to achieve model goals

Key features:

- Payers partnering to support participants needs for success, including technical assistance, data, and peer-to-peer learning
- Access to independent practice facilitation and coaching, especially for small and safety net organizations who request it

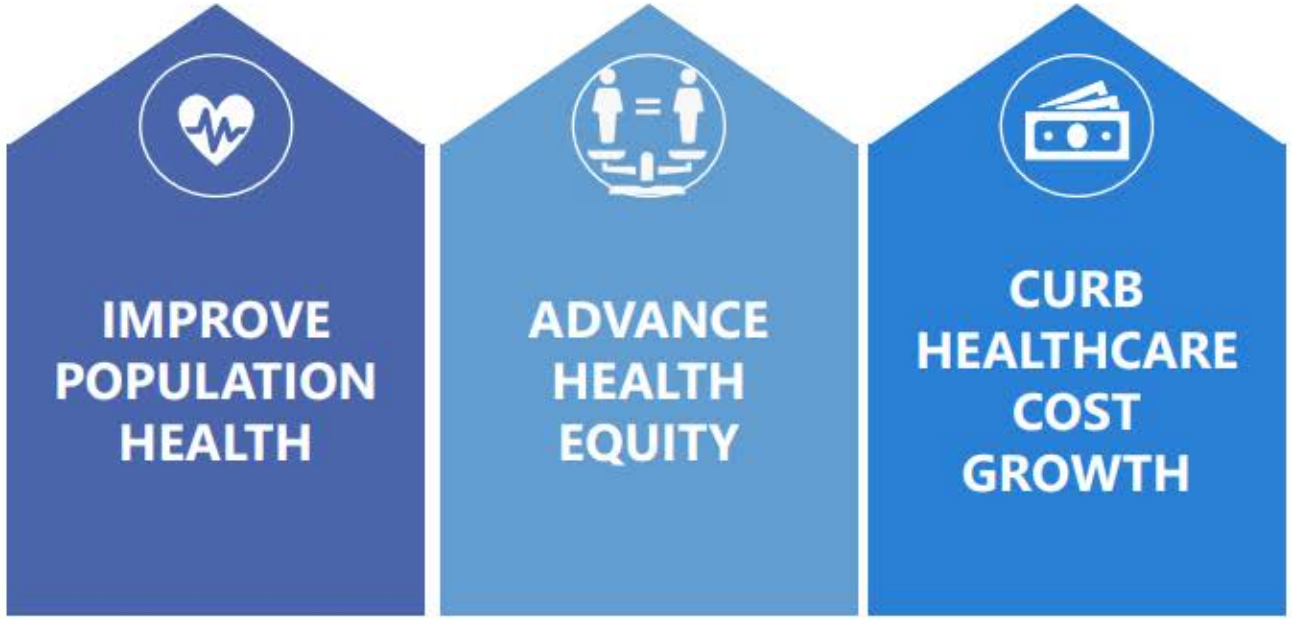
Making Care Primary: Participating States

MCP selected eight (8) states using several factors, including geographic diversity, health equity opportunity, population, and in partnership with state Medicaid agencies (SMAs) to better align Medicare and Medicaid payers on quality measurement, data requirements, and learning priorities.



States Advancing All-Payer Health Equity Approaches and Development

CMS's goal in the AHEAD Model is to collaborate with states to improve population health; advance health equity by reducing disparities in health outcomes; and curb health care cost growth.



CMS will support participating states through various AHEAD Model components that aim to increase investment in primary care, provide financial stability for hospitals, and support beneficiary connections to community resources.

https://www.cms.gov/priorities/innovation/innovation-models/ahead

States Advancing All-Payer Health Equity Approaches and Development

Model Elements

- **Supports statewide transformation** to curb rising health care costs and invest in primary care

- **Improves care coordination** with primary care and other outpatient providers

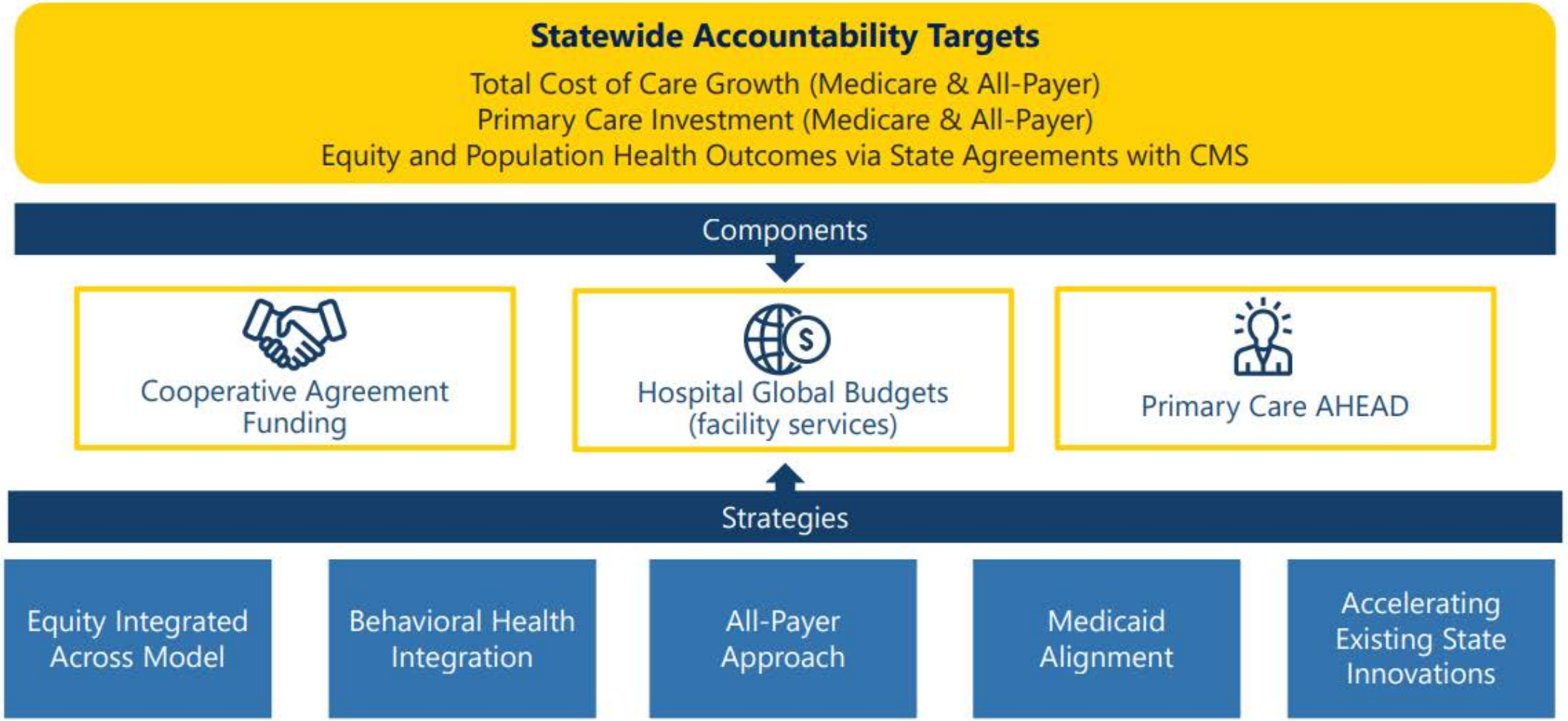
- **Improves population health** through statewide health promotion efforts

- **Gives states and providers additional tools and incentives** to align care transformation activities across health care delivery and public health systems

- **Advances health equity** through new policies or programs

AHEAD Model At-A-Glance

The States Advancing All-Payer Health Equity Approaches and Development, or the AHEAD Model, is a flexible framework designed to improve health outcomes across multiple states.

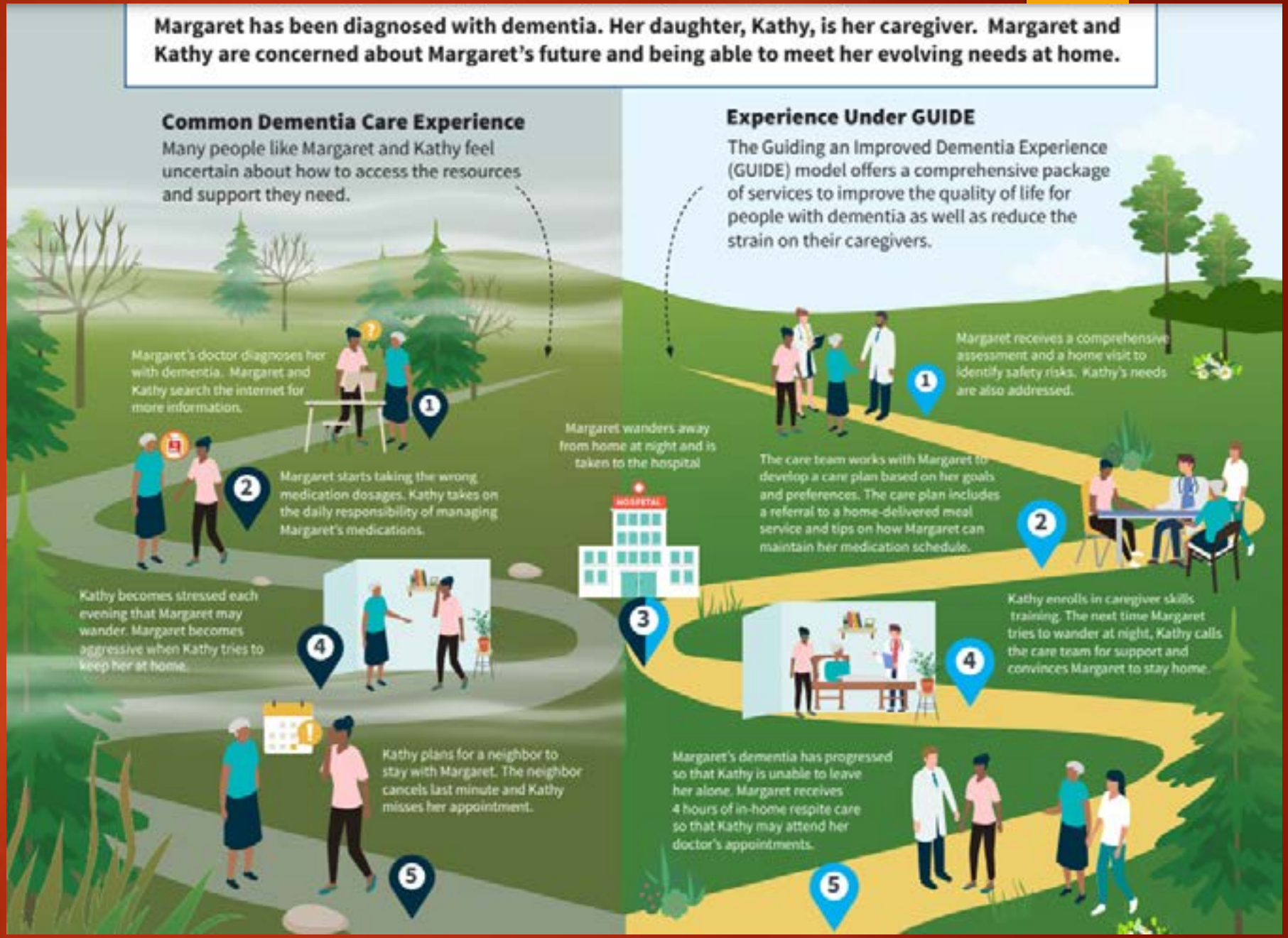


https://www.cms.gov/priorities/innovation/innovation-models/ahead

The GUIDE Model

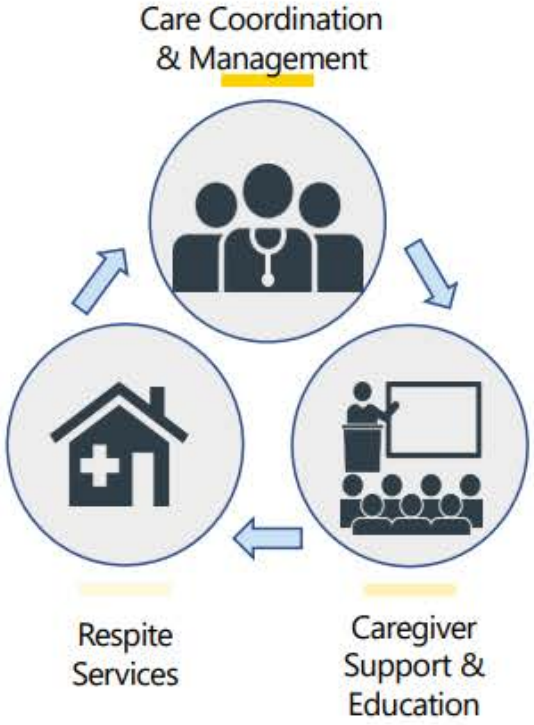
Guiding an Improved Dementia Experience

https://www.cms.gov/priorities/innovation/innovation-models/guide



Model Purpose and Overview

The GUIDE Model will test whether a comprehensive package of care coordination and management, caregiver support and education, and respite services can **improve quality of life for people with dementia and their caregivers** while **delaying avoidable long-term nursing home care** and **enabling more people to remain at home** through end of life.



Care Coordination & Management

Beneficiaries will receive care from an **interdisciplinary team** that will develop and implement a comprehensive, person-centered care plan for **managing the beneficiary's dementia and co-occurring conditions** and provide **ongoing monitoring and support.**

Caregiver Support & Education

GUIDE participants will provide a **caregiver support program**, which must include caregiver skills training, dementia diagnosis education, support groups, and access to a personal care navigator who can help problem solve and connect the caregiver to services and supports.

Respite Services

A subset of beneficiaries in the model will be eligible to receive payment for respite services with no cost sharing, up to a cap of **$2,500 per year**. These services may be provided to beneficiaries in a variety of settings, including **their personal home, an adult day center, and facilities that can provide 24-hour care** to give the caregiver a break from caring for the beneficiary.

https://www.cms.gov/priorities/innovation/innovation-models/guide

Example Beneficiary Persona

Margaret Smith

Situation: Margaret, 82, was diagnosed with Alzheimer's disease by her primary care physician (PCP) two years ago. She now experiences moderate symptoms. Her daughter, Kathy, visits her daily at her home but is unable to provide the increased level of attention she now requires. Margaret is unsure how to access support, and her PCP is not equipped to provide the necessary guidance.

Key Information

Location: Atlanta, Georgia

Family: 2 children, 4 grandchildren

Medical Utilizations in Last Year: 1 Emergency Department visit followed by post-acute care at home

Income: $1,700 per month

Margaret's Needs

- Culturally competent, coordinated care.
- Financial support for out-of-pocket medical costs.
- Support for household and personal tasks, such as cooking, cleaning, bathing, and maintaining a medication schedule.
- Assistance with light activity, such as short walks or physical therapy.

Margaret's Challenges

- Lack of savings for in-home care services and medical costs.
- Suffers from sundowning every evening and often forgets to take medications on time.
- Lives alone in a home with steps, which have caused 2 falls in the last 6 months.
- Struggles with Type 2 Diabetes and impaired vision that limits her ability to drive a vehicle.

Margaret's Experience in the GUIDE Model

Comprehensive Assessment and Care Plan

Margaret receives a comprehensive assessment and develops a care plan with her care team, which addresses her safety walking down stairs.

Ongoing Monitoring and Support

Care navigator checks in with Margaret monthly. Kathy also calls care navigator for suggestions on how to cope with sundowning.

Medication Management

Margaret's care navigator provides tips for Margaret to maintain her correct medication schedule.

Referral and Coordination

Care navigator refers Margaret to a community-based organization that helps her identify service providers.

Cell and Gene Therapy (CGT) Access Model

HEALTH EQUITY & IMPACT ON BENEFICIARIES

The CGT Access Model aims to support beneficiaries and address health equity, in alignment with the CMS Framework for Health Equity in three ways:

COST

Lower the cost of CGTs and enable more people with Medicaid to access potentially transformative treatment.

HEALTH DISPARITIES

Increase access to potentially transformative therapies for all individuals with SCD, including groups who have experienced historic disparities associated with this disease.

ACCESS BARRIERS

Offer states funding for activities that reduce access barriers for people with Medicaid. Require manufacturers to cover certain fertility preservation services, because the care journey for SCD CGT typically results in infertility. Lack of access to fertility preservation services presents a significant access barrier to individuals considering CGT.

BENEFICIARY IMPACT

- Increased access to transformative therapies for SCD
- Reduced burden of SCD for beneficiaries
- Improved quality of life, including the ability to achieve major life goals related to education, work, and family life
- Easier navigation of care due to streamlined authorization process

https://www.cms.gov/priorities/innovation/innovation-models/cgt

Cell and Gene Therapy (CGT) Access Model

CGT ACCESS MODEL PARTICIPANTS	
 **States**	All states and territories that participate in the Medicaid Drug Rebate Program (MDRP) can participate in the model if they meet requirements. States will be able to express their intent to participate by submitting a Letter of Intent (LOI) by April 2024. States may then apply to the model by responding to a Request for Applications (RFA) by February 2025. After states sign an agreement with CMS, states may begin participation in the model between January 2025 and January 2026.
 **MANUFACTURERS**	Manufacturers will be able to apply to the model by responding to a RFA by May 2024. Manufacturers who participate in the MDRP and market U.S. Food & Drug Administration (FDA)-approved or -licensed gene therapies for the treatment of severe SCD are also eligible to participate in the model. Negotiations between CMS and manufacturers are scheduled to take place between May - November 2024.
 **PROVIDERS**	Providers will not be participants in the model.

https://www.cms.gov/priorities/innovation/innovation-models/cgt
https://www.cms.gov/files/document/cgt-model-ovw-fact-sheet.pdf

Cell and Gene Therapy (CGT) Access Model

Model Structure

The CGT Access Model seeks to test whether a CMS-led approach to negotiating and administering OBAs for CGTs, in the context of a comprehensive strategy for addressing a range of barriers to equitable access to cell and gene therapies, will improve access and health outcomes for people with Medicaid, and reduce health care costs.

Role of CMS

CMMI will negotiate key terms and agreements between states and manufacturers, including CGT market access and rebate payments.

Participant Eligibility

All States and Territories that participate in the Medicaid Drug Rebate Program (MDRP) can participate in the model if they meet requirements.

Manufacturers must participate in the MDRP and market FDA-approved or -licensed gene therapies for the treatment of severe SCD.

CMS will negotiate discounted pricing

with manufacturers to relieve the burden on states and increase access for beneficiaries.

CMS will tie manufacturer payment to specific outcomes,

such as reduction in pain-crises and patient-reported outcomes.

CMS will offer optional funding

to states to support activities that promote equitable access to care.

CMS will support states to operationalize the model,

such as providing technical assistance, specifying requirements on data collection, and negotiating the OBAs as well as collecting clinical and claims outcomes.

https://www.cms.gov/priorities/innovation/innovation-models/cgt

Cell and Gene Therapy (CGT) Access Model

MODEL POPULATION

The model population is beneficiaries for whom Medicaid is the primary payer and Medicaid expansion Children's Health Insurance Program (CHIP) beneficiaries ("Title XIX beneficiaries") in fee-for-service and Medicaid managed care.

Manufacturers and states will have the option to include separate CHIP beneficiaries ("Title XXI beneficiaries") alongside Title XIX beneficiaries.

Beneficiaries must receive an FDA-approved CGT for SCD that is covered and paid for by either (1) a participating state as a covered outpatient drug, or (2) a CHIP that participates in the model.

https://www.cms.gov/priorities/innovation/innovation-models/cgt
https://www.cms.gov/files/document/cgt-model-ovw-fact-sheet.pdf

Cell and Gene Therapy (CGT) Access Model: Structure and Impact

Contracting Structure

CMS will facilitate negotiations between states and pharmaceutical manufacturers.

CMS AND MANUFACTURERS

CMS will negotiate key terms for an OBA with manufacturers. Manufacturers will in turn make the negotiated OBA to participating states. Throughout the model, manufacturers will submit patient-level sales data to CMS to cross-check against claims data of patients who receive CGT.

CMS AND STATES

CMS and states would have an arrangement wherein:

1. States will provide data to CMS. CMS will use submitted claims data in the Transformed Medicaid Statistical Information System for model operations and analysis.
2. CMS will provide states with funding to support activities that promote equitable access to care.
3. States will be responsible for their share of the cost of the cell and gene therapy, but at a discounted price tied to specific outcomes, as negotiated by CMS.

STATES AND MANUFACTURERS

The contract between states and manufacturers, with key terms as negotiated by CMS on behalf of states, will be structured as a supplemental rebate agreement. States and Manufacturers will have the option to include separate CHIP programs that will be subject to different considerations.

Within this agreement, manufacturers will be obligated to provide states with supplemental rebates that reflect model-negotiated terms (i.e., pricing, access standards, outcomes). In turn, states will be obligated to implement an agreed-upon standard access policy.

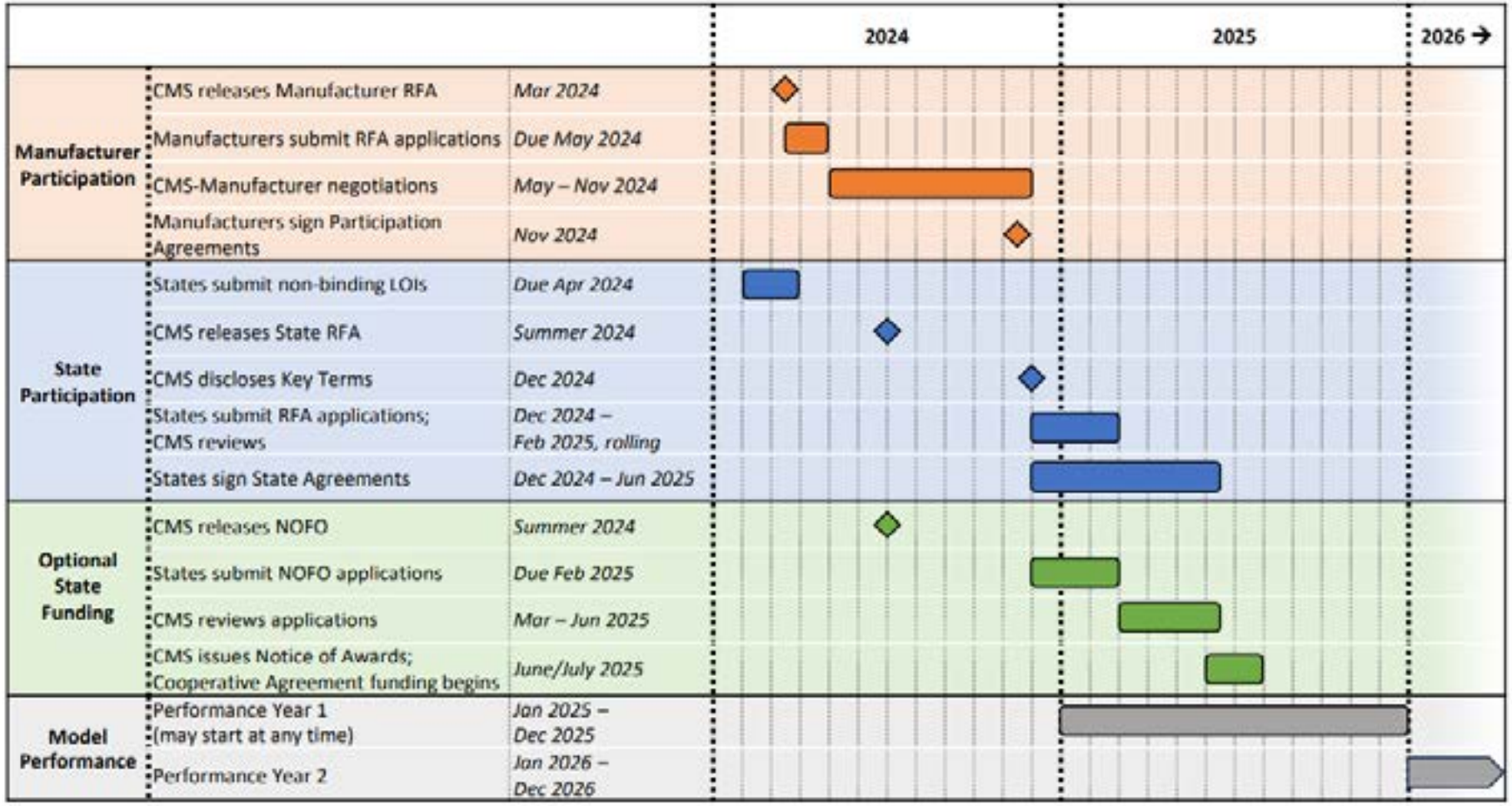
BENEFICIARY IMPACT

- Increased access to transformative therapies for SCD
- Reduced burden of SCD for beneficiaries
- Improved quality of life, including the ability to achieve major life goals related to education, work, and family life
- Easier navigation of care due to streamlined authorization process

Putting it all together

Model and Application Timeline

The CGT Access Model will operate for up to 11 years, depending on the OBA term for each state.

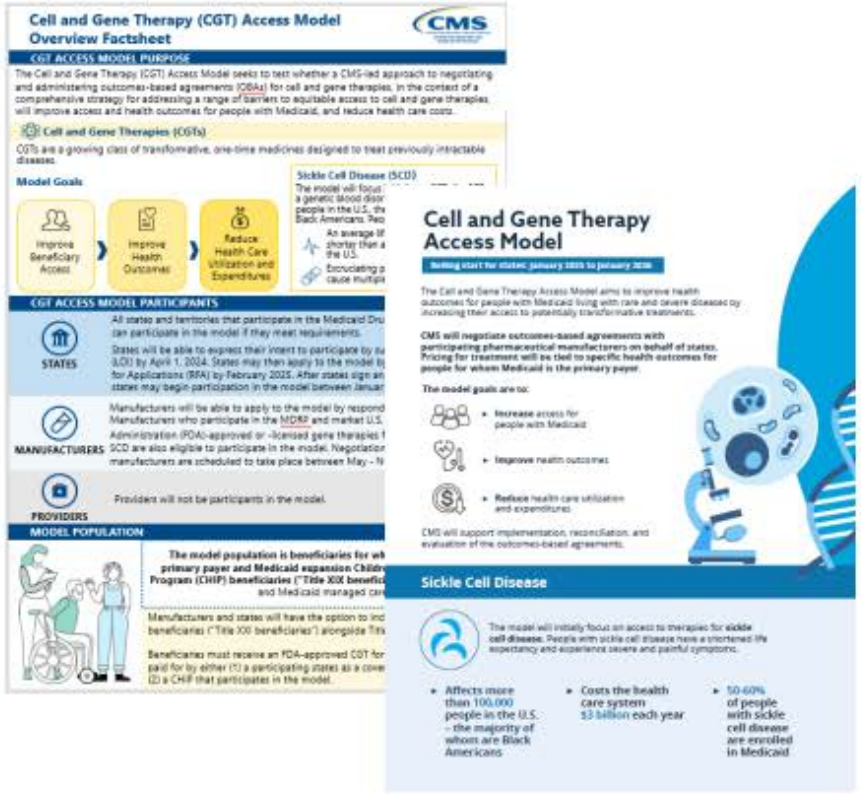


LEGEND

- Manufacturer activities
- State activities
- Funding timeline
- Model performance timeline

Model Resources

The CGT Access Model team has a host of resources to support interested organizations. To see the latest resources, visit the model's website at https://www.cms.gov/priorities/innovation/innovation-models/cgt.



CGTModel@cms.hhs.gov
https://www.cms.gov/priorities/innovation/innovation-models/cgt

https://www.cms.gov/files/document/sickle-cell-disease-action-plan.pdf

Model Factsheet and Infographic
Read through the CGT Model Overview Factsheet and the CGT Model Infographic on the model website to learn more.

Helpdesk
If you have questions for the model team, please reach out to us via email at to CGTModel@cms.hhs.gov.

ACO Primary Care Flex

https://www.cms.gov/priorities/innovation/innovation-models/aco-primary-care-flex-model

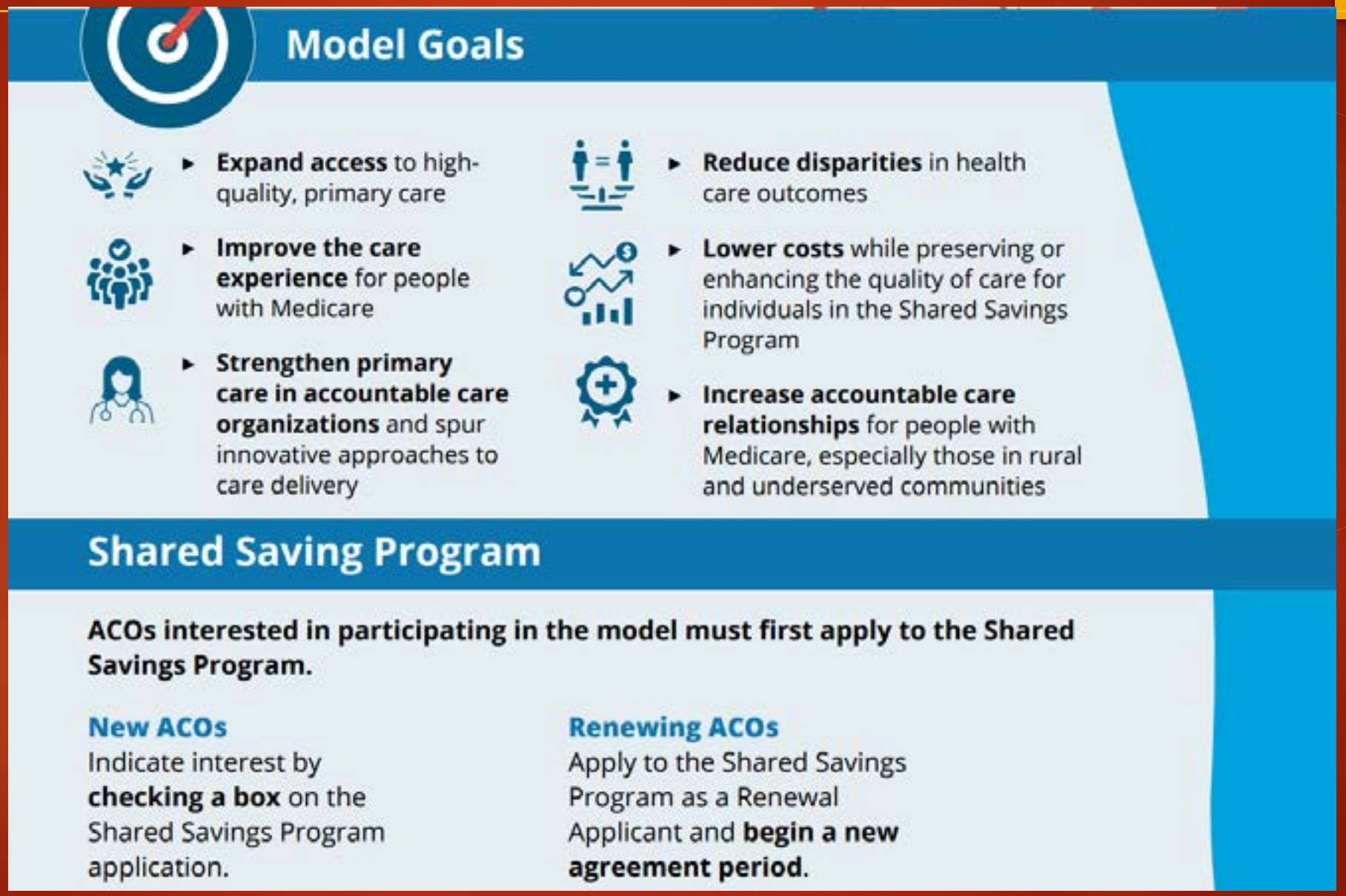
ACO Primary Care Flex Model

2025-2030

The ACO Primary Care Flex Model (ACO PC Flex Model) is a voluntary model focused on improving funding and other resources to support primary care delivery in the Medicare Shared Savings Program. The model incentivizes the development of new, physician-led Accountable Care Organizations (ACOs), particularly those that will support underserved communities, and can help address health disparities.

ACO Primary Flex: Model Goals

https://www.cms.gov/priorities/innovation/innovation-models/aco-primary-care-flex-model



Additional Resources

Medicare Learning Network (MLN) Articles of Interest

Health Equity Services in the 2024 Physician Fee Schedule Final Rule

How to Use the Office & Outpatient E/M Visit Complexity Add-On Code G2211

Medicare and Mental Health Coverage

Check https://www.cms.gov/training-education/medicare-learning-network/resources-training

for more information and future guidance