Revenue Roundtable
December 2017

New and Deleted Modifiers for the Chargemaster

Several new modifiers will be added to the facility's chargemaster to accommodate specific reporting scenarios facing providers next year.

Updated NCCI Manual Instructions

The NCCI Manual has been updated to accommodate the new 2018 CPT codes and unfortunately does contain added instructions which will impact the facility's gross revenue next year.

Probe and Education Audits May Impact the ED

CMS has authorized several MACs to conduct Targeted Probe and Education (TPE) review processes for the facility's reported E&M Codes.

How do you Interpret the 2018 Clinical Laboratory Fee Schedule?

Once you find the links on CMS website to download the Clinical Laboratory Fee Schedule, there are some significant differences found in the file for 2018. What does the data mean?

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The holiday season is here and the December edition of *Revenue Roundtable* would like to provide a brief summary of the 2018 code updates impacting the chargemaster. While not all coding revisions can be reviewed in a single newsletter edition, this final newsletter for 2017 will focus on those codes which have the greatest reimbursement impact under the OPPS payment system while detailing some reporting differences for the Critical Access Hospitals (CAH). Happy holidays from HCS' consulting team to you and your family!

New/Deleted Modifiers for the Chargemaster

Modifier **FX** will continue to be reported by providers on the UB-04 for radiology procedures that are taken using film. Beginning in 2017, claims for X-rays using film must include modifier FX that will result in the applicable payment reduction for which payment is made under the Medicare Physician Fee Schedule (MPFS). Medicare payments were reduced by 20% for providers submitting claims for analog x-ray studies starting in 2017 under a provision in the Consolidated Appropriations Act of 2016.

Modifier FX can easily be accommodated within the facility's chargemaster. Note: CAH facilities are exempt from this reporting requirement.

Modifier **FY**: In the CY 2018 HOPPS Final rule CMS has established a new **"FY**" modifier to be reported on the UB-04 with CPT codes that represent X-rays taken using computed radiography in the outpatient setting. The modifier must be used to report the specific services that are subject to the payment reduction and its accurate use is subject to audit. Computed radiography X-rays will be reduced by 7% from 2018 to 2022 and then increase to a 10% reduction in 2023 and beyond. Modifier –FY, *X-ray taken using computed radiography technology/cassette-based imaging,* can easily by appended to the radiology CPT code within the department's chargemaster. While CMS did not specifically address the CAH facility, if these hospitals are exempt from the FX modifier requirement, it would make perfect sense to also exempt these facilities from reporting the FY modifier as well.

Modifier **CT**, *Computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) XR-29-2013 standard"* was implemented January 1, 2016 and will **continue** in 2018 to be appended to CT services identified by HCPCS codes 70450 through 70498; 71250 through 71275; 72125 through 72133; 72191 through 72194; 73200 through 73206; 74150 through 74178; 74261 through 74263 and 75571 through 75574 (and any succeeding codes). Effective January 1, 2017, the use of this modifier resulted in a payment reduction of 15 percent when the applicable CT services were paid separately.

Two New Modifiers for 340B Participating Facilities

Effective January 1, 2018 CMS is implementing modifier JG, *Drug or biological acquired with 340B Drug Pricing Program Discount* for the payment adjustment for certain 340B-acquired drugs. For those OPPS hospitals participating in the 340B-program, modifier JG must be appended to those drugs containing status indicator "K", *Nonpass-*

New/Deleted Modifiers for 2018 (Cont'd)

Through Drugs and Nonimplantable Biologicals, Including Therapeutic Radiopharmaceuticals. For separately payable drugs with status indicator "K", application of modifier "JG" will trigger a payment adjustment such that the 340B-acquired drug is paid at ASP minus 22.5 percent.

The chargemaster would be the best resource to report this new modifier by appending the JG modifier to the appropriate HCPCS code which would help guarantee accuracy and consistency. As a word of caution, however, CMS can update CPT and HCPCS code's status indicators on a quarterly basis so the facility must include confirming status indicator assignments to the chargemaster update processes if not already performed.

Additionally, CMS is establishing an informational modifier for use by certain providers who will be excepted from the 340B payment reduction, such as rural SCHs, children's hospitals, and PPS-exempt cancer hospitals. These facilities must report modifier TB, *Drug or Biological Acquired With 340B Drug Pricing Program Discount, Reported for Informational Purposes,* to identify OPPS separately payable drugs purchased with a 340B discount. For calendar year (CY) 2018, hospitals that are excluded from the payment adjustment will be required to report informational modifier "TB" for those 340B-acquired drugs with status indicator K, but will continue to be paid ASP plus 6 percent.

CMS indicated the payment policy applies to only those hospitals paid by OPPS for separately payable drugs (status indicator "K") and does not apply to vaccines (status indicator "L" or "M"), or drugs with transitional pass-through payment status (status indicator "G"). Note: Effective January 1, 2018 there are a total of 312 HCPCS assigned with status indicator K.

Providers voiced strong opinions to CMS on the proposed introduction of these two 340B pharmacy modifiers, one of which was the administrative challenges facilities would face if CMS implemented this reporting requirement. With the issuance of the OPPS Final Rule, CMS did state they felt the reporting of JG or TB modifiers does not present administrative burden since many state's Medicaid programs already required a separate modifier be reported for their specific billing requirements.

CMS notes that providers have 12 months after the date of service to timely file a claim for payment. Therefore, for those hospitals that may need more time to ensure that they are in compliance with the modifier requirements, they have 12 months from the date of service to do so. Applying this final payment policy for drugs purchased under the 340B Program results in an estimated reduction of approximately $1.6 billion in separately paid OPPS drug payments. To maintain budget neutrality within the OPPS, the estimated $1.6 billion in reduced drug payments will be redistributed in an equal offsetting amount to all hospitals paid under the OPPS through increased payment rates for non-drug items and services furnished by all hospitals paid under the OPPS for CY 2018.

New/Deleted Modifiers for 2018 (Cont'd)

CMS indicates that they may revisit this new payment methodology in CY 2019 rulemaking. In the meantime, the American Hospital Association, Association of American Medical Colleges as well as other groups are pursuing a lawsuit to stop the move while 340B Health and other groups are lobbying Congress to block CMS's move legislatively. These organizations feel that cuts to the Medicare payments to hospitals for drugs covered under the 340B program will dramatically threaten access to health care for many patients, including uninsured and other vulnerable patient populations.

CMS did not specifically discuss the 340B program and the reduction of net reimbursement as it relates to critical access hospitals, only for those hospitals paid under the OPPS payment system. Since CAH facilities are reimbursed by Medicare at 101 percent of reasonable costs, CAH hospitals are not subject to the Hospital Outpatient Prospective Payment System (OPPS) and reimbursement not impacted.

Deleted Modifier for 2018

A simplistic definition for Stereotactic radiosurgery (SRS) states this treatment is a type of radiation therapy that targets multiple beams of radiation to precisely deliver radiation to a brain tumor while sparing the surrounding normal tissue.

CMS stated in the CY 2016 OPPS/ASC final rule with comment period (80 FR 70336) that the intent of the C-APC policy is to package payment for all services adjunctive to the primary "J1" procedure and that they believed all essential planning and preparation services related to the SRS treatment are adjunctive to the SRS treatment delivery procedure. Therefore, payment for these adjunctive services should be packaged into the C-APC payment for the SRS treatment instead of reported on a different claim and paid separately. To identify services that are adjunctive to the primary SRS treatment described by HCPCS codes 77371 and 77372, but reported on a different claim, CMS established modifier "CP" which became effective in CY 2016 and required the use of the modifier for CY 2016 and CY 2017. The data collection period for SRS claims with modifier "CP" is set to conclude on December 31, 2017. Accordingly, for CY 2018, CMS will be deleting this modifier and discontinuing its required use.

Modifiers Continuing into the New Year

Modifier PN will be used to indicate that an item or service is a nonexcepted item or service which is provided in an off-campus provider-based clinic established after November 2, 2015. For CY 2017, the payment rate for these services will generally be 50 percent of the OPPS rate (there are some exceptions that are spelled out in the interim Final Rule with comment period, including that payment for separately payable drugs will not be reduced). Packaging, and certain other OPPS policies, will continue to apply to such

New/Deleted Modifiers for 2018 (Cont'd)

services. This payment concept is not final, however, and CMS continues to seek public comments on the new payment policies for excepted and nonexcepted off-campus provider-based clinics and the services they provide. Modifier PN was established January 1, 2017 and will continue into next year.

Modifier PN typically resides within the clinic's chargemaster and is reported on the UB-04 claim form.

Modifier PO (*Services, procedures, and/or surgeries furnished at an off-campus provider-based outpatient departments)* will continue to be required for 2018 as well. This modifier is intended to be reported with every CPT and HCPCS code for outpatient hospital services furnished in an off-campus provider-based department of a hospital.

All of the new and continuing modifiers discussed previously can easily be reported by hard-coding or appending these modifiers to the appropriate HCPCS code in the chargemaster.

New Instructions Found in the NCCI Manual 2018

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of Part B claims. The coding policies are based on coding conventions defined in the American Medical Association's *Current Procedural Terminology (CPT) Manual*, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice.

With the introduction of new CPT codes, the reporting guidelines and coding policies found in the NCCI Manuals also need to be updated.

The description for CPT 38220, in 2018 now reads: "*Diagnostic bone marrow, aspirations*". When performing a bone marrow biopsy, the description for CPT 38221 was also changed to: "*Diagnostic bone marrow, biopsy(ies)".* When both an aspiration as well as biopsy are performed, an add-on HCPCS code G0364 was formerly reported as follows: "*Bone marrow aspiration performed with bone marrow biopsy through the same incision on the same date of service".* With the new code, CPT 38222, *Diagnostic bone marrow; biopsy(ies) and aspiration(s),* HCPCS G0364 is no longer necessary and is deleted.

New reporting instructions are found in Chapter 5 of the *National Correct Coding Initiative Policy Manual For Medicare Services* which reads as follows:

When diagnostic bone marrow aspiration(s) is performed alone, the appropriate code to report is CPT code 38220. When diagnostic bone marrow biopsy(ies) is performed alone, the appropriate code to report is CPT code 38221. This code shall not be reported with CPT code 20220 (bone biopsy). When diagnostic bone marrow aspiration(s) and biopsy(ies) are performed on the ipsilateral iliac bone, the appropriate code to report is CPT code 38222. CPT codes 38220 and 38221 may only be reported together if the

NCCI Manual 2018…(Continued)

two procedures are performed without accompanying biopsy(ies) or aspiration(s) respectively on different iliac bones or sternum or at separate patient encounters. If a diagnostic bone marrow biopsy (CPT code 38221) and diagnostic bone marrow aspiration (CPT code 38220) are performed on the same bone, do not report the bone marrow aspiration, CPT code 38220, in addition to the bone marrow biopsy (CPT code 38221).

Instruction notes found in the 2018 CPT codebook advises providers to report CPT codes 38220, 38221 as well as 38222 with modifier 50 if performed bilaterally. Some coding references will/should be updated in the near future based on these CPT reporting instructions. One example is found in The AHA *Coding Clinic for HCPCS Details, 3rd Quarter 2012, Volume 12, Number 3, Page 6 which states:*

QUESTION 7: What is the correct way to report HCPCS code G0364, Bone marrow aspiration performed with bone marrow biopsy through the same incision on the same date of service, at the facility? Is this code reported once and includes both the aspiration and the biopsy? Or should CPT code 38221, Bone marrow; biopsy, needle or trocar, be reported with G0364? Is code G0364 considered a unilateral or bilateral code? If the procedure is performed on the right and left iliac crest, how would the procedure be reported and what would be the appropriate modifier? If performed on different bones or if different incisions were made, would HCPCS code G0364 be an appropriate code assignment for this scenario?

ANSWER: HCPCS code G0364 represents the bone marrow aspiration procedure that is performed with a bone marrow biopsy through the same incision on the same date. Therefore, HCPCS code G0364, Bone marrow aspiration performed with bone marrow biopsy through the same incision on the same date of service, is appropriately reported for the aspiration, and CPT code 38221, Bone marrow; biopsy, needle or trocar, reported for the biopsy performed.

However, if the aspiration and the biopsy are performed at different sites or separate incisions are made, report CPT codes 38221 and 38220, Bone marrow; aspiration only, and append modifier 59, Distinct Procedural Service. ***Since some anatomic sites are not bilateral in nature, modifiers 50, RT or LT would not be appropriate***

Are Venipuncture and Specimen Collection Revenues in Jeopardy?

CMS' reference for billing a specimen collection, such as venipuncture, is shown in the Medicare Claims Processing Manual, Chapter 16, Section 60.1:

60.1 - Specimen Collection Fee (Rev. 1, 10-01-03) B3-5114.1, A3-3628 In addition to the amounts provided under the fee schedules, the Secretary shall provide for and establish a nominal fee to cover the appropriate costs of collecting the sample on which a clinical laboratory test was performed and for which payment is made with respect to samples collected in the same encounter. A specimen

NCCI Manual 2018…(Continued)

collection fee is allowed in circumstances such as drawing a blood sample through venipuncture (i.e., inserting into a vein a needle with syringe or vacutainer to draw the specimen) or collecting a urine sample by catheterization. A specimen collection fee is not allowed for blood samples where the cost of collecting the specimen is minimal (such as a throat culture or a routine capillary puncture for clotting or bleeding time). This fee will not be paid to anyone who has not extracted the specimen. Only one collection fee is allowed for each type of specimen for each patient encounter, regardless of the number of specimens drawn. When a series of specimens is required to complete a single test (e.g., glucose tolerance test), the series is treated as a single encounter.

CPT 36415, *Collection of venous blood by venipuncture,* presently has an MUE value of 2, which seemingly differs from the reference above. However, the 2018 NCCI Manual now provides clarification for facilities to follow that will impact the laboratory department's gross revenue:

CPT code 36415 describes collection of venous blood by venipuncture. Each unit of service (UOS) of this code includes all collections of venous blood by venipuncture during a single episode of care regardless of the number of times venipuncture is performed to collect venous blood specimens. Two or more collections of venous blood by venipuncture during the same episode of care are not reportable as additional UOS. An episode of care begins when a patient arrives at a facility for treatment and terminates when the patient leaves the facility.

Effective January 1, 2018, a facility may report one venipuncture per patient encounter (not per patient day). For patient encounters initiating in the emergency department where a patient presents for evaluation of chest pain, cardiac enzymes and other labs may be collected. The patient may be taken to the Cath Lab. Post-procedure the patient stayed overnight in observation status. Prior to discharge the following day, repeat cardiac enzymes are performed. This scenario will warrant a single charge for specimen collection via venipuncture even though the services were performed on different dates of service. They were, however, performed during the same patient encounter. This will present an operational challenge for many facilities presently capturing venipunctures on a "per day basis" as previously allowed by CMS.

Many commercial payers have not been separately paying for specimen collection procedures in the past, considering them as routine and standard of care and part of the laboratory procedures. However, Medicare has been silent on the separate reporting of specimen collections and has accepted the charge, but rarely paid separately for the service. With this new statement included in the NCCI Manual for 2018, gross revenue will certainly be impacted for many laboratory departments throughout the country.

Other specimen collections are reported by nursing departments utilizing CPT 36591, *Collection of blood specimen from a completely implantable venous access device*

NCCI Manual 2018…(Continued)

or CPT 36592, *Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified.* The NCCI Manual, Chapter 3, has also included the following instructional paragraphs for 2018 reporting:

CPT code 36591 describes "collection of blood specimen from a completely implantable venous access device". CPT code 36592 describes "collection of blood specimen using a central or peripheral venous catheter, not otherwise specified". These codes shall not be reported with any service other than a laboratory service. That is, these codes may be reported if the only non-laboratory service performed is the collection of a blood specimen by one of these methods.

CPT code 96523 describes "irrigation of implanted venous access device for drug delivery system". This code may be reported only if no other service is reported for the patient encounter.

The inclusion of these new instructional paragraphs emphases and provides clarification for the parenthetical statement in the CPT code book found beneath both CPT codes 36591 as well as CPT 36592: (Do not report 36591/36592 in conjunction with other services except a laboratory service). Presently there are no CCI edits prohibiting the separate reporting of either CPT 36591 or 36592 with non-laboratory procedures. With the inclusion of the above instructional paragraphs, an NCCI edit may certainly be forthcoming for 2018 that will not allow CPT 36591 or 36592 to be reported on a claim form with any non-laboratory procedures.

Where is the 2018 Medicare Clinical Lab Fee Schedule?

Have you been searching for the 2018 Clinical Lab Fee Schedule on the CMS website? The fee schedule is not located at the Clinical Laboratory Fee Schedule webpage as they have been in the past. Up to 2017, the Clinical Lab Fee Schedule files were easily downloaded and contained state-specific reimbursement amounts for each of the laboratory CPT and HCPCS codes. For each year, new laboratory test codes are added to the clinical laboratory fee schedule and corresponding fees are developed in response to a public comment process. Also, for a cervical or vaginal smear test (Pap smear), the fee cannot be less than a national minimum payment amount, initially established at $14.60 and updated each year for inflation.

The Protecting Access to Medicare Act (PAMA) establishes that the Medicare payment amount for a test on the CLFS generally will be equal to the weighted median of the private payer rates determined for the test, based on the data that is collected during a data collection period and is reported to CMS during a data reporting period. The statute also provides for a phase-in of payment rate reductions for the first six years of the revised payment system. Specifically, for the first three years after implementation (CY 2018 through CY 2020), payment rate reductions for most CLFS tests, cannot be more than 10 percent per year, and, for the next three years (CY 2021 through CY 2023), the reduction cannot be more than 15 percent per year.

Where is the CLFS? - Continued

Effective January 1, 2018, CLFS rates will be based on weighted median private payer rates as required by the Protecting Access to Medicare Act (PAMA) of 2014. For more details, visit PAMA Regulations which can be directly accessed from the Clinical Lab Fee Schedule website. CMS held calls on the final rule and data reporting.

When downloading the 2018 fee schedule, the first obvious change is the lack of a "Read Me File" that provides a description of the file lay-out, explanation of the different column headings and the rationale about the laboratory changes. The second obvious change is the file name: "Final Private Payer Rate based CLFS Payment". Another significant change is the lack of state-specific reimbursement rates. Are providers to assume all states will be paid based on a national rate? The column headings appear confusing when trying to determine what reimbursement would be expected for 2018 for a specific laboratory CPT code. Are providers to use the 2018 Payment W/Cap column, or the NLA column which represents National Limitation Amount?

For Critical Access Hospitals (CAH), which are generally paid for outpatient laboratory tests on a reasonable cost basis instead of by the fee schedule, net reimbursements will not be impacted.

New Probe and Education Audits Beginning for Hospital's E&M Codes

In the September's newsletter of Revenue RoundTable, an article discussing the Evaluation and Management Code Creep provided an overview of the Medicare claims data for calendar years 2013, 2014 and 2015 showing a slow but steady creep to the higher E&M codes of 99284 and 99285 for hospital emergency room encounters.

In the proposed and final *Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs, 2018 (CMS-1678)* CMS did not mention any concerns over emergency department E&M volumes and did not reveal any plans of changing current payment policies.

We now see some industry chatter and some auditing activity where CMS may have either changed their minds or want to see what criteria providers are utilizing that might be useful when/if they issue national guidelines in the future.

In an article posted on the WPS Government Health Administrators website dated November 15, 2017, CMS has authorized a targeted probe and educate (TPE) review process to focus on the review of CPT Codes 99281-99285 Emergency department visits for facility services, specifically Type A Emergency Room encounters. WPS is one of several MACs that will begin the TPE reviews in the near future.

CMS promised for years to produce E/M facility fee coding guidelines for clinics and EDs, but they never materialized. Instead, hospitals were to develop their own methodology for reporting E/M levels of service consistent with hospital resource use and to apply them consistently. For clinics,

TPE Audits- Continued

this is not quite as an important issue since the 2014 OPPS regulation compressed five CPT codes into one HCPCS code, but hospitals must continue to report ED visit based on facility-specific criteria.

WPS instructed hospitals to provide the visit record showing the signs/symptoms that support the medical necessity of the intervention, the internal guidelines used to determine the HCPCS equivalent CPT code (99281-99285) for the hospital resources being billed, as well as the number and type of interventions under the facility charge.

WPS GHA staff will review the claim documentation to determine whether or not the submitted documentation meets the reported CPT code requirements.

CMS has been silent concerning the facility's E&M criteria since 2008 when it was stated:

CMS expects that each hospital's internal guidelines should:

- Follow the intent of the CPT code descriptor—the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code
- Be based on hospital facility resources, not physician resources
- Be clear to facilitate accurate payments and be usable for compliance purposes and audits
- Meet HIPAA requirements
- Require only documentation that is clinically necessary for patient care
- Not facilitate upcoding or gaming
- Be written or recorded, well documented, and provide the basis for selection of a specific code
- Be applied consistently across patients in the clinic or emergency department to which they apply
- Not change with great frequency
- Be readily available for fiscal intermediary (or, if applicable, MAC) review
- Result in coding decisions that could be verified by other hospital staff, as well as outside resources

Notice the guidelines do not say the codes must be distributed across the five E&M levels or any particular bell curve should be achieved. Some facilities legitimately will report a large percentage of level 4 and 5 visits, while others may skew more to the level 2 or 3. It depends on what type of patients are seen in the ED. Medicare has stated, however, that national claims data has noted a slight skew to the right year after year.

With the new TPE review, providers are once again reminded to be sure the criteria utilized to report emergency department's E&M codes are simple to understand, do not include criteria for separately reportable procedures, represent resources utilized to treat the patient and are supported by charted documentation. How does your facility's bell curve line up? Providers need to be prepared, because TPE reviews can be coming your way in the very near future.

Newsletter/About HCS

Revenue Roundtable Newsletter

Welcome to the Revenue Roundtable Newsletter. HCS HealthCare Consulting Solutions would like to introduce you to this bi-monthly newsletter, developed for the healthcare professional working within a variety of settings. The future newsletters will feature industry experts who will discuss best practices for a variety of topics plaguing healthcare providers ultimately impacting the facility's bottom line.

Subscription is "free". Comments and questions are always welcomed. Recipients of this newsletter are encouraged to share with colleagues and co-workers. To submit subscription requests, ask questions or communicate directly with the "Revenue Roundtable" newsletter editors, please e-mail: newsletter@hcsglobal.net

Contributing to this month's Revenue RoundTable news articles is Glenda Schuler.

Glenda brings an extensive background in chargemaster, billing, operations, ICD-10-CM/PCS, DRG coding and hospital CPT-4 coding, and has over 30 years of healthcare industry experience and expertise in all areas of health information, medical records, utilization review, patient access and business services. Additionally, she's an expert in third party reimbursement, electronic submission of claims, billing and collections, and revenue cycle solutions.

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About HCS

HealthCare Consulting Solutions (HCS) provides a broad spectrum of services and solutions in revenue cycle management, chargemaster, strategic pricing, coding, documentation, reimbursement, billing, compliance and education for hospitals and physician practices. Now in its twenty-second year, HCS prides itself on adding new services to better meet the ever-expanding needs of the health care industry.

HCS specializes in assisting health care providers become more efficient through increasing their payment incentives and growth in a compliant business environment. HealthCare Consulting Solutions focuses on hospital and physician consulting services that include:

- Inpatient (MS-DRGs), Outpatient (APCs) and Physician Practice Due Diligence & Compliance Risk Assessments including RAC, CERT, ZPIC, MAC/Carrier and OIG target areas;

Newsletter/About HCS…Continued

- CAH and Rural Health Clinic Compliance Audits and Education/ Training; DMEPOS Reviews, Operational Assessments and Education/Training;
- IRF, IPF, SNF, HHA and Hospice Reviews;
- Chargemaster Assessments with Training and Education;

HCS Seminars: Our seminar and education/ training division provides chargemaster, coding, billing and compliance educational programs for state hospital associations, hospital systems, and National Group Purchasing Organizations.

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On behalf of the staff, consultants, Glenda Schuler, Jeff Neustaedter and other team members of HCS HealthCare Consulting Solutions, we would like to take this opportunity to thank you for the support you have shown for the *Revenue Roundtable* newsletter. HCS would also like to wish you, your family and friends a very happy holiday season and a healthy and happy new year.

We will see you all in 2018 to tackle the new reimbursement and reporting challenges.