MEDICARE RULES
Global period, key changes in 2017 fee schedule final rule

There are fewer reporting requirements in the 2017 Medicare Physician Fee Schedule (PFS) final rule, thanks to CMS significantly relaxing its global surgical period reporting requirement, according to an exclusive analysis by The Business of Medicine.

One of the top provisions in the 2017 PFS proposed rule pertained to data reporting for all CPT codes with a 10-day or 90-day global period. As a prelude to eliminating the global surgical package, CMS planned to collect data on the types of services furnished during 10-day and 90-day global periods so that it could properly value surgical services. This provision would’ve required the addition of various new G-codes to claim lines for services furnished during the global period, and would impact a significant number of surgical procedures that are routinely performed by physicians across many specialties.

In the 2017 PFS final rule, CMS is making the following changes to the global period reporting provision:

- **Only providers in 9 states will be affected.** In the single biggest change to the provision, CMS is exempting all practices from reporting except those in the following nine states. If you are not in one of these states, your providers are exempt.
  
  - Florida
  - Kentucky
  - Louisiana
  - Nevada
  - New Jersey
  - North Dakota
  - Ohio
  - Oregon
  - Rhode Island

- **Small providers in the 9 states are exempt.** Even if your practice is within one of the nine states listed above, your providers will only be required to report data if their practice has 10 or more total practitioners (including non-physician practitioners). If your practice

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has fewer than 10 providers total, and you are in one of the nine states, you are still exempt from data reporting.

- **Data collected only for high-volume codes.** CMS is limiting data collection to CPT codes reported annually to Medicare by more than 100 providers, reported more than 10,000 times annually, or have more than $10 million in allowed charges annually. It’s not immediately clear how many codes, for both minor and major procedures, will escape these criteria, but CMS will post a final list of affected CPT codes on its website before Jan. 1, 2017. *The Business of Medicine* will follow this aspect of the rule as it develops.

- **No new G-codes.** Rather than using the proposed set of 10 new G-codes, existing CPT code 99024 (postoperative follow-up visit, normally included in the surgical package, to indicate than an E/M service was performed during a postoperative period for reasons related to the original procedure) will be used for data reporting. This makes reporting much simpler if your providers are still required to report. CMS could have required modifiers and units to be appended to 99024 to capture more data, but decided against it.

- **Only post-op visits will be captured.** Because CMS won’t create the new G-codes (which were only proposed, and thus were never assigned specific digits), the agency is limited in the data it can capture. Thus 99204 will only be used to report post-op visits, and not pre-op visits or non-face-to-face contact with patients, as the proposed rule called for.

- **Reporting becomes mandatory in July 2017.** This clarifies a statement in the proposed rule that global period data reporting may or may not become mandatory. Now CMS states that the reporting will be optional for procedures performed on or after Jan. 1, 2017, but mandatory for procedures performed on or after July 1, 2017.

**Other 2017 highlights**

Overall, the final rule for 2017 contains fairly few major provisions that weren’t already outlined in the proposed rule. Here’s a bullet-point list of the other highlights:

1. **Conversation factor up in 2017.** The overall Medicare Part B conversion factor, which is the dollar value that each

Relative Value Unit (RVU) is multiplied against to generate a fee for a reported code, is actually increasing in 2017. The conversion factor will be $35.89, up from $35.80 in 2016. The conversion factor in the proposed rule was $35.7751, which would’ve been less than in 2016.

2. **Primary care payment provisions finalized.** Several provisions aimed at increasing payment for primary care services appear in the final rule, mostly unchanged from the proposed rule. As covered in the July issue of *The Business of Medicine*, these include increased payment for chronic care management (CCM), two new CCM codes, and new prolonged service codes for non-face-to-face prolonged evaluation and management services. A new code that would boost payment for E/M services for patients with mobility problems, GDDD1, received an official assigned HCPCS code (G0501), but it will not be a paid code because CMS reversed course at the last moment.

3. **Endoscopy RVU changes.** CMS has moved ahead with multiple RVU changes for endoscopies billed by ENT physicians. Some include increased practice expense inputs for the equipment, while others reduce RVUs for the physician work component. A full analysis of these values will appear in the next issue.

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**Trump victory heralds major changes for physicians**

Donald J. Trump’s victory over Hillary Clinton in the presidential election, combined with Republicans regaining full majorities in both houses of Congress, means that major regulatory changes are coming for the healthcare industry.

This time, physicians could see the multi-faceted Affordable Care Act, or “Obamacare,” repealed, and the Merit-based Incentive Payment System (MIPS) along with it. That could just be the tip of the iceberg, because Republicans could choose to keep some elements of the law, while adding others, either as amendments or via new legislation.

Look for a detailed reaction to the significance of President Trump, and the impact of his administration on the healthcare industry, in the next issue of *The Business of Medicine.*

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4. Medicare Advantage enrollment changes. CMS is finalizing a proposal to require providers to enroll in Medicare Part B, including undergoing the usual screening process, in order to provide items and services under contract with a Medicare Advantage (MA) organization. In another change for MA payers, CMS is finalizing a proposal that requires them to be more transparent. MA plans must now release data on their bid pricing to participate with Medicare, as well as data on their medical loss ratios.

Remember, these points reflect our initial analysis of the 2017 PFS final rule. Look for more details in the December issue of The Business of Medicine.

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**COMPLIANCE**

3 ways to satisfy MIPS reporting in 2017

You have several options to guarantee that your Medicare payments won’t take a hit in 2019 under the new Merit-based Incentive Payment System (MIPS), according to an exclusive analysis of the MIPS final rule by The Business of Medicine. The final rule generally reduces the difficulty of MIPS reporting and offers easier reporting options during 2017 and 2018, which CMS is classifying as “transition” years.

“Through a staged approach, we can develop policies that are operationally feasible and made in consideration of system capabilities and our core strategies to drive progress and reform efforts,” CMS writes in the MIPS final rule. “We envision that it will take a few years to reach a steady state in the program, and we therefore anticipate a ramp-up process and gradual transition with less financial risk for clinicians in at least the first two years.”

These first two years will be used to focus MIPS on “encouraging participation and educating clinicians,” CMS writes. They will also be used to expand on Advanced Alternative Payment Models (advanced APMs), which allow participating providers to avoid MIPS reporting. The agency hopes advanced APMs will ultimately overtake MIPS in the pay-for-performance arena.

For now, let’s take a look at how CMS is allowing you to “ramp-up” your MIPS participation with these options for reporting in 2017 that ensure no payment hit in 2019:

1. **The bare minimum (little to no chance of positive update).** This option guarantees that your providers will not receive a negative payment adjustment in 2019, but it also means they won’t have much of a shot at any of the positive payment adjustments either. This option doesn’t even require a full 90-day reporting, and is satisfied by reporting any of the following:

   a. All meaningful use measures in 2017 (meaningful use is now called the “advancing care information performance category”). Five measures are required, which is reduced from the proposed rule.

   b. One quality measure (based on the Physician Quality Reporting System or PQRS, which is now simply the “quality performance category”).

   c. One activity in the “improvement activities performance category,” which includes clinical practice improvement activities such as beneficiary engagement, care coordination, etc.

2. **Mid-level participation (possibility of positive update).** Similar to the first option, if you go a step further on your reporting in 2017, you’ll not only avoid a negative adjustment but also have a decent chance at receiving a positive adjustment. You’ll need a minimum 90-day reporting period for any of the following:

   a. All meaningful use measures in 2017.

   b. At least two quality measures under the quality performance category for a period of 90 days or longer.

   c. At least two improvement activities for a period of 90 days or longer.

3. **Year-round reporting (high chance of positive update).** Providers that choose to report year-round will have an excellent chance at earning a positive update. Remember, MIPS is budget-neutral, which means that the highest performers will be rewarded while the lowest performers will be penalized. You’ll need to report year-round any of the following:

   a. All meaningful use measures in 2017.

   b. At least two quality measures under the quality performance category for a period of 90 days or longer.

   c. At least two improvement activities for a period of 90 days or longer.
a. All meaningful use measures in 2017.
b. At least two quality measures under the quality performance category.
c. At least two improvement activities.

Do you qualify for the low-volume exemption?

The MIPS final rule makes it easier for practices that simply don’t see many Medicare patients to avoid MIPS reporting entirely via the “low-volume threshold.” A full exemption from MIPS is given to practices that are below the low-volume threshold, which existed in the proposed rule but has been made significantly more generous in the final rule. Here’s how it works.

For any MIPS-eligible provider, the threshold is either $30,000 in Part B billing charges or 100 Part B beneficiaries seen, over a non-consecutive 24-month period. This was up from only $10,000 in Part B billing charges in the proposed rule (the 100-beneficiary provision is unchanged).

You don’t need to take any action to qualify. CMS determines who qualifies for the low-volume exemption by analyzing your claims data. For each eligible provider, Part B claims data from two distinct periods will be used: from Sept. 1, 2015 to Aug. 31, 2016 (dates before the 2017 MIPS reporting period), and claims data from Sept. 1, 2016 to Aug. 31, 2017 (dates during the 2017 MIPS reporting period). Whether your provider exceeds $30,000 in Part B billing charges over those periods will depend on the patients they see and the codes reported.

While CMS has officially projected that approximately 32% of Part B providers will qualify for the low-volume exemption, the reality is that a provider’s specialty will have an outsize impact on whether they will bill less than $30,000 or see fewer than 100 unique Part B beneficiaries over those two 12-month periods. Consider this rough

estimate based on average E/M reimbursement: A physician who sees two Medicare patients for office visits each day, averaging $80 billed per visit, will generate $40,000 in Part B charges over just 12 months (assuming two weeks off for vacation). This is well over the threshold, which is also based on 24 months of charges.

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EDITORIAL

At CMS, conspiracy or incompetence?

According to a recent survey of Americans, only 17% were satisfied with the way our government is working. And it’s no surprise since, in my opinion, the number one item that the government produces is confusion. So, it should be no surprise that less than half of physicians would recommend the same career to their children. One in three said that if they had to do it over again, they would choose a different career path. In that same survey, the authors reported that nearly 70% of physicians feel that their clinical autonomy and their decisions are sometimes or often threatened. I don’t care who you are, that’s sad.

There are many reasons that physicians give so I am not going to project my opinion onto others, but I can give you some examples that, if nothing else, frustrate the heck out of pretty much everyone who has to do business with CMS. We all know about the ALJ problem. It is projected that there will soon be a backlog of 1.5 million ALJ appeals. In FY 2016, OMHA’s total annual adjudication capacity totaled approximately 85,000 appeals. That’s a backlog of nearly 20
years. Heck, that’s worse than the backlog of court cases in India; not a very good benchmark for the U.S. The backlog becomes even more frustrating when the data shows that over 60% of cases reviewed result in either a full or partial reversal in favor of the provider.

So here’s one more issue to add to the list of complaints against CMS. Recently, we were contacted by one of our clients regarding the use of a specific orthopedic procedure code and whether it violated NCCI edit policies when used with other procedure codes for the same patient by the same provider on the same day. The issue was first raised by my colleague Sean Weiss, who heads up the Appeals and Regulatory Compliance division at DoctorsManagement, LLC. Specifically, according to Sean, the NCCI edits have denied CPT code 29823 (arthroscopic shoulder debridement, extensive, with several other arthroscopic shoulder procedures) such as 29827 (arthroscopic rotator cuff repair), or 29824 (arthroscopic distal claviculectomy).

In a recent change, CMS stated that, effective July 1, 2016, this situation would be remedied via an update to the NCCI database, with these restricted edit pairs being retired. This meant that, effective July 1, 2016, a practice would be able to separately bill for 29823 alongside the other procedures listed above and expect to be paid.

Seems simple enough, but when Grant Huang, DM’s Director of Content followed up on this, what he found was more confusion than clarity. Grant found that, even though the NCCI edit database had been updated, the NCCI manual had not and Chapter IV, Section E, Paragraph 6 of that manual states the following: "With the exception of knee arthroscopy, (29877, 29874, G0289) debridement should not be reported with another surgical arthroscopy procedure, same joint, same encounter." So the wording in the NCCI manual conflicted with the updated release and the information in the database. Which one is correct?

Well, Grant followed up with an email to CMS detailing the problem and looking for some guidance as to whether the client could, in fact, now bill and expect to be paid based on the elimination of these edit pairs from the database. Here was the response from CMS:

*I apologize for the delay in our response. In general, changes to the NCCI edits may be made on a quarterly basis. However, the NCCI Manual is only updated annually. The edits noted..."
Imagine calling the IRS to ask whether a certain deduction is permissible and the “expert” on the other end of the line says “yes.” So, you take that deduction and then two years later are told it was not, in fact, permissible and you have to pay it back along with penalties and interest. The “expert” was wrong, but you are told that it was your responsibility to get this right, not that of the IRS expert. And I give this example from personal experience. Wouldn’t you be mad?

While I am critical of the work that CMS does, I don’t normally hurl insults without having some factual support so when I use the word incompetence, I am doing so with a complete understanding of what it means and how it is applied. In general, incompetence means the inability to do something successfully. I say that a 4% success rate, which is a 96% failure rate, adequately defines the inability to do something successfully. Waiting almost 20 years for a hearing that, according to statute, shouldn’t take more than a few months? I say that is the inability to do something successfully. Having 60% or more of your findings overturned on appeal? The inability to do something successfully. Not being able to update a written policy except once a year, creating conflict, chaos and confusion? The inability to do something successfully.

This problem has become so big that it overwhelms logic and reason. It has become like a speeding train heading down a steep grade. Apply the brakes and all you get is smoke. Try to change direction and you get derailed. After working in this industry for some 40 years in many different capacities, at least to me, our industry starts to look like the island of misfit toys. I have a friend who thinks that this is all being done on purpose; that it is some grand conspiracy to make such a mess out of the current system that nationalized healthcare starts to look like the only option left. For me, I tend to follow Hanlon’s Razor, one of my favorite eponymous laws. In general, it states the following: “Never attribute to conspiracy that which is adequately explained by incompetence.”

And that’s the world according to Frank. Many thanks to Grant Huang and Sean Weiss of DoctorsManagement for their contributions to this article.

— Frank Cohen (fcohen@drsmgmt.com). The author is Director of Analytics and Business Intelligence at DoctorsManagement.
MIPS sees changes in its final rule

CMS has chosen to compromise with providers in its final rule for the Merit-Based Incentive Payment System (MIPS), not only offering easier reporting during the first two years of the program, but also reducing the amount of measures required for MIPS components.

CMS has stated that 2017 will be a transition year, during which providers and the agency itself will “build capabilities to report and gain experience with the program.” Let’s take a deeper look at how the MIPS final rule differs from the proposed rule.

First, remember that MIPS consolidates four existing Medicare quality programs into a single new program, and each of the four programs have been renamed as MIPS performance categories. They are Quality (formerly PQRS), Advancing Care Information (formerly meaningful use), Clinical Practice Improvement Activities (same name), and Cost (formerly Value-based Payment Modifier). Each category is weighted a different amount but all contribute towards a single MIPS “composite” score which is a value from 1 to 100.

1. Cost category won’t count in 2017. The cost performance category, previously slated to be worth 10% of your MIPS score, now won’t be counted during the 2017 reporting period for MIPS, a major change in the final rule that skews the other three categories. Now the quality performance category will be worth 60% of your MIPS score, while advancing care information will be worth 25% and clinical practice improvement 15%. The cost category will still be calculated by CMS based on your claims data and will count toward your MIPS score in years 2018 and beyond.

2. Meaningful use reporting requires less measures. You will only need to report a total of five measures under the advancing care information performance category which replaces meaningful use. This is down from 11 measures in the proposed rule, and while it represents a concession by CMS, it may not help you as much as you think. Many practices who are able to report all 11 measures because they’ve done it under the old meaningful use program will have no problem continuing to do so, which means they’ll be likely to get higher scores and more MIPS money than practices that just choose to do the easier five-measure minimum.

3. Payments and bonuses for 2019. The maximum Medicare Part B payment adjustment, positive or negative, will still be 4% in 2019 based on 2017 reporting. There is a separate $500 million budget set aside in the MIPS program to reward providers who participate and score exceptionally well, with CMS setting a threshold score to determine who gets bonus payments from this budget. In the final rule, CMS has set a MIPS score of 70 or higher as its threshold for a share of that $500 million pot. The MIPS baseline score will be 3 points, which means any provider scoring 3 points or higher will avoid a negative adjustment. This is a very low baseline, which means only providers who completely avoid MIPS will go below 3 points and receive a negative payment adjustment. Instead, most providers will receive a neutral adjustment and some will receive a positive adjustment.

4. Advanced Alternative Payment Models (APMs) still in progress. Another way out of MIPS reporting is participation in Alternative Payment Models (APMs) that are determined to be “advanced” by CMS. This includes participating in certain Accountable Care Organizations (ACOs) and Medicare Shared Savings Programs (MSSPs), so long as they are certified “advanced” by CMS.

More APM details to come

Providers who participate in an advanced APM are able to avoid MIPS reporting entirely because CMS exempts them. They also receive a regular positive payment update of 5% to their Medicare fee schedule rates each year, with more future bonuses in future program years.

Despite the release of the MIPS final rule, full details on advanced APMs are still incomplete, our analysis shows. CMS states in the final rule that it expects to release a longer, more detailed list of payment models that will be designated as “advanced” APMs later this year, though time is rapidly running out. The list of ACOs currently recognized as advanced is short, but the agency is required to release its more complete list before Jan. 1, 2017 so that practices could consider whether they would be eligible for APM participation.

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